The Great Medical Malpractice Hoax:

NPDB Data Continue to Show
Medical Liability System Produces Rational Outcomes

Congress Watch

January 2007

Acknowledgments

This report was authored by Public Citizen's Congress Watch Legislative Assistant Seth Oldmixon with data compiled by Congress Watch Junior Researcher Lara Chausow. Congress Watch Director Laura MacCleery, Legislative Counsel Linda Andros, and Special Counsel Barry Boughton provided editorial advice.

About Public Citizen

Public Citizen is a non-profit organization based in Washington, D.C. representing consumer interests through lobbying, litigation, research, and public education. Since its founding in 1971, Public Citizen has fought for consumer rights in the marketplace, safe and affordable health care, campaign finance reform, fair trade, clean and safe energy sources, and corporate and government accountability. Public Citizen has five divisions and is active in every public forum: Congress, the courts, governmental agencies, and the media. Congress Watch is one of the five divisions.

This report analyzes data in the National Practitioner Data Bank Public Use File, dated 31 December 2005. Data are available for a portion of 1990 and for full years thereafter. Most information in this report covers annual periods from 1991 to 2005. Where annual comparisons are not being made, Public Citizen's analysis covers the entire period of the database, *e.g.*, 1990 to 2005. The index used for inflation adjustments in this report is the Medical Care Services series of the Consumer Price Index - All Urban Consumers, as reported by the U.S. Department of Labor Bureau of Labor Statistics.

Public Citizen's Congress Watch
215 Pennsylvania Ave S.E.
Washington, D.C. 20003

P: 202-588-1000
F: 202-547-7392
www.citizen.org

Contents

q. Improve Physician Oversight
    i. Open the National Practitioner Data Bank
    ii. Improve State Medical Board Web Sites
    iii. Reform State Medical Board Governance
    iv. Improve State Medical Board Funding and Staffing
    v. Overhaul Medicare Quality Improvement Organizations

The Medical Liability Reform Debate in Context

In his 2006 State of the Union Address, President Bush called on Congress to restrict patient access to the courts, claiming that access to healthcare is threatened because "lawsuits are driving many good doctors out of practice."[1] But, according to statistics published by the American Medical Association (AMA), the number of practicing physicians is growing faster than the population.[2]

President Bush has claimed that medical malpractice lawsuits send physicians' malpractice insurance premiums "skyrocketing."[3] But recent news reports reveal that medical malpractice insurers are making huge profits.[4] In Florida, one of the AMA's "crisis" states, the Office of Insurance Regulation reported that the 15 largest medical malpractice insurers saw profits of $803 million in 2005.[5]

It is clear that this call for limits on the ability of injured patients to seek redress in court is just one piece of a larger effort by the business lobby to protect businesses from being held accountable when they recklessly or negligently hurt people.

To enlighten the debate about the most effective ways to ensure patient access to high-quality health care, Public Citizen reviewed the most recent publicly available data from the federal government's National Practitioner Data Bank (NPDB). The NPDB contains data on malpractice payments made on behalf of doctors as well as information about disciplinary actions against them by state medical boards or hospitals. Most payers of malpractice claims are insurance companies; but the data also include payments by entities such as state-run insurance funds and self-insured health care providers.

Overall, the data show that President Bush is misdiagnosing the health care problem. The court-based compensation system is, on the whole, a rational one that provides money for valid claims and dismisses invalid ones. These findings are confirmed by other research, including a recent study conducted by researchers from the Harvard School of Public Health in which the authors found that "portraits of a malpractice system that is stricken with frivolous litigation are overblown," going on to note that "the malpractice system performs reasonably well in its function of separating claims without merit from those with merit and compensating the latter."[6]

This report examines the issue of medical liability in two parts. The first part reviews NPDB data and shows that the claims of the business and medical lobbies are exaggerated and unsupported by the facts. The second part examines data related to physician error and discipline. This section notes some disturbing trends and reveals that the real medical crisis is the high incidence of preventable medical error, as well as the lack of accountability for a small set of doctors who commit a substantial number of avoidable errors that seriously injure patients.

Fundamentally, an agenda that blames injured patients and seeks to close access to the courts – contravening a Constitutional right – is about protecting business profits over patient health. It is far past time for real health care reform, and for a health care system that puts patient safety first.

Key Findings

- **Medical Malpractice Payments Are Actually Declining.** The number and the total value of malpractice payments to patients have been flat since 1991. Both show a significant decline since 2001, when the last so-called "crisis" began.[7]

    - The number of malpractice payments declined 15.4 percent between 1991 and 2005.
    - Adjusted for inflation, the average annual payment for verdicts declined 8 percent between 1991 and 2005.
    - Payments for million-dollar verdicts were less than 3 percent of all payments in 2005.

- **Payments Correspond to Severity of Injury.** The medical liability system is not irrational – patients do not win big jury awards for frivolous claims. Instead, evidence shows the current system works reasonably well. Patients with minor injuries receive little compensation, while the bulk of malpractice awards occur in cases involving severely debilitating injuries or death.
    - Over 64 percent of payments in 2005 involved death, or major or significant injuries.
    - Payments for "insignificant injury" were less than *one-third of 1 percent* of payments in 2005.

- **Patient Safety Is the Real Crisis.** The latest NPDB data underscore the fact that the real medical malpractice crisis continues to be inadequate patient safety, rather than the legal system. Instead of being distracted by business lobby myths about the court system, heath care providers should improve patient safety and better protect the health of patients.

- **Improving Patient Safety Will Save Lives.** One-third of malpractice cases resulting in a malpractice payment in 2005 (4,504) involved the death of a patient.[8] Yet, as a 1999 landmark study by the Institute of Medicine showed, an estimated 44,000 to 98,000 patient deaths occur each year as a result of preventable medical errors in hospitals.[9] Stemming preventable errors alone would, conservatively, prevent ten times as many deaths as are now accounted for by malpractice cases.

Note on the Data

Those making malpractice payments are required to report them to the NPDB under provisions of the Health Care Quality Improvement Act of 1986. The NPDB makes available an aggregated Public Use File that omits all personal or hospital identifying information. Information provided to the NPDB is confidential except it is disclosed to medical boards, hospitals and HMOs. Within the health care industry, the NPDB provides a repository of data which entities employing doctors can query as part of a background check.

Part I: The Medical Liability System Produces Rational Outcomes

The Doctors Company, a medical malpractice insurance carrier, claims that, "[u]nlimited and unpredictable jury awards lead to unlimited and unpredictable risk for liability insurers. Because insurance premiums are set by assessing the risk, premiums in states without effective reforms have skyrocketed."[10]

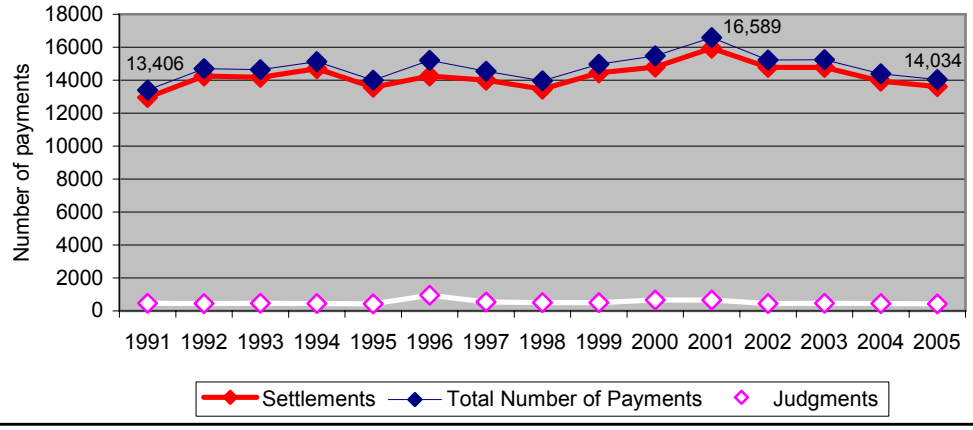
The latest national data on physician malpractice payments, however, show that malpractice awards are neither "unpredictable" nor skyrocketing. In fact, Public Citizen's analysis of information from the NPDB reveals major flaws in the insurance and business lobby's story.

Annual Number of Malpractice Payments Is Down

During a July 13, 2006, hearing by the Subcommittee on Health of the House Committee on Energy and Commerce, U.S. Rep. Nathan Deal (R-Ga.) said, "[t]here is no denying the fact that there is a medical liability crisis in this country."[11]

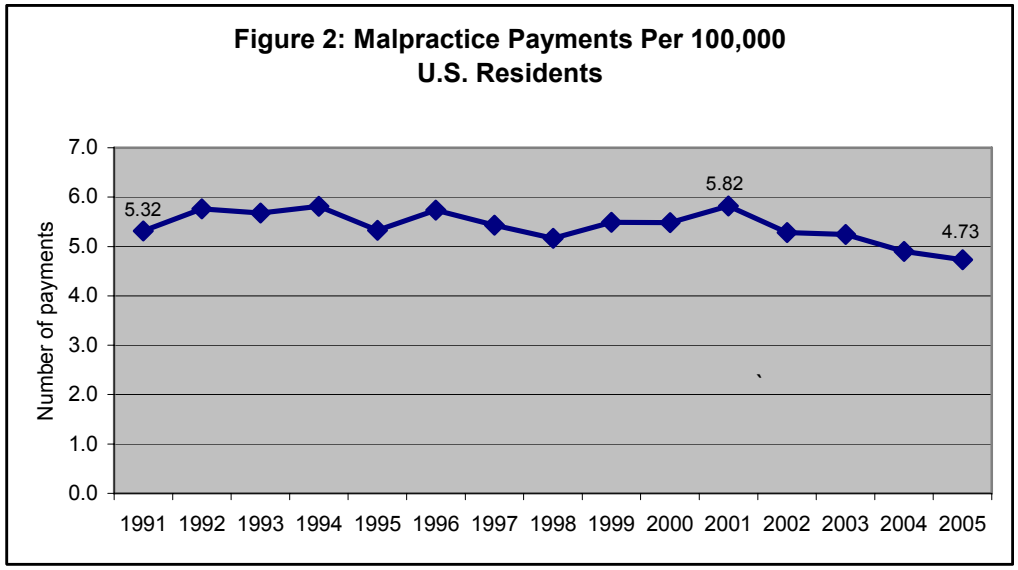
But the number of malpractice payments paid on behalf of doctors declined substantially over the past four years – from 16,588 in 2001 to 14,033 in 2005, a drop of 15.4 percent. Over the past 14 years, the number of payments rose only 4.7 percent. (Figure 1)

Figure 1: Total Number Of Malpractice Payments With Judgments and Settlements



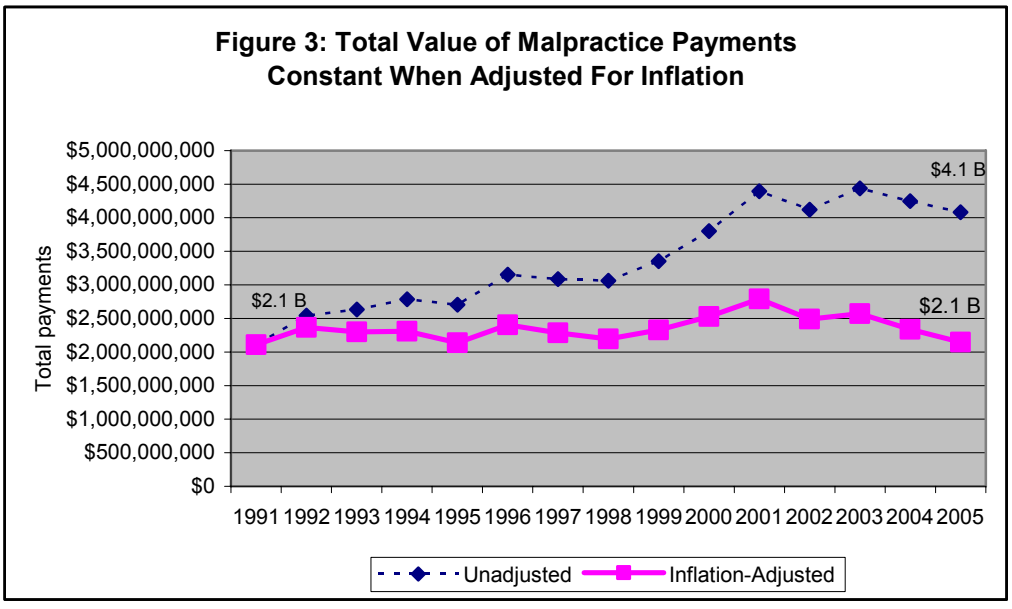
Medical Malpractice Payments per Population Continue to Decline

The number of payments per 100,000 people in the U.S. also fell since 2001 – from 5.82 to 4.73 – a decline of 18.6 percent.[12] Since 1991, the number of payments per 100,000 people declined more than 10 percent. (Figure 2)



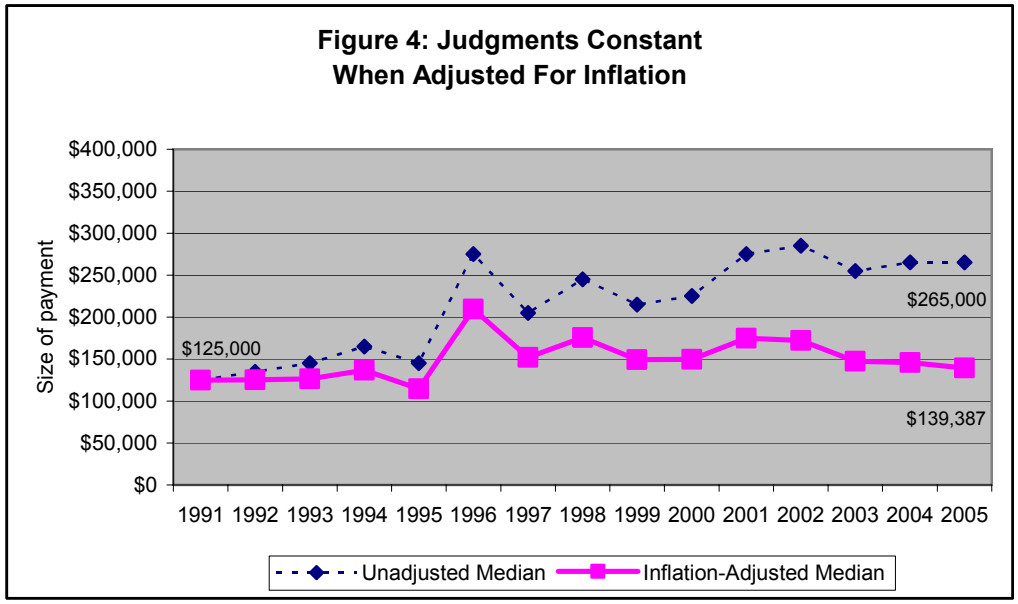
Total Value of Malpractice Payments Flat Since 1991

When adjusted for medical care services inflation, the total value of malpractice payments changed very little from 1991 to 2005 – rising from $2.11 billion to $2.14 billion. This modest increase reflects an average annual growth rate of less than half of one percent. (Figure 3)



Judgments Are Not Irrational

American Medical Association President Donald Palmisano told the 2004 Annual Meeting of the AMA House of Delegates that "what is driving this crisis are the out-of-sight awards some runaway juries are handing out in certain liability cases."[13] This assertion is incorrect on the facts – when adjusted for inflation, the median judgment grew only from $125,000 in 1991 to $139,100 in 2005, a mere $14,000 over 14 years. Such a modest increase hardly suggests that juries are irrational. (Figure 4)

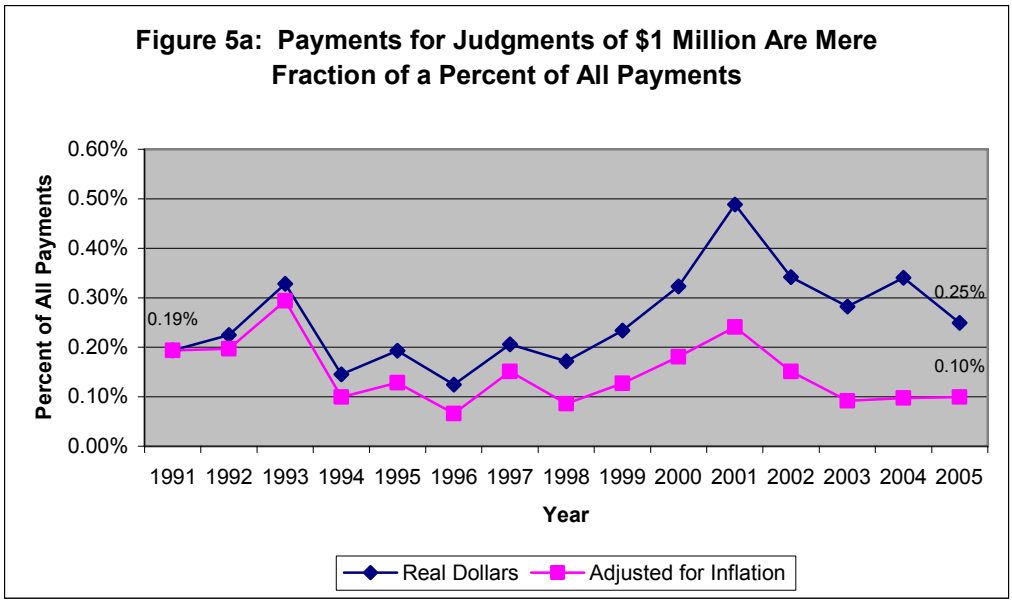


Million-Dollar Judgments Are Less Than 1 Percent of the Total Number of Payments

The Chamber of Commerce's Institute for Legal Reform claims that, "[s]ince 1994, the average medical malpractice verdict has increased to $3.5 million from $1.1 million."[14] This misleading statistic is meant to leave readers with the impression that plaintiffs regularly receive millions of dollars from lawsuits. The Chamber's statistic is particularly misleading because most verdicts are reduced by judges, often pursuant to state law. What a jury awards is often not the actual amount paid to compensate the victim.

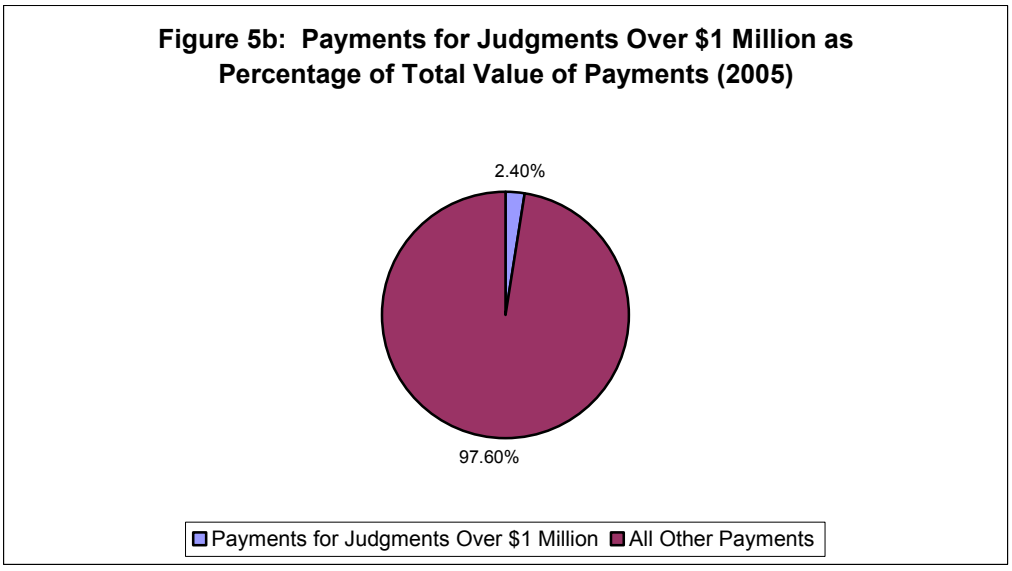
In fact, according to NPDB data, the annual average payment for a medical malpractice verdict has not exceeded $1 million in real dollars since the beginning of the NPDB. The average payment for a medical malpractice verdict in 1991 was $284,896. In 2005, the average was $461,524. Adjusting for inflation, however, shows that the average is actually *declining*. The 2005 average adjusted for inflation is only $260,890 — a decline of 8 percent since 1991.

The truth is, the number of payments for judgments of $1 million or more is tiny — never exceeding one-half of one percent of the annual total number of malpractice payments over the last 14 years. In 2005, they were only one-quarter of one percent of all payments. (Figure 5a)



Million-Dollar Judgments Were Less Than 3 Percent of Total Value of Payments in 2005

Contrary to the impression sought to be created by the Chamber of Commerce, over 97 percent of the total value of malpractice payments are payments under $1 million. The few million-dollar verdicts are only a miniscule portion of the total value of medical malpractice payments. Furthermore, using 2005 as an example, payments of $1 million or more were less than three percent of the total value of all judgments. (Figure 5b) In the same year, payments of $5 million or higher were less than *one-half of one percent* of the total value of all judgments.



Severe Injuries Account for a Majority of Payments

In 2003, President Bush described the medical liability system as "a giant lottery."[15] This assertion, however, is unsupported by the facts. Rather than providing irrational awards to undeserving plaintiffs, the current medical liability system is rational in its outcomes. Over 64 percent of payments in 2005 involved death, or major or significant injuries. Thirty-two percent of the number of payments in 2005 involved cases in which the patient died. Insignificant injuries, by contrast, were less than 2 percent of the number of payments. (Figures 6a and 6b)

Figure 6a: Most Severe Injuries Account For Majority of Number of Payments

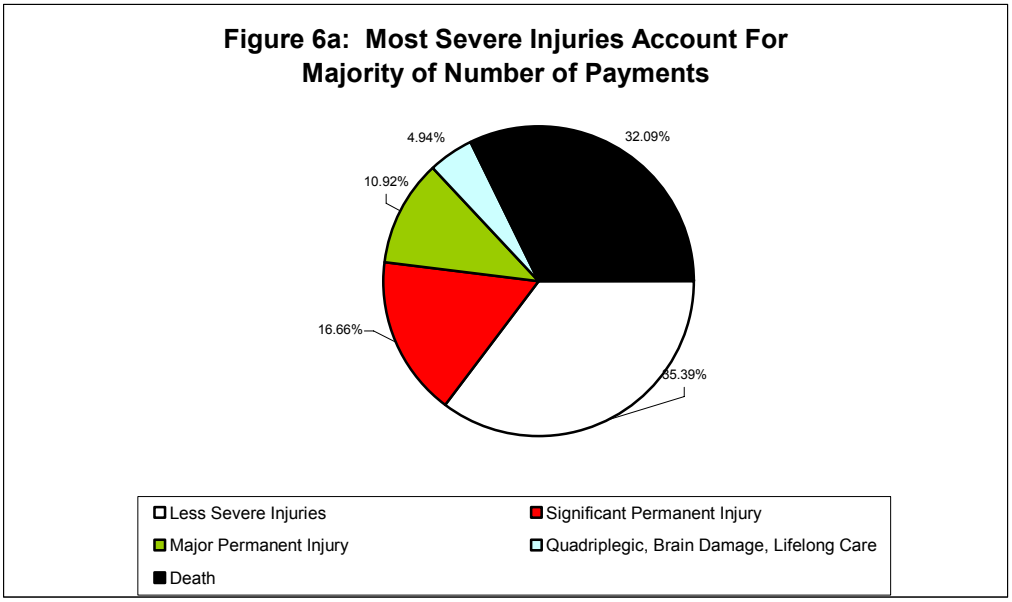
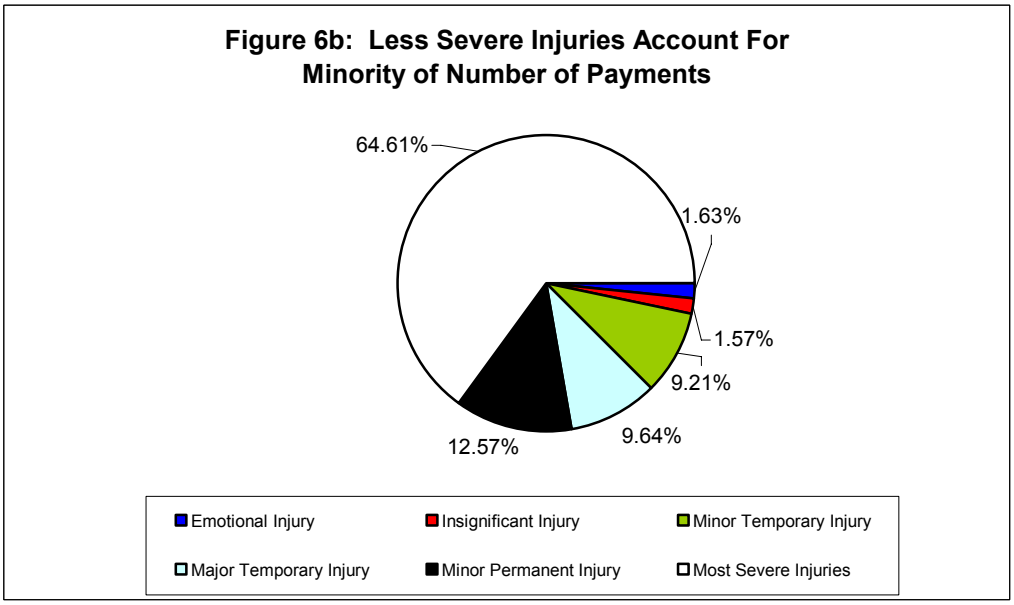


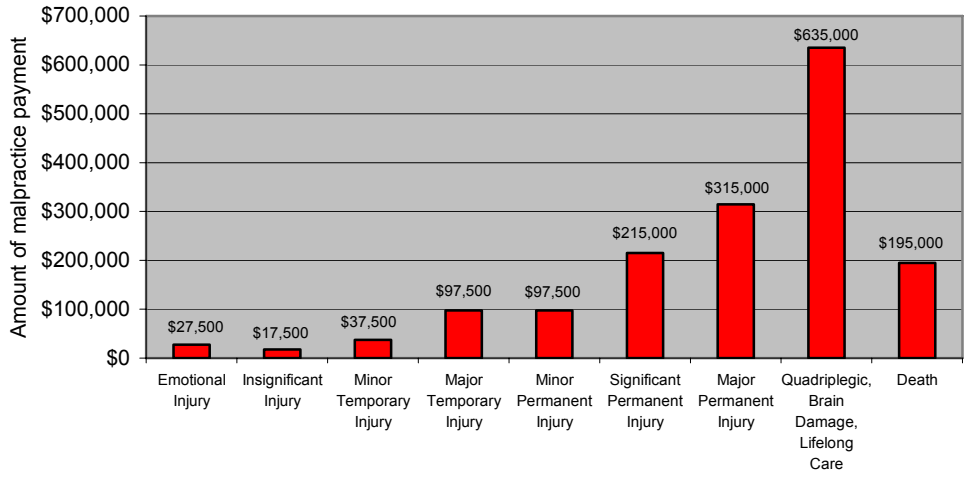
Figure 6b: Less Severe Injuries Account For Minority of Number of Payments



Medical Liability System Is Rational In Outcomes

The values of payments made to injured patients correspond appropriately to the degree of harm suffered by the victims. Victims with a "minor permanent injury" receive 55 percent less than those suffering a "significant permanent injury." The highest payments go to the families of victims who died as a result of medical malpractice. This confirms the findings of the Harvard School of Public Health recently published in the New England Journal of Medicine[16] and completely refutes assertions that medical justice is "worse than random."[17] (Figure 7)

Figure 7: 2005 Median Payment By Injury Type



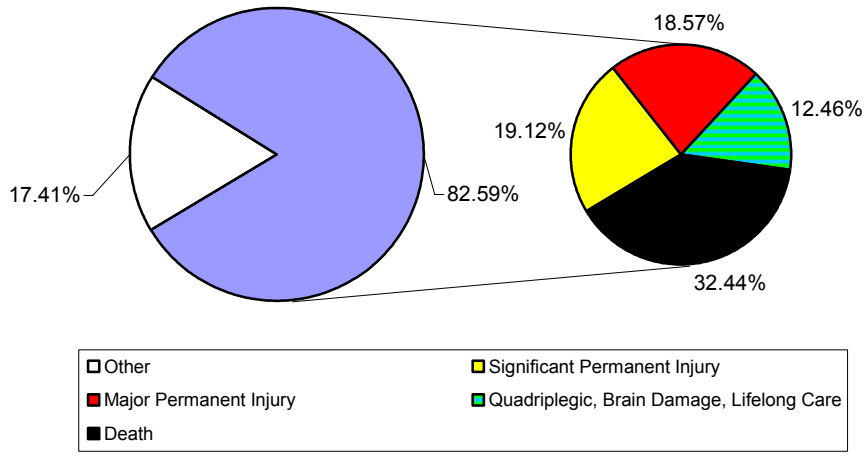
Categories of severity are those used in the NPDB.

82 Percent of Total Value of Payments Compensate Most Severe Injuries

As noted, the value of payments, as a percentage of the whole, corresponds to the severity of the injury. Payments for "emotional injury" are a very small part of the total value of payments – less than 1 percent of the medical malpractice payments in 2005. Payments for "insignificant injury" are *less than one-third of 1 percent of payments*.[18]

In fact, even "minor permanent injury" is less than 8 percent of payments. "Significant permanent injury" is 82.6 percent of the total value of payments, and "death" accounts for more than 32 percent of payments for the most severe injuries. (Figure 8)

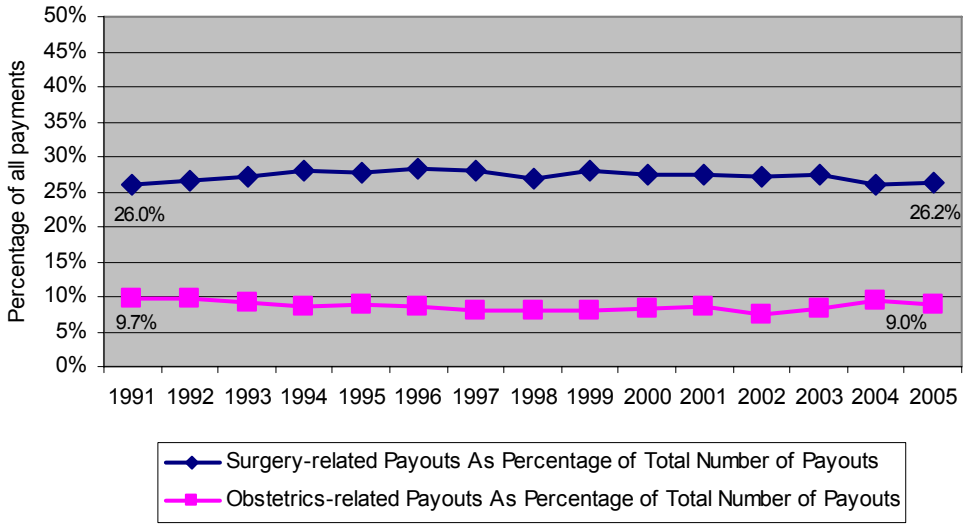
Figure 8: Over 82 Percent of Total Value of Payouts Compensate Most Severe Injuries



The Proportion of Surgical and Obstetrics Payments Flat Since 1991

The proportion of surgical and obstetrics payments as a part of all payments was virtually unchanged between 1991 and 2005. In 1991, 9.7 percent of all payments were for obstetrics cases; in 2005, the figure decreased to 9.0 percent. Surgical cases accounted for 26.0 percent of payments in 1991, and 26.2 percent of payments last year. Claims that surgeons and ob/gyns face a growing threat of litigation are simply not borne out by the facts. (Figure 9)

Figure 9: Trends In Surgical and Obstetrics Payments



Part II: Patient Safety and Doctor Discipline

In 1999, a landmark study by the Institute of Medicine found that an estimated 44,000 to 98,000 patient deaths occur each year as a result of preventable medical errors in hospitals.[19] A new report by the Institute of Medicine, published in July of 2006, found that "medication errors are surprisingly common and costly to the nation."[20] This is the true health care crisis. Attention focused on the false claims of the business lobby diverts much-needed resources for work to save lives by reducing preventable errors.

By enacting measures to improve patient safety, doctors and hospitals can lower their exposure to liability while at the same time improving the quality of health care they provide to their patients. The potential for patient safety initiatives to lower costs and save patients' lives is well demonstrated by the success of reforms adopted by anesthesiologists in the 1980s – by adopting practice guidelines to protect patient safety, both the number of deaths and the value of malpractice premiums dropped for anesthesiologists.[21]

In addition, state medical boards are falling behind in their efforts to ensure that physicians who commit repeated acts of medical negligence are held responsible for their actions. In 2004, problems with the Nevada State Medical Board were found to be so pervasive that Assemblywoman Barbara Buckley stated that:

> "The board doesn't care about the inaccurate numbers it reports, the inconsistencies in the actions it takes, the backlogs in its work or the horrible instances of failing to catch doctors doing harm that undermine the public's faith in the board."[22]

The problem of State Medical Boards' failure to enforce high standards of care is not limited to Nevada. Our analysis of NPDB data shows that only 33 percent of doctors who made 10 or more malpractice payments received any disciplinary action by their state medical board. Even more disturbing, NPDB data show that physicians with *up to 31 medical malpractice payments totaling millions of dollars in damages* never received any disciplinary action.

We are fortunate to live in a country with a high number of highly qualified physicians. In order to best protect their reputation and practice, and to protect the health and well-being of patients, we must focus attention and resources on the real problems. By focusing on patient safety, we can dramatically lower both the cost of malpractice insurance and the number of avoidable medical injuries.

In a recent article in the New England Journal of Medicine, Senators Hillary Clinton and Barack Obama wrote that "the [medical liability reform] discussion should center on a more fundamental issue: the need to improve patient safety."[23] What seems like a fundamental part of our health care system has been too often overlooked – the need to regularly update patient safety guidelines in order to reduce the risk of avoidable medical injury.

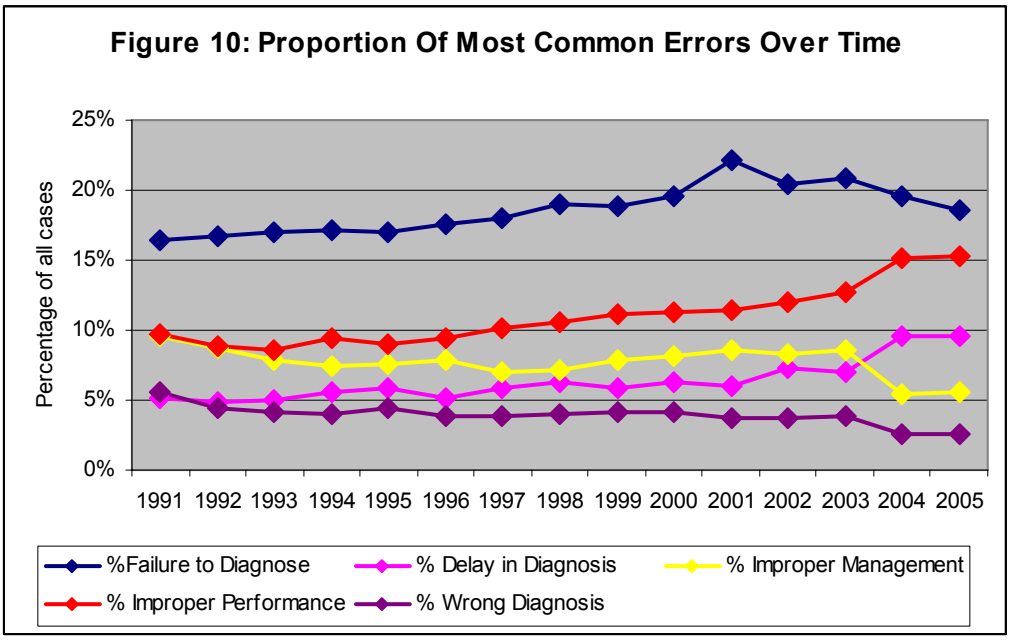
In the American health care system, state medical boards are responsible for ensuring that the physicians practicing in state meet high standards of competency and care. Unfortunately,

state medical boards too often ignore individuals with repeated problems. This can result in tragedy, as happened in 2001 when a surgeon practicing in Hawaii implanted the shaft of a screwdriver in a patient's spine. During the trial in which the surgeon was found liable for medical malpractice, it was uncovered that the physician, credentialed to practice in Hawaii, had previously been suspended from practicing in both Oklahoma and Texas.[24]

The latest NPDB data show that patient safety and doctor discipline are two areas of the health care industry that require immediate attention.

Some Common, Preventable Errors Are Increasing

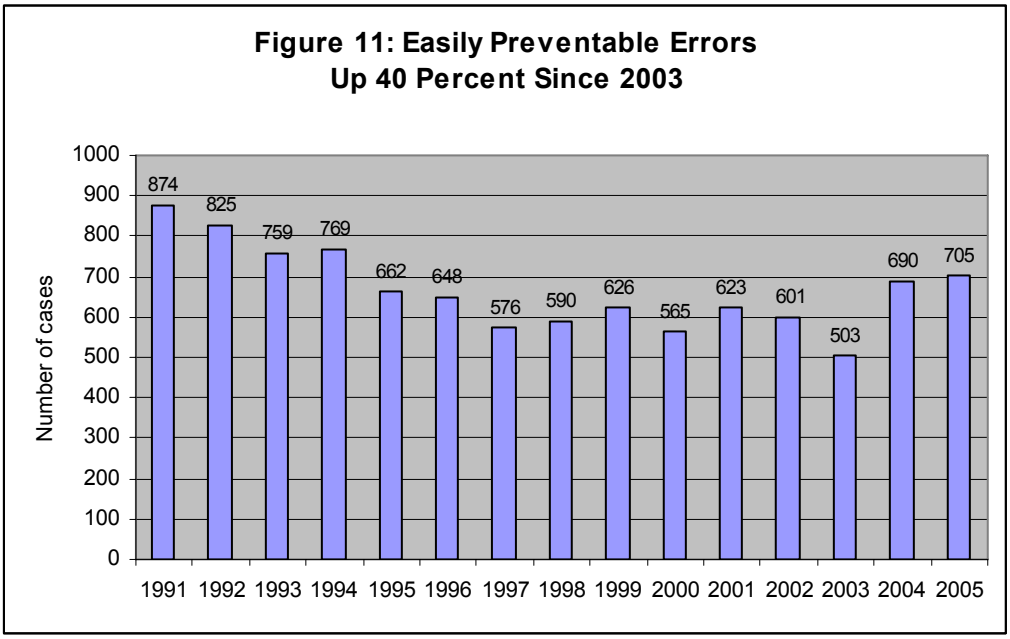
Several of the most common types of errors producing malpractice payments significantly increased over time as a proportion of all errors.[25] Meanwhile progress has stalled in reducing the errors that are easiest to avoid. "Failure to diagnose" cases, for example, grew from 16 percent of payments in 1991 to 19 percent in 2005. "Improper Performance" cases grew from 10 percent to 15 percent of payments. (Figure 10)



Error classifications as listed in the NPDB.

Easily Preventable Errors Show a Marked Increase Since 2003

The number of payments for easily avoidable errors, such as leaving a foreign object inside a patient, or operating on the wrong body part, fell from 874 in 1991 to 576 in 1997, and then remained relatively constant until 2004, when incidents increased dramatically. The most recent data reflect the highest number of such errors in 11 years. (Figure 11)



Easily preventable errors include: Surgical or other foreign body retained, wrong body part, wrong patient, wrong treatment, wrong medicine, failure to protect against infection, and wrong blood type. These identifications are taken from the NPDB.

Since the Beginning of the NPDB, 5.9 Percent of U.S. Doctors Were Responsible for 57.8 Percent of the Number of Medical Malpractice Payments

The insurance lobby continues to perpetuate the myth that medical malpractice litigation is a giant "lottery" in which lawsuits are random events unrelated to quality of care. If this were so, we would expect to find that a large proportion of U.S. doctors were responsible for malpractice payments. But data from the NPDB shows that the problem of malpractice is not random. In fact, since the inception of the NPDB, only 18 percent of doctors have been responsible for even a single malpractice payment. A serious problem is the small percentage of doctors who paid multiple claims and who are responsible for much of the malpractice in America. By strengthening patient safety and training while disciplining repeat offenders, the amount of malpractice could be dramatically reduced.

- The vast majority of doctors – 82 percent – have never had a medical malpractice payment since the NPDB was created in 1990.

- Just 5.9 percent of doctors have been responsible for 57.8 percent of all malpractice payments since 1991, according to data from September 1990 through 2005. Each of these doctors made at least two payments.

- Just 2.3 percent of doctors, having three or more malpractice payments, were responsible for 32.8 percent of all payments.

- Only 1.1 percent of doctors, having four or more malpractice payments, were responsible for 20.2 percent of all payments.

Figure 12: Number and Amounts of Medical Malpractice Payments To Patients Paid on Behalf of Doctors, 1990-2005

Number of Payment Reports	Number of Doctors Who Made Payments	Total Number of Payments	Percent/Total Doctors (777,859)*	Percent of Total Value of Payments	Percent of Total Number of Payments	Total Amount of Payments
All	140,008	223,617	18.00%	100.00%	100.00%	$50,807,346,000
1	94,293	94,286**	12.12%	41.27%	42.16%	$20,966,431,500
2 or more	45,715	129,331	5.88%	58.73%	57.84%	$29,840,914,500
3 or more	17,596	73,325	2.26%	33.09%	32.79%	$16,809,942,400
4 or more	8,144	45,106	1.05%	20.18%	20.17%	$10,250,793,100
5 or more	4,091	28,989	0.53%	12.93%	12.96%	$6,570,145,650

* Based on number of physicians in 1998, the midpoint of the period studied, as reported by the American Medical Association.
** Numbers in columns two and three of this row do not correspond precisely as a very small number of payment reports in the NPDB do not include an amount.

Doctors with Repeated Malpractice Payments Experience Few Consequences

Unfortunately, state medical boards and health care institutions do not do enough to rein in those doctors who repeatedly make medical errors and commit medical negligence. According to Public Citizen's analysis of NPDB data, disciplinary actions such as license suspension or revocation are infrequent for physicians whose negligence caused multiple malpractice payments.

- Only 8.61 percent of doctors who made two or more malpractice payments were disciplined by their state board.
- Only 11.71 percent of doctors who made three or more malpractice payments were disciplined by their state board.
- Only 14.75 percent of doctors who made four or more malpractice payments were disciplined by their state board.
- **Only 33.26 percent of doctors who made 10 or more malpractice payments were disciplined by their state board** – meaning two-thirds of doctors in this group of egregious repeat offenders were not disciplined at all.

Figure 13: U.S. Doctors with Repeated Medical Malpractice Payments Who Were Disciplined (Reportable Licensure Actions) by State Medical Boards, 1990—2005

Number of Payment Reports	Number of Doctors Who Made Payments	Number of Doctors With One or More Reportable Licensure Actions	Percent of Doctors With One or More Reportable Licensure Actions
2 or more	45,715	3,935	8.61%
3 or more	17,596	2,061	11.71%
4 or more	8,144	1,201	14.75%
5 or more	4,019	733	17.92%
10 or more	481	160	33.26%

Many Serious Repeat Offender Doctors Are Not Disciplined

The extent to which some doctors have repeated malpractice claims without being disciplined is illustrated by the following NPDB descriptions of 21 physicians licensed to practice medicine. Even though they have between 4 and 31 malpractice payments (totaling more than $8 million per doctor), these physicians were not disciplined by their state medical boards. The physicians are not publicly identified; the NPDB protects the identity of these physicians by assigning a random number to each.

- **Physician Number 33041** had at least 31 malpractice payments between 1993 and 2005, nine for failure to use proper aseptic technique, five for unspecified errors, three for improper management of obstetrics cases, three for improper performance of surgery, three for retained foreign object during surgery, two for failure to treat, one for surgery on the wrong body part, one for failure to obtain consent for surgery, one for delay in treatment of fetal distress, one for failure to treat fetal distress, one for an improperly performed delivery, and once for improper technique. The total damages were $10,150,000.

- **Physician Number 43923** had at least 21 malpractice payments between 1992 and 2003, eight times for improperly performed surgeries, three times for unnecessary surgeries, twice for unspecified equipment errors, twice for surgeries on wrong body parts, a failure to obtain consent before surgery, a failure to obtain consent before blood work, a wrong treatment, an unspecified surgical error, a retained foreign body during surgery and an improper management of medication. The total damages were $8,722,500.

- **Physician Number 35454** had at least 18 malpractice payments between 1991 and 2005, 12 times for improper performance of surgery, twice for improper management of surgery, once for equipment problems during surgery, once for failure to obtain consent for surgery, once for an unnecessary surgical procedure, and once for an unspecified surgical error. The total damages were $8,237,500.

- **Physician Number 14045** had at least 14 malpractice payments between 1991 and 2002, 12 times for delayed performance or improper management of obstetrics cases, once for wrong treatment or procedure and once for an unspecified obstetrics error. The total damages were $10,175,000.

- **Physician Number 59910** had at least 14 malpractice payments between 1994 and 2005, three for failure to monitor, three for improper performance, seven unspecified errors, and once for surgery on the wrong body part. The total damages were $10,555,000.

- **Physician Number 71888** had at least 14 malpractice payments between 1995 and 2004, once for failing to supervise, twice for failing to use proper aseptic technique, twice for improper delivery choice, once for improper treatment management, once for patient positioning, five for improperly performed surgeries, and four unspecified errors. The total damages were $8,007,500.

- **Physician Number 33166** had at least 13 malpractice payments between 1991 and 2005, nine for improper management, improper choice of delivery method, delay in performance or failure to treat fetal distress in obstetrics cases, one for improper performance of surgery, once for failure to diagnose, one for failing to use proper aseptic technique, and one unspecified obstetrics error. The total damages were $10,035,000.

- **Physician Number 118361** had at least 9 malpractice payments between 1998 and 2005, 6 for unspecified errors, once for delay in performance, once for failing to use proper aseptic technique, and once for an improperly performed C-section. The total damages were $8,177,500.

- **Physician Number 25596** had at least 9 malpractice payments between 1992 and 2005, five for improper performance, twice for improper management of a pregnancy, once for improper delivery choice, and once for an unspecified obstetrics error. The total damages were $8,085,000.

- **Physician Number 23951** had at least 8 malpractice payments between 1992 and 2005, twice for wrong diagnoses, twice for unspecified treatment errors, twice for improper management of surgery, an improper performance of surgery, and a failure to obtain consent or a lack of informed consent. The total damages were $11,215,000.

- **Physician Number 24852** had at least 7 malpractice payments between 1993 and 2003, four for improperly performed surgeries, twice for unspecified surgery errors, and once for an unspecified monitoring error. The total damages were $8,762,000.

- **Physician Number 17150** had at least 7 malpractice payments between 1992 and 2005, five for unspecified errors, once for an unnecessary surgical procedure, once for improper management, and once for failing to use proper aseptic technique. The total damages were $8,457,500.

- **Physician Number 26686** had at least 6 malpractice payments between 1994 and 2002, twice for improper management of pregnancies, an improperly performed C-section, an improperly performed procedure, a retained foreign body during surgery and an unspecified obstetrics error. The total damages were $15,050,000.

- **Physician Number 493** had at least 6 malpractice payments between 1992 and 2003, twice for improperly performed surgeries, twice for unspecified surgical errors, a failure to perform surgery and an unspecified treatment error. The total damages were $9,790,000.

- **Physician Number 1994** had at least 6 malpractice payments between 1993 and 2002, once for a retained foreign body during surgery, improper performance of surgery, a delay in treatment, a delay in performance in an obstetrics case, once for an unspecified obstetrics error, and once for an unspecified surgery error. The total damages were $8,363,750.

- **Physician Number 127552** had at least 5 malpractice payments between 1998 and 2005, once for delay in diagnosis, once for failure to treat fetal distress, once for improper management, an improperly performed delivery, and a retained foreign body during surgery. The total damages were $8,470,000.

- **Physician Number 122127** had at least 4 malpractice payments between 1998 and 2002, twice for failure to use proper aseptic technique, a wrong diagnosis and an improperly managed surgery. The total damages were $12,890,000.

- **Physician Number 164595** had at least 4 malpractice payments between 2001 and 2005, once for failure to treat, and three times for failure to use proper aseptic technique. The total damages were $9,615,000.

- **Physician Number 182994** had at least 4 malpractice payments between 2002 and 2005, once for failing to perform a surgery, once for an improperly performed surgery, once for an unspecified surgery error, and once for a misdiagnosis. The total damages were $8,670,000.

- **Physician Number 21415** had at least 4 malpractice payments between 1991 and 2003, twice for delays in diagnosis, once for failing to use aseptic technique, and an unspecified obstetrics error. The total damages were $8,577,500.

- **Physician Number 71514** had at least 4 malpractice payments between 1995 and 2001, twice for failures to diagnose and twice for failing to use proper aseptic technique. The total damages were $8,435,000.

Part III: Recommendations for Action

While data continue to show that the medical liability system produces rational outcomes, the government as well as health care providers can and should take steps to reduce preventable errors, protecting patients and doctors alike. A "systems approach" to patient safety advocated by the Institute of Medicine (IOM) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is an important tool to protect the health and safety of patients. As noted earlier, in the 1980s, anesthesiologists showed that proactive measures to enhance patient safety are proven to save lives, reduce the number of lawsuits and cut costs.[26]

We are encouraged by the passage of the Patient Safety Act of 2005, and call on the Department of Health and Human Services to promulgate the necessary regulations and to implement the act as soon as possible. Furthermore, we recommend the following:

Improving Patient Safety Systems

Congress Should Establish a National Mandatory Adverse Event Reporting System

Twenty-five states currently have legislation or regulations establishing adverse event reporting systems.[27] Of these, 24 are mandatory. Adverse event reporting systems allow hospitals to share information in order to conduct root cause analysis of adverse events, and subsequently improve patient safety by, for example, correcting faulty systems. While these state reporting systems represent a positive step in patient safety, much more can be done. Federal policy makers should review the current state systems to determine the most effective methods for data collection and analysis. To best protect all Americans, Congress should streamline error reporting by establishing a national mandatory adverse event reporting system based on the best practices demonstrated by the current state systems.

Hospitals Should Use Computer Physician Order Entry Systems

Medication errors are among the most common preventable mistakes. In July 2006, the Institute of Medicine released a report concluding that there are at least 1.5 million preventable medication errors that cost the U.S. over $3.5 billion.[28] One of the recommendations in the IOM report is to "invest in technologies that have been demonstrated to be effective, but are not yet widely implemented in most organizations, such as computer physician order entry (CPOE)".[29] CPOE is an electronic prescribing system that intercepts errors where they most commonly occur – at the time medications are ordered. Physicians enter orders into a computer, rather than on paper, thus resolving potential miscommunications, and orders are automatically checked for potential problems, such as drug interactions or allergies. In spite of these benefits, fewer than 5 percent of hospitals have implemented CPOE.[30]

Hospitals Should Follow JCAHO Guidelines to Prevent Wrong Site Surgery

Amputating the wrong limb, operating on the wrong side of the body or the wrong patient – these are mistakes that should never occur in a modern hospital. Nevertheless, in April 2006, *USA Today* quoted Dr. Dennis O'Leary, President of the JCAHO, as saying the problem is "getting worse."[31]

In 2003, the JCAHO published guidelines for preventing wrong site surgery that include:

- A pre-operative verification process to ensure that all parties are fully informed about the intended patient, procedure, and site;
- Visibly marking the operative site; and
- A "time out" period immediately preceding the procedure to conduct a final verification of the correct patient, procedure, and site.

By implementing these simple pre-operative procedures, a terrible and costly form of medical error could be eradicated.

Hospitals and Medical Practices Should Limit Physicians' Workweeks to Reduce Fatigue-Induced Error

American physicians are famous for their extensive work hours. Researchers from Harvard Medical School, University of British Columbia, and hospitals in Massachusetts and British Columbia concluded that "extended-duration work shifts were associated with an increased risk of significant medical errors, adverse events, and attentional failures."[32] In 2003, the Accreditation Council for Graduate Medical Education issued duty hour standards for residents that limited residents to 80 hours on-duty per week, averaged over four weeks. But these standards stop far short of an appropriate limit on the number of consecutive hours that it is safe for a physician to work. By averaging the number of hours per week over a four-week period, residents can still be required to work in one session far longer than it is safe. Duty hours for all physicians should be limited to 80 hours per week, not averaged over a month. By legitimately limiting the number of consecutive work hours required of physicians, fatigue-induced error could be considerably reduced.

Hospitals Should Perform More Autopsies

In their 2000 report, *To Err is Human,* the Institute of Medicine noted that autopsies "are an excellent way to refine clinical judgment and identify misdiagnosis."[33] A 2002 report published by the Department of Health and Human Service Agency for Healthcare Research and Quality (AHRQ) concluded that "[t]he use of autopsy data to correct inaccuracies in epidemiologic data would likely confer multiple benefits on the health care system as a whole.[34] Despite these benefits, the rate of autopsy in the U.S. has declined significantly over the years. According to the AHRQ, "[i]n 1994, the last year for which national U.S. data exist, the autopsy rate for all non-forensic deaths fell below 6 percent."[35]

Improve Physician Oversight

Congress Should Open the National Practitioner Data Bank

Information about doctor discipline, including state sanctions, hospital disciplinary actions, and medical malpractice awards, is now contained in the National Practitioner Data Bank (NPDB). While the Department of Health and Human Services, which controls the NPDB, makes available a Public Use File for statistical research, the names of the doctors are kept secret from the public. Congress should lift the veil of secrecy and allow individuals access to the information they need to make the best and most informed choice about which doctors they want to provide medical care for themselves and their families.

Congress Should Overhaul Medicare Quality Improvement Organizations

Quality Improvement Organizations (QIOs) are a national network of 53 organizations under the direction of the Center for Medicare & Medicaid Services (CMS) in the Department of Health and Human Services. QIOs are charged with ensuring that patients receive timely, quality healthcare and investigating complaints about substandard care. Unfortunately, the system has broken down. In March 2006, Senator Charles E. Grassley (R-Iowa) wrote a letter to CMS stating that "there is sparse evidence that QIOs are effective."[36] Congress should instruct CMS to improve transparency and responsiveness in the beneficiary process. QIO documents should be made subject to discovery in criminal, civil, and administrative proceedings.

States Should Improve State Medical Board Web Sites

The ability of individuals to make informed decisions about their doctors is vital to consumer safety. While now most state medical boards provide some physician information on Web sites, information about disciplinary actions varies greatly, is often inadequate, and can be difficult to access.[37] In order to improve the quality and accessibility of information about doctor discipline, state legislatures should pass legislation requiring state medical boards to obtain and publish on the Internet verified criminal, malpractice, and hospital disciplinary information about physicians. State medical boards should empower consumers to make informed choices when selecting a physician. As Dr. Peter Lurie of Public Citizen's Health Research Group recently noted, "[T]here can be no meaningful consumer choice if critical information is denied to patients."[38]

States Should Reform State Medical Board Governance

Too many state medical boards are unhelpfully dependent on professional medical societies. These links result in a lack of meaningful oversight on the part of state medical boards. To resolve this problem, medical boards (and separate disciplinary boards, where present) should be appointed by the governor, and the governor's choice of appointees should not be limited to a medical society's nominees. Furthermore, a minimum of 50 percent of the members of each state's medical board should be well-informed and well-trained members of the public who have no ties to the health care industry, and, preferably, are experienced patient advocates. Needless to say, medical boards' top priority should always be protecting public health, not the careers of individual physicians.

States Should Improve State Medical Board Funding and Staffing

In order for state medical boards to properly function, they require improved funding and staffing. State legislatures should permit medical boards to spend all of the revenue from medical licensing fees, rather than forcing them to turn over a portion to the state treasury. Boards should hire adequate staff to investigate all complaints within 30 days, review all malpractice claims filed with the board, ensure compliance with reporting requirements, and monitor and regularly visit doctors who have been disciplined to ensure their compliance with imposed sanctions. State medical boards should also hire investigators to review pharmacy records, consult with medical examiners, and perform targeted office audits of doctors practicing alone and suspected of substandard performance.

Please credit Public Citizen for information in this report as follows: Public Citizen's analysis of malpractice payments as reported in the National Practitioner Data Bank Public Use File for the years 1990 to 2005.

For a copy of data underlying any portion of this report, please contact Lara Chausow at 202-454-5186.

Endnotes

[1] Bush, G. W. Address Before a Joint Session of the Congress on the State of the Union, January 31, 2006.
[2] "Claims of Doctor Supply Crisis Not Supported by Facts." Public Citizen, May 8, 2006.
[3] President George W. Bush. President Proposes Major Reforms to Address Medical Liability Crisis. Greensboro, North Carolina. July 25, 2002.
[4] Wagner, Michael. "Profits, Executive Pay Up at Malpractice Insurer." Triangle Business Journal. June 16, 2006.
[5] St. John, Paige. "Malpractice Payouts Dropping." Pensacola News Journal. December 7, 2006.
[6] DM Studdert, MM Mello, AA Gawande, TK Gandhi, A Kachalia, C Yoon, AL Puopolo, and TA Brennan, Claims Errors, and Compensation Payments in Medical Malpractice Litigation, N Engl J Med 2006; 354:2031.
[7] Total values were inflation-adjusted to 1991 dollars using the Medical Care Services factor of the Consumer Price Index, All Urban Consumers. Data extracted on August 17, 2006.
[8] NPDB data for 2005 list 14,034 incidents of medical malpractice. Of those, 4,504 include an outcome of death.
[9] Kohn LT, Corrigan JM, Donaldson MS, eds. To Err is Human: Building a Safer Health System. Washington, DC: National Academy Press, 2000.
[10] http://www.thedoctors.com/newsroom/issues/medmalcrisis.asp. Visited: 19 September 2006.
[11] The Committee on Energy and Commerce. "Not Every Malpractice Claim Requires a Lawsuit, Congress Told." July 14, 2006. http://energycommerce.house.gov/108/News/07142006_1991.htm. Visited: 19 September 2006.
[12] Population estimates for each year were extracted from the U.S. Census online database.
[13] Palmisano, Donald. Address of the President. 153rd Annual Meeting, American Medical Association House of Delegates. June 12, 2004. http://www.ama-assn.org/meetings/public/a04/calltoordera04.pdf
[14] http://www.instituteforlegalreform.com/issues/index369e.html?p=medical. Visited: 19 September 2006.
[15] Bush, G.W. "President Calls for Medical Liability Reform." University of Scranton. Scranton, Pennsylvania. January 16, 2003. http://www.whitehouse.gov/news/releases/2003/01/20030116-1.html
[16] DM Studdert, MM Mello, AA Gawande, TK Gandhi, A Kachalia, C Yoon, AL Puopolo, and TA Brennan, Claims Errors, and Compensation Payments in Medical Malpractice Litigation, N Engl J Med 2006; 354:2024-33.
[17] PK Howard, Is the Medical Justice System Broken?, Obstetrics & Gynecology, Vol. 102, No. 3, September 2003: 446-449.
[18] The total value of payments in 2005 for injuries classified in the NPDB as "emotional injury" was $22,548,000, or .55 percent of the total value of all payments, $4,082,205,250. Injuries classified as "insignificant injury" totaled $12,191,400, or .30 percent of the total value of all payments.
[19] Kohn LT, Corrigan JM, Donaldson MS, eds. To Err is Human: Building a Safer Health System. Washington, DC: National Academy Press, 2000.
[20] Institute of Medicine. http://www.iom.edu/?id=35961. Visited: 19 September 2006.
[21] Schoenbaum, Stephen; Bovbjerg, Randall. Malpractice Reform Must Include Steps to Prevent Medical Injury. Annals of Internal Medicine. 2004;140:51-53.
[22] Mullen, Frank X, Jr. Investigation Shows Medical Board Often Allows Troubled Doctors to Practice Despite Serious Mishaps. Reno Gazette-Journal, February 16, 2004.
[23] Clinton, Hillary; Obama, Barack. "Making Patient Safety the Centerpiece of Medical Liability Reform." N Engl J Med. 2006 May 25;354(21):2205-8.
[24] Thompson, R. "Hospital, Doctor Charged $5.6 Million for Screwdriver Implant." Honolulu Star-Bulletin. Vol. 11, Issue 73 - March 14, 2006.
[25] Categories of error as tracked by the NPDB.
[26] Schoenbaum, Stephen; Bovbjerg, Randall. Malpractice Reform Must Include Steps to Prevent Medical Injury. Annals of Internal Medicine. 2004;140:51-53.
[27] http://www.pstoolbox.org/
[28] Institute of Medicine. Preventing Medication Errors. July 20, 2006. p.5
[29] Institute of Medicine. Preventing Medication Errors. July 20, 2006. p. 222.

[30] Piechowski, Rod. "Making CPOE Work: Redesign Workflows to Optimize Benefits." Patient Safety & Quality Healthcare. March/April 2006.
[31] Davis, Robert. "'Wrong Site' Surgeries on the Rise." USA Today. April 17, 2006.
[32] LK Barger, NT Ayas, BE Cade, JW Cronin, B Rosner, FE Speizer, CA Czeisler. "Impact of Extended-Duration Shifts on Medical Errors, Adverse Events, and Attentional Failures." PLoS Medicine. Vol. 3, Issue 12. December 2006.
[33] Institute of Medicine. To Err is Human. 2000. p. 269
[34] *Autopsy as an Outcome and Performance Measure*. Summary, Evidence Report/Technology Assessment: Number 58. AHRQ Publication No. 03-E001, October 2002. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/clinic/epcsums/autopsum.htm
[35] ibid.
[36] Senator Charles E. Grassley. Letter to Mark McClellan, Administrator, Centers for Medicare and Medicaid Services. March 3, 2006.
[37] 2006 Report of Doctor Disciplinary Information on State Web Sites. Public Citizen. 17 October 2006.
[38] Public Citizen. "New Jersey Ranks First, North Dakota Ranks Last for Doctor Disciplinary Information on State Medical Board Web Sites." October 17, 2006.