

***FAILING TO ACT:***  
**NEW YORK STATE'S DEPARTMENT OF HEALTH  
AND THE PATIENT SAFETY CRISIS**  
**EXECUTIVE SUMMARY**

This report examines New York State's leading programs designed to protect patients from substandard health care. It examines the New York State Health Department's efforts to police questionable doctors and physicians' assistants, to educate the public and to track medical mistakes.

**SUMMARY OF FINDINGS**

**Finding:** New York State is taking fewer actions against physicians and physicians' assistants (PAs), despite a doubling of resources, legal reforms and its stated goal of reducing medical injuries.

**Finding:** Of that shrinking percentage, those few physicians and PAs who are disciplined are often punished for reasons that have nothing to do with their competency to deliver safe and quality medical care.

**Finding:** A substantial proportion of the Health Department's Office of Professional Medical Conduct (OPMC) sanctions are based the results of discipline meted out in other jurisdictions. The percentage of sanctions based on investigations originally initiated by OPMC in New York is declining.

**Finding:** A large percentage of sanctions imposed by OPMC permit physicians and PAs to continue to practice without interruption in New York State.

**Finding:** Scores of physicians' profiles are missing critical information, three years after enactment of the law.

**SUMMARY OF RECOMMENDATIONS**

**Disclose quality information to the public.** New York State must mandate reporting of hospitals' and physicians' comparative performance.

**Require physicians to demonstrate their medical skills.** New York State should require that physicians periodically demonstrate their continued competence as a condition of licensure.

**Mandate that the OPMC use medical malpractice information to initiate investigations.** The OPMC must proactively review physicians' malpractice experience and initiate investigations as appropriate.

**Require that health professionals report medical mistakes to patients.** New York State should codify the ethical requirement that health care providers and professionals inform patients or patient's family or friends when a medical errors causing harm has occurred.

**Regulate surgeries performed in physicians' offices.** New York State should require that serious harm occurring as a result of office-based surgery be reported to the Health Department.

**Create an OPMC consumer assistance office.** A consumer-friendly office should be created to help consumers understand when a complaint is appropriate for OPMC, if not where else to seek redress, and to shepherd them through the process, including advising them about the progress of the complaint.

**Get the public involved in OPMC.** The Board of Professional Medical Conduct should have more public members, they should be included in leadership positions, and hearing and appeals panels should, in some cases, consist of a majority of public members.

**Punish physicians and providers who don't report observed medical misconduct.** Few physicians report observed misconduct by their colleagues and co-workers. Once an action is taken against a physician, OPMC should review the relevant medical records to identify and if appropriate to punish any physician who has observed, but failed to report medical misconduct.

**Require that the Patient Safety Center refer to OPMC the names of physicians who have failed to disclose practice information for their profile.** There appears to be physicians who have either filed incomplete profiles, or none at all. The Department must act.

**Require that all health facilities and physicians' offices post information on how patients and other members of the public can access the physician profiles program.** The public should have easy access to physicians' background information. New York State requires the disclosure of such information, but the public is largely unaware of the existence of this data. In addition, many disciplined physicians are allowed to continue to practice and there is virtually no way for patients to know this fact.

## ***FAILING TO ACT:*** **NEW YORK STATE'S DEPARTMENT OF HEALTH AND THE PATIENT SAFETY CRISIS**

People approach hospitals and health care professionals expecting to be helped – to find relief or cure for their symptoms caused by illness and disability. But every health care intervention has a risk of harm. Often, that harm is due to the unavoidable risk inherent in the nature of the treatment – for example every prescription drug has the potential to be toxic as well as beneficial. But far too frequently, patient harm occurs because of a preventable medical mistake – for example, a wrong and toxic dose of a drug is administered to a patient by mistake.

The protection of patients from avoidable harm at the hands of New York's licensed health care providers and professionals is the responsibility of the Governor, the state legislature, the Department of Health, and to a lesser extent, other state agencies. Yet, despite verbal assurances that patient safety is an important issue in New York State, our findings indicate otherwise. Indeed we find no evidence that state policy makers and state government are working with a sense of great urgency and priority that we suggest is appropriate for a problem that kills thousands of New Yorkers each year and injures many more. This is especially unforgivable when so much is known about how to reduce the human and economic toll from medical errors. And, while New York's political leadership often point to New York as a leader in high quality medicine, our findings lead us to conclude that view is simply wishful thinking.

### **BACKGROUND: THE IOM STUDY AND THE NEW YORK STATE RESPONSE**

#### *To Err is Human*

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

## LEADING CAUSES OF DEATH IN AMERICA<sup>1</sup>

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

As the above chart shows, patient deaths resulting from medical mistakes in hospitals are either the fifth or ninth leading cause of death in America. Furthermore, the IoM estimated that \$17 to \$29 billion (\$1 to \$2 billion in New York State) is added to the nation's health bill for taking care of the medical needs of patients injured by medical mistakes. The \$17-29 billion cost estimate dwarfs the aggregate of the medical malpractice premiums currently paid by physicians nationwide.<sup>2</sup>

Moreover, the IoM estimates of injury and cost are considered by many experts to be low because the report did not look at medical errors occurring outside of hospitals; for example, 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.

### *New York State Health Department's Response*

Soon after the Institute of Medicine called for a 50 percent reduction of medical errors by within five years, New York State's Health Commissioner pledged to meet the IoM goal.

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<sup>1</sup> U.S. Centers for Disease Control and Prevention and the Institute of Medicine. From New York State Conference of Blue Cross and Blue Shield Plans, "The Facts About Medical Errors," [www.nysblues.org](http://www.nysblues.org).

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

## **THE FIRST LINE OF DEFENSE – THE OFFICE OF PROFESSIONAL MEDICAL CONDUCT**

State government is traditionally charged with licensing and monitoring the conduct of health care professionals. In New York State the first line of defense in assuring that misconduct by physicians and physician assistants (PAs) is investigated and, when appropriate, punished, is the Health Department's Office of Professional Medical Conduct (OPMC).

The vast majority of physicians in New York State practice medicine that meets the high standards of professional conduct. However, those who are guilty of misconduct can cause enormous pain and suffering for their patients. Because it is the licensing authority, the state must act forcefully and quickly to minimize the harm to patients that is often the result of professional misconduct.

### **THE OFFICE OF PROFESSIONAL MEDICAL CONDUCT**

There are 74,063 licensed physicians in New York, of which 56,995 actively practice medicine within the state.<sup>3</sup> New York licensed physicians practicing out of state, or otherwise not in active practice in New York, must keep their license current by paying the \$600 biennial fee – a custom common in other professions.

The OPMC is charged with monitoring physicians and physician assistants and intervening when it concludes that such professionals pose a threat to the public because of their misconduct. It employs a staff of investigators and prosecutors to investigate complaints and file charges. The Board of Professional Medical Conduct (BPMC) is responsible for hearing cases and taking action against licensees after they have been formally charged by the OPMC. The Board is comprised of almost 200 members that are available to hear cases against physicians in the presence of an administrative law judge. Usually a three member BPMC panel – two physicians and one "public" member – sit to hear the case and decide the punishment. The vast majority of formal charges brought by the OPMC staff result in an action being taken against a licensee by the BPMC panel.

### **1996 REFORMS**

In 1996 changes in state law governing professional medical conduct were enacted in order to strengthen the OPMC's ability to investigate and punish physicians. This section examines the actions taken against physicians by the OPMC during the administration of Governor Pataki to see if the anticipated

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<sup>3</sup>The Federation of State Medical Boards of the United States, Inc., *Summary of 2002 Board Actions*, April 2003.

improvements in enforcing physician discipline have actually occurred. For our analysis we have relied on information derived from reports of completed disciplinary actions routinely disseminated by the Health Department. This information is posted on the Department's website and provides the names of physicians and physician assistants who were punished by OPMC, the action taken against them and a very brief summary of the charges and findings.

Governor Pataki proposed changes in state law with two major objectives. First, to hire a larger and better-trained investigative and prosecutorial staff so as to more effectively discover and punish misconduct. To fund this expansion New York biannual physician licensing fees were doubled to \$600 and the revenue dedicated to OPMC. A second objective was to remove certain legal obstacles that prevented OPMC from taking timely actions against dangerous and criminal doctors.<sup>4</sup> The Governor stated, "Patients who put their lives and health in the hands of doctors have a right to know quickly if physicians break that trust. Doctors deserve the public's respect and this legislation will help ensure that they keep it by strengthening confidence in the physician discipline process."<sup>5</sup>

What follows is an analysis of the trends in OPMC's annual disciplinary actions for the years both before and after the 1996 changes in the law. We reviewed OPMC's performance to see to what extent, if any, the objectives of 1996 changes in law had been met and whether the Governors promise of "strengthening the confidence in the physician discipline process" has been achieved.

**FINDING: NEW YORK STATE IS TAKING FEWER ACTIONS AGAINST PHYSICIANS, DESPITE REFORMS, ADDITIONAL RESOURCES, AND A STATED GOAL OF REDUCING MEDICAL INJURIES.**

A review of OPMC activity from 1995 through 2002 reveals a total of 2,789 sanctions against physicians. OPMC's productivity shows a disturbing trend: despite steady growth in the number of physicians practicing in the state, the number of sanctions is declining. According to the tallies kept by Federation of State Medical Boards on physician discipline in all states, the number of OPMC sanctions in 2002 was the lowest since 1998 – the year in which a number of "improvements" to the discipline process took effect. Moreover, New York State's national ranking in terms of disciplinary actions dropped to its lowest during the Pataki Administration.

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<sup>4</sup>The 1996 state budget increased physicians' licensing fees from \$300 to \$600 every two years. Chapter 627 of the laws of 1996 (Senate bill 7779) strengthened OPMC's policing powers.

<sup>5</sup> Governor Pataki news release, "Governor Pataki Moves to Improve Doctor Discipline," 6/5/96.

**NUMBER OF OPMC “PREJUDICIAL ACTIONS” TAKEN AGAINST  
PHYSICIANS<sup>6</sup>**

<b>Year</b>	<b>Number of prejudicial actions</b>	<b>Total number of physicians in New York State</b>	<b>National Ranking<sup>7</sup></b>
1995	336	66,817	17
1996	314	67,218	18
1997	334	69,340	16
1998	346	70,180	16
1999	365	71,010	14
2000	390	72,290	10
2001	365	72,920	14
2002	339	74,063	20

In 1996, legislation was passed that made it easier for the Health Department to sanction physicians guilty of misconduct. For example, the new laws discontinued the practice of automatically "staying" (allowing the physician or PA to continue to practice despite the penalty, essentially a form of probation) the determination of a board or committee of medical conduct pending an appeal initiated by either the licensee or the department of health in cases when the doctor's misconduct was determined to be egregious, grossly incompetent or grossly negligent as defined in the public health law.

In addition, the state doubled physicians' licensing fees and earmarked the additional revenue for OPMC enforcement efforts through the addition of more investigators and prosecutors.

Despite these changes, starting in the year 2000, the OPMC began taking fewer actions against physicians and PAs. Underlying their support of the 1996 changes in the law by policymakers and advocates was the assumption that adding more and better trained investigators and prosecutors would result in more sanctions for misconduct. In fact, the opposite has occurred. As the above chart shows, fewer actions of being taken, despite an increasing number of state-licensed physicians and no evidence of a decline in the amount of medical misconduct.

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<sup>6</sup> Federation of State Medical Boards, *Annual Reports* 1995 through 2002.

<sup>7</sup> Public Citizen Health Research Group, "Ranking of State Medical Board Serious Disciplinary Actions in 2002," see Table 2.

**FINDING: TOO FEW PHYSICIANS ARE BEING DISCIPLINED AND NOT ENOUGH ARE BEING SANCTIONED FOR JEOPARDIZING PATIENT HEALTH AS A RESULT OF POOR QUALITY MEDICAL CARE.**

Very few of New York State's doctors ever face a serious disciplinary action. The 339 completed actions taken by OPMC in 2002 must be judged in light of the staggering number of patients harmed by negligent medical care annually. *The Harvard Study of Medical Practice*, a rigorous research study of negligent medical care commissioned by the New York Legislature, found that 1 percent of the representative sample of those treated in hospitals in the state were injured due to negligence. For one out of four such patients, the injury was fatal. Applying this to all those hospitalized in New York State in any given year translates into nearly 7,000 deaths and 20,000 injuries.<sup>8</sup> The Harvard findings were consistent with other studies conducted in the state of California and by the federal government's Institute of Medicine.<sup>9</sup>

Studies have shown that when these estimates are expanded to include general medical practice outside of the hospital, the potential harm by physicians is even greater. According to researchers who published their findings in *The Journal of Family Practice*, an "in-depth interview with 53 family physicians revealed that 47% of the doctors recalled a case in which the patient died due to physician error. Only four of the total reported errors led to malpractice suits, and none of these errors resulted in an action by a peer review organization."<sup>10</sup>

In addition, a recent Florida study documented unnecessary injuries occurring in physicians' offices. According to the study of surgical errors in physicians' offices, patients were ten times more likely to be harmed due to medical errors than when they had the same surgery in more highly regulated health care facilities.<sup>11</sup>

Given the magnitude of medical negligence, we believe there should be more actions taken against incompetent physicians. According to Public Citizen Health

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<sup>8</sup>Brennan, T. et al, Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I, *New England Journal of Medicine*, Vol. 324, No. 6, 2/7/91, p.373.

<sup>9</sup> Wolfe, S., M.D. et al, Questionable Doctors Disciplined by State and Federal Governments, *New York Edition*, 1998, Public Citizen Health Research Group, p. 10. Institute of Medicine, *To Err is Human*.

<sup>10</sup> Wolfe, S., M.D. et al, Questionable Doctors Disciplined by State and Federal Governments, *New York Edition*, 1998, Public Citizen Health Research Group, p. 10.

<sup>11</sup> Vila, H., Soto, R., et al, Comparative Outcomes Analysis of Procedures Performed in Physician Offices and Ambulatory Centers, *Arch Surg/Vol. 138, Sept. 2003*, p. 991.

Research Group, "It is not unreasonable to estimate that at least 1 percent of doctors in this country deserve some serious disciplinary action each year."<sup>12</sup> Using Public Citizen's estimate, the OPMC should be disciplining at least 740 physicians (approximately twice the present number) each year.

Public Citizen's estimate was derived from the analysis of studies published by Tufts University and the AMA. In fact, the Tufts study shows that the Public Citizen estimate may be a conservative one. According to that study, "physician-owned malpractice insurers sanctioned 13.6 of every 1,000 doctors they covered."<sup>13</sup>

Despite the well-documented evidence that patients are needlessly injured and killed as a result of substandard medical care, only a small portion of OPMC actions are based on clinical quality concerns. Since 1995, in no year did it appear that a majority of OPMC actions were based on a judgment that there was substandard quality care. The vast majority of OPMC actions are either based on an out-of-state action against a physician holding a New York State license or stem from physician misconduct (criminal behavior for example) that is unrelated to clinical quality. With greatly increased resources, it was hoped that OPMC could do a better job of ferreting out incompetence. The evidence suggests that has not happened.

**PERCENTAGE OF OPMC ACTIONS TAKEN DUE TO  
POOR QUALITY CARE<sup>14</sup>**

<b>Year</b>	<b>Percentage actions based on poor quality care</b>
1995	23.5%
1996	22.5%
1997	29.5%
1998	32.9%
1999	40.3%
2000	38.9%
2001	31.2%
2002	28.6%

<sup>12</sup>Wolfe, S. M.D. et al, Questionable Doctors Disciplined by State and Federal Governments, New York edition, 1998, Public Citizen Health Research Group, p.12.

<sup>13</sup> Schwartz, W. et al. The Role of Physician-Owned Insurance Companies in the Detection and Deterrence of Negligence, *Journal of the American Medical Association*, 1989, 260(10), p. 1342-1346.

<sup>14</sup> Actions taken from reports issued by OPMC, percentage by authors. Reviewers examined OPMC report summaries and determined if the action taken was based on in-state, poor quality care. Terms used in OPMC reports that were in-state and which used the terms "negligence," "failure to maintain records," "misconduct," were considered "poor quality care." The authors conducted no independent review of OPMC records to confirm the performance, we relied entirely on publicly disclosed summaries.

**FINDING: A LARGE PERCENTAGE OF OPMC ACTIONS WERE BASED ON ACTIONS AGAINST A LICENSEE BY OTHER STATES, THE FEDERAL GOVERNMENT OR THE COURTS, NOT DIRECTLY AS THE RESULT OF AN OPMC-INITIATED INVESTIGATION.**

During the period January 1995 through the December 2002, the OPMC sanctioned 2,789 physicians and physician assistants who were licensed to practice in New York State. However, a large percentage was actions based on the convictions or sanctions of physicians by other governmental agencies. As the chart below shows, in the last two years a majority of OPMC actions were based on investigations and prosecutions by others. In fact, in the best year (1998) nearly 40 percent of actions were based on the work of other jurisdictions. By comparison, the national average of actions by state physician discipline agencies based on actions of other jurisdictions for that year was 27 percent, according to the Public Citizen Health Research Group.<sup>15</sup>

By 2002, according to our analysis, over half of OPMC sanctions were based on disciplinary actions taken by a federal or another state agency. While it is important that the OPMC act when another agency has identified physician misconduct, it is the more critical task of identifying and punishing misconduct by doctors who are currently active in New York State that must occupy the attention of OPMC investigators.

**PERCENT OF ACTIONS TAKEN INITIATED BY OPMC<sup>16</sup>**

<b>Year</b>	<b>Percentage of OPMC-initiated actions</b>
1995	34.8%
1996	39.9%
1997	48.6%
1998	60.8%
1999	55.5%
2000	55.5%
2001	46.8%
2002	43.1%

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<sup>15</sup> Wolfe, S., M.D., et al, Questionable Doctors Disciplined by State and Federal Governments, New York Edition, 1998. Public Citizen Health Research Group, p. 23.

<sup>16</sup> Actions taken from reports issued by the OPMC, percentage by authors. Reviewers used OPMC reports to determine the source of the action. If the action against a physician was taken based on another state's action, or by the federal government, or by other agencies (the courts), the action was deducted from the total actions that year. The remaining total was then divided by the total actions taken and produced the above percentage.

**FINDING – A LARGE PERCENTAGE OF PHYSICIANS WHO WERE SANCTIONED CONTINUE TO PRACTICE.**

A large percentage of physicians who were sanctioned by the OPMC continued to practice. It is highly unlikely that such physicians’ patients are aware of their physician’s punishment. A patient can only find out about such a disciplinary action if: (1) they know how to access this information through the Health Department's web-site<sup>17</sup> or 800 hot line number; and, (2) they take the initiative to do so. There is at present no requirement that patients be routinely told that their physician is practicing under some sanction and/or license limitation. The chart below focuses on the percentage of physicians who practice in New York State, were disciplined by the Department of Health and, as a result, lost their license to practice for more than 30 days in one year.

**PERCENTAGE OF DISCIPLINED NEW YORK STATE PHYSICIANS WHO WERE DISCIPLINED AND WHO LOST THEIR LICENSE, FOR MORE THAN ONE MONTH<sup>18</sup>**

<b>Year</b>	<b>Percentage of physicians who lost their license</b>
1995	59.5%
1996	62.9%
1997	49.5%
1998	53.0%
1999	46.3%
2000	57.5%
2001	59.8%
2002	44.8%

**NEW YORK’S PATIENT SAFETY CENTER**

In 2000, the creation of a Patient Safety Center was touted by Governor Pataki as an important patient safety measure.<sup>19</sup> Although originally envisioned to have other safety responsibilities, the Center was subsequently assigned the newly created Physician Profile program that permitted New Yorkers to easily access a doctor’s background. Governor Pataki and the legislature supported physician profiles because, in the words of the Health Department:

“Deaths can be avoided by providing patients with access to information that better informs them of physicians’ education, training, credentials and

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<sup>17</sup>Address for the website is: [www.health.state.ny.us/nysdoh/opmc/main.htm](http://www.health.state.ny.us/nysdoh/opmc/main.htm). Disciplinary and other information about physicians can also be found at [www.nydoctorprofile.com](http://www.nydoctorprofile.com).

<sup>18</sup> This category examines the percentage of physicians who lost their license. This category includes “revocations,” surrenders,” and “suspensions” that exceed 30 days.

<sup>19</sup> Governor Pataki comments on Patient Health Information and Quality Improvement Act of 2000, <http://www.health.state.ny.us/nysdoh/healthinfo/pataki.htm>.

experience and enables patients as consumers to actively participate in one of the most important health care decisions – the choice of physician. Immediate adoption of this rule is necessary in order to provide access to information, as well as timely reporting of updated or new information, which is of the utmost importance to consumers making decisions concerning access to high quality health care services.”<sup>20</sup>

The profiling system requires physicians to self-report educational, board specialty, disciplinary, hospital credential and malpractice history, among other information. The inclusion of malpractice information – while publicly available at any courthouse – was vigorously opposed by the Medical Society of the State of New York. As part of the compromise that led to passage of the legislation, the profile system provides only limited malpractice information. Physicians only must post categorical information about the size of malpractice judgments or settlements and in the case of settlements. In addition, physicians are required to report all payments that result from a verdict and only required to report all settlement information once they have paid three or more settlements over ten years. Prior to a third settlement, information about the first and second settlement is not required to be posted on the profile unless the Commissioner deems it important for consumers to know of such payments. The Department has required that physicians report information on the first two settlements if the malpractice resulted in the “death or permanent injury” of the patient.<sup>21</sup>

**FINDING: PHYSICIANS’ PROFILES APPEAR TO BE MISSING CRITICAL INFORMATION. WORSE, MANY PHYSICIANS’ PROFILES ARE STILL NOT COMPLETE THREE YEARS AFTER ENACTMENT OF THE LAW.**

In May 2003, our groups reviewed physicians’ profiles posted on the state website and found it lacking. We collectively filed a complaint with the Department regarding the failure of some physicians to disclose information on their profiles.

We compared that profile information with data obtained from commercially and publicly available sources. We reviewed all malpractice actions listed for years 2001 and 2002. In cases where there was a verdict, a settlement resulting from a wrongful death, or a “permanent” injury we checked to see if that payment had been recorded on the Department’s physician’s profile. Obviously, we had to rely on the accuracy of the sources and of the summary of the case.

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<sup>20</sup> Title 10 NYCRR, Part 1000, “physician profiling”

<sup>21</sup> Title 10 NYCRR, Part 1000.3 (b)(2).

Presuming the data we used for validation was correct; we potentially identified fifty physicians whose profile was missing required and critically important information. Our organizations requested that the Department comprehensively review the information contained in the physician profiles, starting with the malpractice data, for accuracy and completeness. It was our understanding that state law already requires that malpractice insurance carriers report all malpractice payments to the department. If insurance carriers are in compliance, the Department has readily available a comprehensive database of malpractice payment information and should be able to easily verify the validity of the information submitted for posting. The Department has to date not responded to our complaint.

Prior to issuing this report, we reviewed the physicians that we had identified as missing critical information on their profiles in our May complaint to the Health Department. This report's review found that 42 of the 50 *still* are missing information that should be contained on their profile or their profile was absent completely.

## **HOSPITAL REPORTING IN NEW YORK – A DISAPPOINTING TRACK RECORD**

### **Why “performance” reporting improves medical care.**

Nationally, experts have concluded that the adage “practice makes better” applies to much of medical care. A growing number of published studies do provide evidence that volume and high quality outcomes are related for a number of diverse medical conditions and interventions such as cardiac surgery, cancer and AIDS treatment. In light of such studies, and because it makes common sense, it is reasonable to view procedural and diagnostic volume as an important indicator of a hospital's or physician's experience.<sup>22</sup>

In the mid-1990s, the General Accounting Office issued a report on how consumers and employers perceive their health information needs. The GAO found that employers and consumers were using available health information to select providers and plans. Employers were using health information to monitor the performance of providers and to negotiate with insurance carriers. The GAO quoted one employer as stating, "We'd like to get some kind of value-based decision for purchasing health care."

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<sup>22</sup> Chassin, M., *Achieving And Sustaining Improved Quality: Lessons From New York State and Cardiac Surgery*, *Health Affairs*, Vol.21 No., 4, July/August 2002.

Yet both groups wished that they had access to more specific and unbiased information. According to the GAO, "Employers and consumers we interviewed also reported that the most useful information would measure health care outcomes." The GAO reported that one comment heard during their interviews was, "The number one thing people ask ... is not ... 'Am I going to get that mammogram?' it's ... 'Am I going to die?'"<sup>23</sup>

In addition to the public demand for better public disclosure of health data, there are beneficial "sentinel effects" to public disclosure as well. The term "sentinel effect" describes the powerful influence on physician and hospital behavior that often occurs when details about the quality of their practice and their experience are shared with other physicians and health professionals and with the public.

Second opinion programs for surgery are illustrative of this sentinel effect. The fact is that most second opinions agree with the first doctor's recommendations. Yet second opinion programs have shown to reduce medically unnecessary surgery and are mandatory in many insurance plans. It appears that the "first opinion" is likely to be more medically appropriate when it is understood it will be reviewed by a peer. Besides mandatory second opinions for certain procedures, many health plans insist on both pre-admission reviews before non-emergent hospitalization. Peer review and pre-certification are centerpieces of today's managed care approach to health insurance and reimbursement benefits.

#### **New York State, once a leader in disclosure.**

Quality and performance information shared with the public can exert great leverage on medical practice. In a statement commenting on the then just-released Harvard Medical Practice Study (February 28, 1990), former New York State Health Commissioner David Axelrod said:

*"The most important single development in the evolution of oversight, the definition of malpractice and its standards, may be the burgeoning of provider-specific information available to all parties of interest. The wide availability of information on the outcomes of care and procedures may serve as an incentive for the future conduct of health care providers in preventing substandard medical practice."*

New York's Health Department concluded in 1990 that disclosing information about hospitals performance would enhance patient safety. As discussed above studies done in New York and other states show that, in general, hospitals, doctors

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<sup>23</sup> General Accounting Office, "Health Care: Employers and Individual Consumers Want Additional Information on Quality," (September, 1995).

and medical support teams that do a higher number of procedures in a given year have a better outcome record.<sup>24</sup>

New York State's Cardiac Surgery Bypass report is an example of how successful disclosure can play a major role in improving the quality of medical care. Since 1989, hospitals collect and report to the Health Department detailed information on the pre-operative condition of all cardiac bypass patients, as well as information on the risk-adjusted outcomes of those patients' treatment.

Since the state's first disclosure of surgeon and hospital-specific risk-adjusted cardiac bypass surgery mortality rates and volume, there has been a dramatic reduction in cardiac surgery mortality rates. According to the Department, the state average risk adjusted operative mortality rates for cardiac bypass patients dropped by 41 percent over the first three years of the program.<sup>25</sup> Public release of this data has clearly forced hospitals and surgeons to re-examine their practices and has resulted in a reduction of operative risks for patients.

Unfortunately, the state appears to have become less interested in the cardiac surgery performance reporting program over time. The most current cardiac surgery report is woefully out of date; there has been only one report on angioplasty, also out of date, and no reports on pediatric cardiac surgery or valve surgery. While willing to take credit for national leadership in this area, the state appears less willing to devote the resources necessary to ensure that the data is current and that all cardiac procedures are included.

#### **The failure to expand the program.**

In 1996, as part of the Health Care Reform Act, the State Health Department was required to expand its system for reporting hospital data. Building on the success of the Cardiac Bypass Surgery Mortality reports, policymakers were hoping that New York would expand hospital performance measurement and reporting to include other types of surgical and treatment procedures.

Despite the success of public disclosure of cardiac bypass operative mortality data and the approval of the legislation by the Governor and state lawmakers, creating a statutory requirement, the State Health Department has yet to produce these report cards.

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<sup>24</sup> For the most recent article on this issue, see Birkmeyer, J., Stukel, T., et al. Surgeon Volume and Operative Mortality in the United States, *New England Journal of Medicine*, 349:22, 11/27/03, p.2117.

<sup>25</sup> Chassin, M., Achieving And Sustaining Improved Quality: Lessons From New York State and Cardiac Surgery, *Health Affairs*, Vol.21 No., 4, July/August 2002, p. 45.

**Recent calls for expansion of health care disclosure, consumer groups issue their own analysis.**

In an effort to build pressure on the Department to act, a consumer organization analyzed hospital reporting data and released its own report. Published by the Center for Medical Consumers, the report examined carotid endarterectomy surgery (CE) volumes of New York doctors and hospitals. The report found that, despite the overwhelming published evidence that surgeons and hospitals performing low volumes of this procedure put patients in greater jeopardy, *one third of New York surgeons who performed the operation did only one procedure in the year 2000.*<sup>26</sup>

Based on what is known about the relationship of volume and outcome for CE, the reality that so many surgeons who perform this complex, risky vascular procedure do so only once a year should give New Yorkers reason for concern.

Using published definitions of low volume, the groups' analysis showed that in the year 2000 **more than 50% of the surgeons and almost 85% of the hospitals that performed CE in New York State fell into the low-volume category.** As a result, barring publication of the groups' report, hundreds of New Yorkers contemplating carotid endarterectomy surgery would have no way to know how to avoid being put in harm's way.

Based on the analysis of hospital and surgeon specific carotid endarterectomy surgery volumes in New York State, the organizations urged that the New York State Department of Health require that hospitals apply for approval to perform carotid endarterectomy under article 28 and New York State's Certificate of Need program. The Department of Health and the State Hospital Review and Planning Council would then apply approval review criteria for CE surgery, including setting minimum hospital volume standards, as it has applied when reviewing applications for establishing cardiac surgery programs.

In addition, the groups urged that the Department of Health evaluate the current criteria used by hospital credentialing committees to credential doctors to perform CE surgery. Current criteria appear to permit very low volume surgeons (performing 4 or fewer CE surgeries) to be credentialed despite the potential risk they present to patients. The Department has ignored these recommendations.

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<sup>26</sup> Some of the physicians listed as doing only one CE procedure may have had their license number incorrectly entered when the hospital submitted data. Therefore it is possible that some of the very lowest volume physicians listed in this report did not actually perform a CE.

## **HOSPITAL INCIDENT REPORTING – THE N.Y.P.O.R.T.S. SYSTEM**

Reacting to a perceived malpractice insurance “crisis” in 1985, the New York legislature enacted a law establishing a hospital incident reporting system. Incident reporting was envisioned as a proactive way to identify and correct problems in hospitals that were the result of negligence or poor quality care. In 1996, former Health Commissioner Barbara DeBuono, formed a state working group to revamp the incident reporting system, after several previous reforms had failed to produce the desired improvements.

This last iteration of the hospital incident reporting system, NYPORTS, has now been in place for almost five years. NYPORTS (New York Patient Occurrence Reporting and Tracking System) was cited as a model state mandatory reporting system in the 1999 IoM’s landmark report on medical errors, “*To Err is Human.*”<sup>27</sup> Despite such praise, NYPORTS has in fact been slow to achieve its goal of accurate reporting of hospital incidents and events causing patients serious harm.

The present State Health Commissioner, Antonia Novello, has often cited NYPORTS as an example of New York’s leadership in reducing medical errors. However, it is important to note that NYPORTS was not specifically designed to track and reduce medical errors. Despite being seen as a model program, NYPORTS has had to overcome difficult problems. Even though it operates under a legislative mandate, under-reporting of adverse events by hospitals has been a concern. To its credit the Department has been proactive in insisting that hospitals improve the accuracy of their reporting. And, NYPORTS appears to produce far more reports than comparable voluntary programs such as the JCAHO Sentinel Event Reports.

As with any system reliant on self-reporting, it can be hard to distinguish between the quality of the reporting accuracy itself and a hospital’s performance. For example, the public as yet cannot be certain whether a high number of reports signifies that a hospital is doing a good job of reporting or providing poor quality care. This confusion can only be resolved if there is confidence that all hospitals are reporting what is required by law. Compliance can only be evaluated by a system of random audit, which utilizes other data sources to confirm the quality of reporting. Again, to its credit, the Health Department has contracted with IPRO

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<sup>27</sup> National Academy of Sciences’ Institute of Medicine, To Err is Human: Building A Better Health Care System, November 1999, p. 107.

and the School of Public Health, Albany, for limited evaluations of compliance. But because auditing is expensive it has proceeded at too slow a pace.

NYPORTS and previous iterations of hospital incident reporting systems have achieved a few stunning successes. For example, New York's Health Department was the first to discover the danger inherent in laparoscopic gallbladder surgery when performed by inexperienced surgeons. The discovery was made because the incident reporting system revealed a number of deaths had occurred as a result of a procedure which, when done by traditional open methods, had virtually no operative mortality.

NYPORTS has been publishing on-line and hardcopy advisories on a regular basis alerting hospitals to potential health and safety problems revealed by analysis of NYPORTS data and where known, suggested means to avoid them.

NYPORTS is finally turning its attention to medical errors specifically (many incidents presently reportable under NYPORTS are likely due to error but not categorized as such). The Agency for Health Care Quality and Improvement (AHRQ) has recently published 26 performance measures for judging the comparative safety of hospitals. Some of these measures are an exact match to events that are required to be reported under NYPORTS. The Department, in partnership with researchers at the School of Public Health at Albany and AHRQ are currently analyzing which safety measures can be incorporated seamlessly into NYPORTS. This would provide the means to establish a medical error baseline for the state permitting the tracking of progress, if any, in error reduction over time.

Under New York State law, much of the information submitted by hospitals to NYPORTS is protected from disclosure. The state has in the past published reports on the original incident reporting system-using information whose release is not prohibited by law. Such reports have not been forthcoming for more than a decade.

NYPORTS, used in conjunction with the state's SPARCS system, which was recently expanded to include hospital emergency room information, and a rigorous system of random audit to ensure accuracy, has the potential to be the country's premier state mandated system for identifying medical errors, preventing their reoccurrence and improving the overall quality of care. However, NYPORTS, along with other safety and quality initiatives, is not at present a priority of the Department. It must become a priority if it is ever to realize its potential for making substantive improvements in patient safety.

A real patient safety effort by the state would require a fiscal commitment many times what is currently invested. It would require a public commitment to making safety and quality improvement of highest priority. But, the Governor, the legislature and state agencies lack a sense of urgency in undertaking major programs to reduce medical errors. Despite the Institute of Medicine's finding that thousands of New Yorkers continue to be needlessly killed or suffer serious injury from preventable mistakes, the state is failing to take this threat seriously and act decisively.

## **PROTECTING PATIENTS: REAL REFORM MEASURES**

Policymakers must make protecting New Yorkers' safety when they encounter the health care system as their number one priority. Common sense proposals called for by the IoM and others should be the first steps taken by Governor Pataki and state lawmakers and include:

1. **More reporting of hospitals' and physicians' health care comparative safety and quality.** Consumers should have easy access to hospital safety and 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. Physician profiles should be expanded to provide information on experience where available.
2. **Create a system of periodic recertification of physicians.** Both the IoM<sup>28</sup> and the State Health Department<sup>29</sup> have recommended that physicians be recertified to assure that they continue to practice as competent professionals. Over time, physicians may see some of their skills erode and it is increasingly hard but critically important for them to keep current with the latest medical research and advances in technology. In an effort to identify physicians with eroding skills *before* a patient gets harmed, a system of recertification based on evaluating competency should be required as a condition of continued licensure.
3. **Require the State Health Department to routinely 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 they pay very

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<sup>28</sup> National Academy of Sciences' Institute of Medicine, To Err is Human: Building A Better Health Care System, November 1999, p. 10.

<sup>29</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.

high premiums that 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.<sup>30</sup> The force of law should back up this common sense ethical requirement.
5. **Mandate more rigorous oversight of office-based surgeries.** The state should require that doctors report serious patient harm that is the result of an office-based surgical procedure to the Health Department.
6. **Create an OPMC consumer assistance office.** A consumer-friendly office should be created to help consumers understand when a complaint is appropriate for OPMC, if not where else to seek redress, and to shepherd them through the process, including communication as to the progress of the complaint.
7. **Increase public involvement in the physician discipline process.** The Board of Professional Medical Conduct should have more public members, they should be included in leadership positions and the hearing and appeals panels should, in some cases, consist of a majority of public members. The definition of public representative should be redefined so as to exclude all health care professionals and anyone working in the health care industry. The list of physician and public members should be published annually on the web site and include names, affiliations and identify who nominated the member to serve.
8. **Punish physicians and providers who don't report observed medical misconduct.** Few physicians report misconduct by their colleagues and co-workers. Under New York law, such failures to report observed misconduct is itself misconduct. Once an action is taken against a physician, OPMC should review the relevant medical records to identify and if appropriate to punish any physician who has failed to report observed medical misconduct.
9. **Require that the Patient Safety Center refer to OPMC the names of physicians who have failed to disclose practice information for their profile.** The public should have easy access to physicians' background information. New York State requires the disclosure of such information, but the public is largely unaware of the existence of this data. In addition,

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<sup>30</sup> American Medical Association, Current Opinions of the Council on Ethical and Judicial Affairs, E-8.12 "Patient Information."

many disciplined physicians are allowed to continue to practice and there is virtually no way for patients to know this fact.

10. **Require that all health facilities and physicians' offices post information on how patients and other members of the public can access the physician profiles program.** The public should have easy access to physicians' background information. New York State requires the disclosure of such information, but the public is largely unaware of the existence of this data. In addition, many disciplined physicians are allowed to continue to practice and there is virtually no way for patients to know this fact.