BRIEFING BOOK

MEDICAL MALPRACTICE: BY THE NUMBERS

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January 2023 Update
# BRIEFING BOOK

## MEDICAL MALPRACTICE: BY THE NUMBERS

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Experts say and data show that, even with its problems, the current medical malpractice system works.

The best way to reduce malpractice litigation is to reduce the amount of malpractice.

PART 2: MEDICAL MALPRACTICE, HEALTH CARE COSTS AND “DEFENSIVE MEDICINE”

Stripping away patients’ legal rights will not lower (and may increase) health care costs; “tort reform” does not reduce medical tests and procedures (“defensive medicine”).

Studies establishing “defensive medicine” are unreliable.

“Defensive medicine” is Medicare fraud.

The real reason doctors order too many tests and procedures: workload and revenue.

PART 3: PHYSICIAN SUPPLY AND ACCESS TO HEALTH CARE

“Tort reform” does not improve access to care; physician shortages result from factors having nothing to do with liability.

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Premium spikes that doctors periodically experience are unjustified price-gouging and are not caused by jumps in lawsuits or claims.

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Industry insiders have historically said that capping damages will not lower insurance rates.

Strong insurance regulatory laws are the only way to control insurance rates for doctors and hospitals.

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PART 1: MEDICAL MALPRACTICE LITIGATION

EXPERTS AGREE THAT WHEN CASES ARE FILED, THEY ARE NOT “FRIVOLOUS”; FEW INJURED PATIENTS FILE CLAIMS OR LAWSUITS YET IT IS STILL DIFFICULT FOR THEM TO WIN CASES.

“CSP STAT Civil: Trial Court Caseload Overview, Data Table – Malpractice Medical, Incoming Cases” and “CSP STAT Civil: Trial Court Caseload Overview, Data Table – Total Civil and Total Tort, Incoming Cases,” National Center for State Courts, 2022.

According to calculations of the most recent data released by the National Center for State Courts (NCSC):

- Medical malpractice cases represented a tiny percentage of state civil caseloads in 2021, ranging from 0.01 to 0.56 percent.¹ This range is consistent with NCSC data from the previous nine years.²

- Medical malpractice cases accounted for an extremely low percentage of state tort caseloads in 2021, ranging from a low of 0.53 percent to a rare high of 9.29 percent.³ This range is consistent with NCSC data from the previous nine years.⁴


Doctors prevailed in 81.9 percent of medical malpractice cases alleging injury from image-guided procedures. According to researchers, “This figure is in accordance with previous results finding that verdicts favor the physician in approximately 80 to 90 percent of cases that proceed to jury verdict.”⁵


- “[M]edical liability insurers have always known that most patients who bring medical malpractice claims have suffered significant injuries, and that many of those claims meet the legal standard for tort liability. They have also known that many of those injuries are preventable and, thus, that hospitals and other places where patients receive care still have room for improvement.”⁶

- “[P]atients must sue to obtain recoveries and, to sue successfully, they must hire attorneys. Because malpractice cases are expensive to prepare and are defended zealously by insurers, plaintiffs’ attorneys choose cases with care.”⁷
“Medical Harm: Patient Perceptions and Follow-up Actions,” Johns Hopkins University School of Medicine Professor of Surgery Martin A. Makary et al., 2014.

Researchers found that a lawsuit was filed on behalf of the patient in 19.9 percent of harms. In other words, “approximately 1 in 5 patient harms resulted in a lawsuit.” As the authors explained, “This is similar to the Harvard Medical Practice Study, which reported an estimated ratio of adverse event to malpractice claim of 7.6:1. Other studies have estimated that as few as 2% to 3% of patients pursue litigation. These findings all suggest that the vast majority of patient harms never result in a lawsuit.”

“Measuring Diagnostic Errors in Primary Care,” Johns Hopkins University School of Medicine Associate Professor of Surgery Martin A. Makary and Johns Hopkins University School of Medicine Associate Professor of Neurology David E. Newman-Toker, 2013.

“Only about 1% of adverse events due to medical negligence result in a claim.”

“Medical malpractice: Why is it so hard for doctors to apologize?” University of Massachusetts Medical School Chief of Pediatric Cardiology Darshak Sanghavi, 2013.

“Contrary to many doctors’ beliefs, there is no epidemic of frivolous lawsuits” and “when doctors make an actual mistake, the system is slightly biased in their favor.”


Experts say that those who try to argue that the system is flooded with frivolous lawsuits deceptively interchange the terms “claims” and “lawsuits” to try to make their case. In other words, “[M]isleading impressions about the medical malpractice system, such as the AMA’s statement that ‘75 percent of medical liability claims are closed without a payment to the plaintiff’ (AMA 2006) depend wholly on failing to distinguish between weak cases, which tend not receive payment, and strong cases, which every study shows to receive payment at a higher rate than that suggested by the AMA. Distinguishing between the two groups of studies is important because a claim presented to an insurer is not the same as a lawsuit. And claims against multiple defendants may lead to recovery from only one, leaving three claims without a payment but an incident with evidence of negligence.”

American Tort Reform Association General Counsel Victor Schwartz, 2011.

“It is ‘rare or unusual’ for a plaintiff lawyer to bring a frivolous malpractice suit because they are too expensive to bring.”
THE NUMBER ("FREQUENCY") AND SIZE ("SEVERITY") OF MEDICAL MALPRACTICE CLAIMS, LAWSUITS AND PAYOUTS ARE LOW.

See also PART 8: THE IMPACT OF COVID

Medical Malpractice Litigation: How It Works, Why Tort Reform Hasn't Helped, Pritzker Law School and Kellogg School of Management Professor Bernard S. Black et al., 2021.

Six top medical malpractice researchers examined data about jury verdicts and insurance payouts and found the following:

- Industry campaigns focused on jury verdicts are disingenuous, “based on an incomplete and potentially misleading factual foundation.”

- There is a “large gap” between what juries award and what insurers actually pay, which is far less.
  - Seventy-four percent of patients receive less than what a jury awards whether the wrongdoer is a physician, hospital or nursing home.
  - On average, juries award about twice as much as an injured patient ultimately receives, and the larger the verdict, the relatively less the injured patient receives.
  - When verdicts are more than $2.5 million, 95 percent of patients receive less than that – on average 55 percent less.
  - If a verdict exceeds $10 million, the patient receives on average 65 percent less than the verdict.

- While health care providers carry medical malpractice insurance, it is often minimal and insufficient to cover the harm they cause.
  - In Texas, while there is a “widely held belief that policies with $1 million per occurrence limits are standard,” the authors found that between 1986-2003, “the median nominal policy limit was $500,000. Only 34 percent of the policies had nominal limits of $1 million…. By contrast, 33 percent had nominal limits of $200,000 or less.”
  - The researchers found that “this standard size has not changed, to our knowledge, since at least the 1980s, even though nominal prices have more than doubled since then. This suggests that real policy limits are likely dropping in other states too.”

- Injured patients collect, on average, only 15 percent of verdicts that exceed a provider’s policy limit.
• While cases involving newborns who are catastrophically injured may result in higher jury verdicts, “perinatal physicians carry less insurance than other physicians and have reduced their insurance coverage over time.” That means these babies can be severely undercompensated for the lifetime of care they will require.


• “The number of paid claims each year against physicians and other health care practitioners declined steadily from 2001 to 2016 and has remained steady since then. The best data come from the National Practitioner Data Base,” which show that the number of paid claims against all individual health care providers shrunk “from 19,772 paid claims in 1991 to 11,538 in 2019 – a drop of 42 percent.” (Note that some of this reduction may be due to physician migration into larger hospital systems. Claims may be settled by hospitals and not by individuals.14)

• For physicians, “the drop has been even sharper, falling 47 percent between 2001 and 2019. Setting aside the low 2020 number as a pandemic aberration, the 2019 numbers are the lowest recorded since NPDB began collecting statistics in 1991, amounting to 61 percent of the number of paid claims in that year.”

• “When the statistics are adjusted to take population growth into account…the number of paid claims for all practitioners reported by NPDB is now less than half of what it was in 1991 (47%).”

• “A detailed review of the NPDB data from 1997 to 2014 found that ‘[t]he decrease occurred across all specialties, although the magnitude of the decline varied markedly by specialty, and was significant in each specialty except cardiology.’ The study found that in 2014 one paid claim was reported each year for every 100 physicians. By 2019, only one claim was paid for every 28,572 Americans.”

• A.M. Best data from 2011-2019 show that nominal payments “did begin to rise again in 2011 and have risen slowly for nearly a decade. …. Nevertheless, the rate of growth has been modest. Nominal payments since 2011 have risen 3 percent annually, only 0.8 percent faster than consumer prices” and “more slowly than the medical inflation that drives settlement costs up….”

• “[L]arge settlements constitute a surprisingly small fraction of all claims and have remained a small fraction” from 1991-2020. Settlements between a half million and one million dollars as well as those at or above $1 million in 2020 dollars “have declined in frequency since their peak in 2003-04.” Moreover, the number of settlements over $1 million in 2020 dollars “has fallen by 38 percent since its peak in 2003.”15

“At The Doctors Company, we have seen a drop from a high of 17 claims per 100 physicians in 2000 to fewer than seven claims per 100 physicians today.”

A Call for Action: Insights from a Decade of Malpractice Claims, Coverys, 2020.

- Closed claims data from 2010-19 show that “general claims trends from the past decade remained mostly stagnant. Between 2010 and 2019, the overall closed-with-indemnity-payment rate was essentially flat, averaging slightly more than 23%.”
- “Claims frequency has trended downward to an average of 4.4 percent.”

The Power to Predict, CRICO Strategies, 2020.

Analysis of 37,000 medical professional liability (MPL) cases closed between 2014 and 2018 showed that 70 percent closed without an indemnity payment.


- “Overall MPL case frequency dropped 27% from 2007-2016, with an especially compelling trend for obstetricians-gynecologists.”
- “Fewer cases are being asserted relative to the physician population. The 2016 rate, 3.7 cases per 100 physicians, reflects a steady downward trend.”
- “For ob/gyns (whose rate is historically higher than the average for all MDs), the risk of having an MPL case filed against them dropped 44% from 2007–2016.”
- On average, from 2007-2016, 70 percent of cases closed without payment.
- “MPL indemnity payment trends for the 10-year study period were not dramatic. The median payment increased in line with inflation (from $110K in 2007, to $120K in 2016). The average payment, even though distorted by a few atypical payouts, grew on average 3% annually (from $298K to $360K). While that outpaced the consumer price index, it fell below medical inflation, a fair proxy for medical expenses which, along with policy limits, heavily influence payments.”
- “Certainly, extraordinary jury awards draw media attention, pique the interest of reinsurers, and can skew the focus of patient safety improvements, but they remain rare. Per 1,000 cases closed, only one or two cases closed with more than $5 million indemnity. Outlier payments (those exceeding $11M) had a minimal impact on overall indemnity trends.”

“Severity (size of claims) always increases due to medical inflation. However, if severity is rising, look to changes in health care. With the growing migration of doctors into hospital systems, there inevitably will be one larger combined payout instead of fewer smaller payouts split between doctors and hospitals. However, that does not lead to an impact in insurers’ overall costs.”


The med mal insurer examined over 1,200 pediatric patient claims filed against doctors that closed from 2008-2017 and found that only 37 percent resulted in payment.20


An analysis of all paid malpractice claims from the National Practitioner Data Bank from 1992-1996 to 2009-2014 revealed the following21:

- The overall rate of claims paid on behalf of physicians dropped by 55.7 percent.
- Only 7.6 percent of paid claims exceeded $1 million.
- 32.1 percent of paid claims involved a patient death.
- Error in diagnosis was the most common type of allegation, present in 31.8 percent of paid claims, followed by surgical errors (26.9 percent) and errors related to medication or treatment (24.5 percent).


- When adjusted for medical care inflation, claims per physician are at their lowest level in four decades.
- Total medical malpractice payouts have never spiked and have generally tracked the rate of inflation.22


According to the Doctors Company, one of the nation’s largest malpractice insurers, “the rate of claims has dropped by half since 2003.”23
“The Receding Tide of Medical Malpractice Litigation Part 1: National Trends,”
University of Illinois Professor of Law and Medicine David A. Hyman et al., 2013.

Hyman and colleagues Bernard S. Black and Myungho Paik, both from Northwestern University, found:

- “[A]ll states have experienced large drops in paid claims per physician and payout per physician…. [T]he per-physician rate of paid med mal claims has been dropping for 20 years and in 2012 is less than half the 1992 level.”
- “We find large drops in paid claim rates per active physician nationally and in no-cap states. ... From 1992-2012, paid claims per physician dropped by 57% nationally, including 51% in the 20 no-cap states, 57% in the 19 old-cap states, and 64% in the 12 new-cap states.”
- “This trend applies to med mal suits generally, not just to paid claims and not just to claims against physicians. We find similar trends for med mal lawsuits in the 18 states where we have data on lawsuits.”

❖ A SMALL NUMBER OF DOCTORS ARE RESPONSIBLE FOR MOST MALPRACTICE PAYOUTS; INCOMPETENT PHYSICIANS ARE RARELY HELD ACCOUNTABLE BY STATE MEDICAL BOARDS OR THE FEDERAL GOVERNMENT.

Ranking of the Rate of State Medical Boards’ Serious Disciplinary Actions, 2017-2019,
Public Citizen, 2021.

“Given the observed wide variation in serious disciplinary actions taken per 1,000 physicians across states and the District of Columbia, it is clear that many, if not most, state medical boards are doing a dangerously lax job in enforcing their states’ medical practice acts. Low rates of serious disciplinary actions suggest that medical boards are not adequately taking actions to discipline physicians responsible for negligent medical care or whose behavior is unacceptably dangerous to patients.”25 (See also PART 8: THE IMPACT OF COVID)

“‘An inherent conflict of interest’: State medical boards often fail to discipline doctors who hurt their patients,” CBS News, 2021.

“‘It’s a very small proportion of physicians that have caused a bulk of the problem,’ says Robert Oshel, who spent 15 years at the federal Department of Health and Human Services in Washington where he worked with the National Practitioner Databank, a federal database used by hospitals to keep track of bad outcomes by doctors. Oshel scoured the databank and calculated that 1.8 percent of doctors are responsible for more than half of all malpractice
payouts. Of that small group, ‘Only 1 in 7 have had action taken against them by any state.’**26

**A Call for Action: Insights from a Decade of Malpractice Claims, Coverys, 2020.**

Closed claims data from 2010-19 show that “63% of surgical claims involve a surgeon with multiple claims.”**27

“Medical Malpractice and Physician Discipline: The Good, The Bad and The Ugly,” Georgetown University Law Professor David A. Hyman, Sharif University of Technology Assistant Professor Mohammad Rahmati and Kellogg School of Management Professor Bernard S. Black, 2020.

Analysis of data on Illinois physicians who held an active license at any point from 1990-2012 revealed the following:

“The ‘bad’ is that a small number of repeat offender-defendants account for a disproportionate share of paid claims and disciplinary actions. Physicians with 2+ paid claims account for only 2.6% of all licensed physicians, but they are responsible for 54% of all paid claims and 52% of payouts. Similarly, physicians with 2+ disciplinary actions account for 0.5% of physicians, but 38% of all disciplinary cases.

“Finally, there is no shortage of ugly in our findings. One ‘ugly’ is the ability of some physicians to retain their licenses despite being frequent flyers in both the med mal and disciplinary systems. Another “ugly” is that a small number of Illinois hospitals have affiliated physicians with records much worse than average for the state as a whole – whether for paid claims, disciplinary actions, or both together.”**28


“[F]or more than two decades, HHS has failed to report nearly two-thirds of medical malpractice payments to the National Practitioner Data Bank (NPDB), as required by law and the department’s own policy. …Public Citizen found that from 1994 to 2016, out of a total of 3,352 medical malpractice payment reports that should have been submitted to the NPDB by HHS, the agency failed to submit 2,113 (63%) of these reports. By not reporting these payments, HHS has compromised patient safety and the integrity of the NPDB….”**29

**“Your Doctor Might Have a Disciplinary Record. Here’s How to Find Out,” ProPublica, December 11, 2019.**

“Doctors can be disciplined for criminal convictions, medical negligence, wrongly prescribing controlled substances and other wrongdoing. Even with a disciplinary record, many doctors continue to practice, some even changing states to do so. Although hospitals
have access to a federal database to look up the disciplinary histories of doctors in every state, the public cannot access it.”


- “The Journal examined 163 malpractice claims against the Indian Health Service that the government settled or lost since 2006. One out of four doctors involved in those cases worked for the IHS despite a history that should have raised red flags by the agency’s own standards, the Journal found. At least 66 of the patients died as a result of the alleged malpractice, the analysis found.”

- “IHS officials hired doctors whom state regulators had punished for transgressions such as drug addiction or sexual misconduct. One doctor who was sanctioned by a state medical board after a patient accused him of sexually abusing her during a surgical exam found work with the IHS, records show.”


Researchers examined Medicare and NPDB data on paid claims against 480,894 doctors from 2003-2015 and found the following:

- Roughly 2 percent of physicians accounted for almost 40 percent of all paid medical malpractice claims.

- “[M]ore than 90 percent of doctors who had at least five claims were still in practice.”

- The “overwhelming majority of doctors who had five or more paid claims…moved to solo practice and small groups more often, where there’s even less oversight, so those problematic doctors may produce even worse outcomes. …This makes sense, in some ways. Doctors with many claims may find it harder to find employment in large groups or in big clinics. Anyone can, however, set up his or her own practice. The general public is much less likely than a potential employer to seek out information about prior lawsuits.”

- “‘There is an emerging awareness that a small group of ‘frequent flyers’ accounts for an impressively large share of all malpractice lawsuits,’” said the study’s lead author.

“Info on doctors is hard to find,” Investigative Post, April 11, 2019.

- “In 2017, almost 1,400 doctors, across [New York State], were on probation. There were more than 75,000 doctors licensed in New York, as of January 2019. Being put on probation is a less serious disciplinary action than a license revocation, or suspension, but more serious than a fine or reprimand.”
• “The onus is on patients to find this kind of information – rather than on hospitals or doctors to proactively disclose it. If a doctor is on probation, for instance, there’s no legal requirement that they tell patients. New York isn’t unusual in this regard.”


• “Hundreds of Florida doctors have paid out multiple malpractice claims – putting patients at risk 15 years after voters passed a law that was supposed to take away their licenses.”

• “The I-Team found at least 120 Florida doctors who racked up three or more malpractice claims over the past decade and state records show only two doctors have had their licenses revoked under the three strikes rule.”

• One doctor “paid out 16 malpractice claims since 2000 – including six cases involving patient deaths. State records show his insurance paid out a total of $2.6 million in those cases.”


• “More than 250 doctors who surrendered a medical license were able to practice in another state, an investigation by the Milwaukee Journal Sentinel, USA Today and MedPage Today found.”

• “In a third of the 250 cases, doctors who surrendered their licenses were able to practice elsewhere without any limitations or public disclosure, simply by changing their addresses. In the other cases, they faced disciplinary action that patients might not be able to find out about.”

• “States can take action against doctors based on license surrenders in other places. But, as with other matters in the broken world of doctor discipline, such a step is spotty. Some states don’t even search a national database of troubled physicians. What’s more, voluntary license surrenders can mean the public gets no access to information about what happened, putting future patients at risk.”


“[P]ublic records show that some dentists have been allowed to practice even after repeated complaints about the quality of care. Other potentially dangerous dentists also have been allowed to stay in practice. In one case, over the past 15 years, the board has provided at least half a dozen chances to a drug-addicted dentist.”

- Only one of “73 doctors around the country with active medical licenses who got FDA warning letters over a 5-year period alleging serious problems” was disciplined by his state medical board. Such letters are “sent after FDA officials conduct inspections at offices, clinics, and medical facilities to determine if federal rules designed to protect patients are being violated.”

- “In all, 28 states have doctors who have been warned yet have been allowed to practice unfettered.”

- “State boards took no action on a wide range of problems: Fertility clinics that didn’t test donors of eggs and sperm for communicable diseases; researchers who didn’t follow rules designed to protect patients who volunteer for trials of drugs and devices; and doctors…who pushed dubious treatments and supplements to unwitting customers.”


- “The National Practitioner Data Bank – the government-sponsored repository for records of medical malpractice judgments and certain other adverse actions – has always been a boogeyman for physicians, a secretive list where you don’t want your name to appear. But at least one regulatory group isn’t paying that much attention to whether physicians are named in it or not.”

- “In 2017, 30 state medical boards in the U.S. backgrounded a physician using the database fewer than 100 times, according to numbers from the Health Resources and Service Administration. Thirteen boards didn’t even check it once. While there are other tools for boards to learn about troubles faced by the physicians they license, experts say the NPDB – despite its limitations – is a key part of any backgrounding process.”


- “Stories about individual doctors avoiding discipline in a second state have been reported before. An investigation by the Milwaukee Journal Sentinel and MedPage Today shows how widespread the problem is: At least 500 physicians who have been publicly disciplined, chastised or barred from practicing by one state medical board have been allowed to practice elsewhere with a clean license. And their patients are kept in the dark – even as more become victims – thanks to an antiquated system shrouded in secrecy.”

- “Among the more than 500 doctors identified by the Journal Sentinel and MedPage Today, the single biggest reason for board action was medical errors or oversights. One fifth of the cases were a result of putting patients in harm’s way. All have slipped through
a system that makes it difficult for patients, employers and even regulators in other states to find out about their troubling pasts. The list represents a fraction of the nation’s roughly 200,000 physicians who hold licenses in more than one state, but likely far underestimates the scope of the problem.**40**


After studying forty-one years of closed case data from Indiana that covered the disciplinary and med mal records of almost 30,000 physicians, researchers found the following**41:**

- “[A] small number of physicians accounted for a heavily disproportionate share of med mal claims. Only 5% of physicians had five or more claims, but they accounted for 45% of all claims and 49% of paid claims.”

- “Even physicians with multiple paid claims are unlikely to be disciplined, and a large share of disciplined doctors had no med mal claims or had no paid claims. Indeed, fully 92% of repeat med mal defendants with 2 or more paid med mal claims were not sanctioned.”

- “Sanctions were not particularly severe, even for physicians who were tagged by both [the medical malpractice and state licensure/disciplinary] systems.”


- “The state Department of Health is required to review every malpractice lawsuit filed against Florida doctors to identify and punish problem doctors. Those reviews rarely lead to discipline, a *South Florida Sun Sentinel* investigation found. The department has reviewed nearly 24,000 resolved state and federal lawsuits against doctors over the past decade but has filed disciplinary charges just 128 times – about one-half of one percent of the cases, records show. While medical malpractice cases are often settled, even those that end in judgments against doctors go unpunished by Florida’s health regulators.”**42**

- Florida regularly allows doctors to continue to see, treat, and operate on people for years after accusing them of endangering patients.
“Doctors on Probation Aren’t Required to Disclose Deadly Medical Mistakes to Patients,” NBC Bay Area, May 15, 2017.

- “More than 600 physicians and surgeons across [California] are currently on probation for a wide-range of violations including sexual assault, insurance fraud, and medical negligence that has resulted in the deaths of patients. Despite the severity of such violations, the Medical Board does not require doctors to notify their patients of their probation status.”

- “Each year, the board receives more than 8,000 complaints concerning physicians and surgeons, with only a few hundred of those complaints resulting in discipline. But even when investigators determine a doctor acted inappropriately, it takes an average of 909 days from when a complaint is submitted before a physician faces any kind of penalty. State regulations allow nearly all of those doctors to continue to see patients in the meantime.”

“The Detection, Analysis, and Significance of Physician Clustering in Medical Malpractice Lawsuit Payouts,” former U.S. Department of Health and Human Services Division of Practitioner Data Banks Associate Director for Research and Disputes Robert E. Oshel and St. Mary’s Medical Center Neurosurgeon Philip Levitt, 2016.

- “Fewer than 2% of all physicians reporting to National Practitioner Data Bank (NPDB) over the past 25 years were responsible for half of all settlements, a total of more than $41 billion….“

- “Physicians who were in the high dollar payout category and had one malpractice claim payout had a 74.5% chance of another payout, more than twice the rate for all physicians who had a single payout…. The likelihood that that physician would have additional payments increased as the number of previous payments increased. Total dollar payouts per physician better predicted future payouts than numbers of payouts.”

- “Because those physicians in the group responsible for 50% of the dollars paid were more likely to have higher payments and to be repeaters than the entire group for the most commonly occurring numbers of payments, it suggests that the best way to identify physicians requiring intervention involves examining the total malpractice dollars paid by physicians.”

- Though 1.8 percent of all physicians were responsible for half the malpractice payments from September 1, 1990 through June 30, 2015, “only a small percentage of those reporting to the data bank lost clinical privileges or were subject to action by licensing boards.” More specifically, “12.6% had an adverse licensure action reported to the NPDB, and 6.3% had a clinical privileges action reported.”

- “The lack of effective action by licensing boards and peer reviewers is a source of distrust of the medical profession. Given the existence of an outlier group responsible for
a high proportion of malpractice payments, whether measured by numbers of payments or total dollar amount of their payments, the rates of discipline among those groups beg the question of the efficacy of peer review at the state boards and hospitals.”

“Prevalence and Characteristics of Physicians Prone to Malpractice Claims,”
Stanford University Professor of Medicine and Law David M. Studdert et al., 2016.

According to the study, which reviewed National Practitioner Data Bank consisting of 67,000 paid claims against more than 54,000 physicians from 2005 through 2014:

- “Approximately 1% of all physicians accounted for 32% of paid claims.”
- “Neurosurgeons, orthopedic surgeons, general surgeons and obstetrician-gynecologists were among those who faced double the risk of future claims, compared with internal medicine physicians, the study showed.”
- However, the risk of a future claim was due to a physician’s past claims history, not their specialty. “The most important predictor of a claim appeared to be a physician’s past claims history. Compared with doctors with one previous paid claim, those with two paid claims had almost twice the risk of having another. Physicians with three paid claims had three times the risk. Those with six or more had more than 12 times the risk, the study found.”
- According to the study’s lead author, Stanford University Professor of Medicine and Law David Studdert, “The results suggest it may be possible to identify ‘claim-prone’ physicians and intervene before they encounter additional claims. I think a lot of liability insurers and health care organizations have not taken that analytical step to really understand who these folks are.”


- “A very small percentage of doctors have accounted for most of the country’s medical malpractice payouts over the last quarter century. That’s according to an analysis done for Consumer Reports of the National Practitioner Data Bank, a federal repository that has collected disciplinary actions and medical malpractice payouts since 1990.”
- “[L]ess than 2 percent of the nation’s doctors have been responsible for half of the total payouts since the government began collecting malpractice information.”
- “Thousands of doctors across the U.S. are on medical probation for reasons including drug abuse, sexual misconduct, and making careless – sometimes deadly – mistakes. But they’re still out there practicing. And good luck figuring out who they are.”
“Some of the most egregious cases raise the question: What does it take for a doctor to have his or her license suspended or revoked?” … “[P]atient advocate Robert E. Oshel, the former official at the NPDB, says medical boards tend to protect their own. ‘They’re run mostly by doctors, and they are often reluctant to take actions against physicians unless they get a lot of pressure, or if something comes out in the press,’ he says.”

**SEXUAL ABUSE OF PATIENTS GOES LARGELY UNPUNISHED.**


NPDB data from January 1, 2003, to December 31, 2017 revealed the following:

- “510 (37.7%) of the physicians with sexual-misconduct–related NPDB reports continued to have active licenses and clinical privileges in the states where they were disciplined, or had malpractice payments due to their sexual-misconduct offenses. Because some physicians may have had active licenses and clinical privileges in states other than the ones in which they were disciplined, an even higher proportion of physicians may have been able to continue practicing medicine because medical boards and health care organizations in these other states may not have taken disciplinary actions against these physicians that resulted in revocation or suspension of their licenses and clinical privileges.”

- “Of the 317 physicians with at least one sexual-misconduct–related clinical-privileges or malpractice-payment report, 221 (69.7%) had not been disciplined by any state medical board for such misconduct during our study period. Importantly, 151 (68.3%) of these 221 physicians committed sexual misconduct involving patient victims and 61 (27.6%) committed sexual misconduct involving multiple victims. Physical sexual contact or relations and nonspecific sexual misconduct were the primary reported forms of sexual misconduct perpetrated by 116 (52.5%) and 85 (38.5%) of these 221 physicians, respectively.”


“[M]edical boards may not always act on complaints of physician sexual abuse of patients, especially when there is no material evidence or witnesses. A 2006 report found that two-thirds of all complaints received by medical boards were closed either due to inadequate evidence to support the charges or because these cases were resolved informally, through a notice of concern or a similar communication with the involved physician. The report noted that only 1.5% of the overall complaints to medical boards reached the formal hearing stage.
“There is evidence that even when medical boards discipline physicians for sexual abuse, those physicians often are permitted to resume medical practice. [M]edical boards did not discipline 70% of the physicians who had peer-review sanctions or malpractice payments made on their behalf due to sexual misconduct.”


• “Often, actions against a physician’s license only occur following a criminal conviction related to medical misconduct.”

• “State boards can request information on physicians too, but its use has been limited and often ignored during licensing. In 2017, 30 state boards used it fewer than 100 times, while 13 never bothered to check it once, according to numbers from the Health Resources and Service Administration.”

• “Inconsistencies across state boards can allow physicians to cross a state border, renew their license, and continue to practice, even after they have had their license revoked. Fifteen states do not share complaints with other medical boards, while 21 denote board actions taken in other states on a physician’s profile.”


• “California is often cited as one of the more rigorous states in overseeing doctors. But, according to the medical board, very few sexual misconduct complaints are reported to the board in the first place, historically under 200 a year. Even fewer result in a formal accusation against a doctor. And when discipline is found to be warranted – typically in fewer than 20 cases a year – the board tends toward leniency, sometimes granting a few years of probation even in instances of severe misconduct, according to a KHN analysis of medical board records.”

• “The number of disciplinary actions taken over the decade is strikingly small given the size of California’s practicing physician population of more than 100,000.”

• “In several cases, the board granted probation knowing the doctor had been convicted of misdemeanor criminal charges stemming from sexual abuse investigations.”

• “According to the board’s disciplinary guidelines, the minimum probation period is seven years for a doctor found to have engaged in sexual misconduct – whether it is a sexual relationship with a patient, sexualized touching during exams or inappropriate sexual conversation. But those ‘minimums’ were not applied in more than half of the probation cases, according to the KHN analysis.”
Crossing the line: Sexual misconduct by nurses reported to the National Practitioner Data Bank, Public Citizen, 2018.

- “[S]tate nursing boards and health care organizations are failing to protect patients from nurses who engage in sexual misconduct.”

- “Only 882 U.S. registered and licensed practical or vocational nurses have been reported to the National Practitioner Data Bank (NPDB) over nearly 14 years (from 2003 through 2016) because of sexual misconduct, according to the study – the first to analyze this national flagging system for sexual misconduct by nurses. While male nurses account for approximately 10 percent of U.S. nurses, they accounted for 63 percent of the nurses reported to the NPDB due to sexual misconduct.”

- “[N]early half of the nurses who engaged in sexual misconduct with patients that led to NPDB malpractice payment reports – 16 out of 33 – were not disciplined by state nursing boards for their misconduct, the study found.”


- “[A]cross the country, most doctors accused of sexual misconduct avoid a medical license review entirely. A study last year found that two-thirds of doctors who were sanctioned by their employers or paid a settlement as the result of sex misconduct claims never faced medical board discipline.”

- “The lenience of penalties for sexually abusive doctors sometimes is a source of frustration even for members of the medical board who administer the discipline…. Sexually abusive physicians are not generally required to apologize or even acknowledge having acted inappropriately in order to keep their license.”


“A broader examination of disciplinary records shows that the [NY] state health department has allowed doctors to keep practicing even when they are repeat offenders who have admitted to misconduct ranging from fraud to sexual abuse of patients to narcotics distribution.”


“Attorney General Christopher S. Porrino says the [State Board of Medical Examiners] has not reinstated any revoked licenses since it instituted reforms in 2015. But a New Jersey 101.5 review of hundreds of pages of consent orders and board decisions found five cases in the last two years in which doctors’ licenses were revoked after they admitted to sexual
misconduct or were convicted of sex crimes but will still be allowed to reapply for their licenses in three to 10 years.”


- An AJC investigation of thousands of sex abuse cases nationwide, as well as model laws identified by regulators, federal officials and patient advocates, revealed that “despite decades of warnings about legal gaps, most states still leave patients vulnerable” to sexually abusive doctors. More specifically, of the 50 states plus D.C., only Delaware managed to score above a 90 out of a possible 100 under the paper’s patient protection analysis. As for the remaining states – one merited an 80; three earned scores in the 70s; 24 states plus D.C. scored in the 60s; twelve states scored in the 50s; and 8 states scored in the 40s. Mississippi was at the bottom of the rankings, at 37 points.

- “The AJC found numerous examples of hospitals and medical boards failing to report disciplinary actions. What’s more, the review found that even when hospitals and medical boards file reports, they may classify violations in a way that conceals the scope of physician sexual misconduct on the very limited portion of the data bank available to the public. Because of such gaps, the AJC – in reviewing board orders, court records and news reports – found about 70 percent more physicians accused of sexual misconduct than the 466 classified as such in the public version of the data bank from 2010 to 2014.”

[HEALTHCARE] MEDICAL MALPRACTICE PAYMENTS ARE NOT ARBITRARY; THEY REVEAL NEGLIGENCE AND FORETELL FUTURE CLAIMS.


- “Using hazard analysis, we study whether various physician characteristics, including prior paid claim history, gender, specialty, years of experience, type of degree (M.D. versus D.O.), country of medical school attendance (U.S. versus non-U.S.), and gender predict future paid medical malpractice (“med mal”) claims, using detailed data on all licensed physicians and all paid claims in Illinois over a 25-year period. This level of granularity is not available using national data. After controlling for other factors, physicians with a single prior paid claim have a four-fold higher risk of future claims than physicians with zero prior paid claims.”

- “Physicians often claim that med mal claims are random events, like being struck by lightning. We find that med mal claims are not random. Certain physician characteristics are consistently associated with higher (or lower) med mal claim risk. These results are
robust to multiple alternative models. Although we have only imperfect measures of skill (i.e., experience and board certification), our findings make it clear that med mal claiming is not random.”

**The Power to Predict, CRICO Strategies, 2020.**

- “Our analysis of 37,000 medical professional liability (MPL) claims and suits identified three key characteristics that, when present, most significantly increase the odds that a given MPL case will close with an indemnity payment.” More specifically, claims and lawsuit data revealed that failure to establish and follow a policy/protocol, patient assessment issues (“i.e., failure to consider and pursue an alternate diagnosis in relation to a patient’s history, symptoms, or test results”) and insufficient documentation of clinical findings, rationale and patient consent fuel med mal payments the most.

- “We can all learn patient safety lessons from the narratives of MPL cases, including those closed without an indemnity payment. Cases that do close with a payment – either through settlement or trial – carry the additional data – and gravity – from such outcomes. That cross-section of evidence is an essential tool for health care providers and MPL insurers trying to understand whether a given case is an outlier or a harbinger of future adverse outcomes.”

**Deep Dive: Safe Ambulatory Care, Strategies for Patient Safety & Risk Reduction, ECRI, 2019.**

A preliminary review of 13,429 claims and lawsuits closed between 2016 and 2018, as reported by the Medical Professional Liability Association revealed, “4,887 closed claims (36%) alleged a diagnostic error, 1,077 (8%) alleged a medication or intravenous (IV) fluid error, and 144 (1%) alleged a patient accident (including falls).”

“Physicians with Multiple Paid Medical Malpractice Claims: Are They Outliers or Just Unlucky?” Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black, Georgetown University Law Professor David A. Hyman and Northwestern University Law School Post-Doctoral Research Fellow Joshua Lerner, 2018.

After examining NPDB 2006-2015 paid claims data, researchers concluded the following:

- “[P]ast paid med mal claims are strong predictors of future paid claims. There are in fact some outlier physicians, with multiple paid med mal claims who are responsible for a significant share of paid claims. Indeed, we find that having even one prior period paid claim triples the likelihood of a future claim. Once a physician – who otherwise has average state- and specialty-specific risk – has two or more prior claims over a limited time period such as three or five years, the likelihood that this was just bad luck is small. With three prior claims, that chance becomes tiny.”
• “Our findings have obvious policy implications. Although many physicians believe that med mal claims are random, we show that there are some outlier physicians who are much more claim-prone than their fellow physicians, and provide rules of thumb for identifying them, relative to a baseline risk level that allows for state-level and specialty-level variation in baseline risk…. The take-home message is simple. When it comes to med mal, past performance predicts future results.”


• “[M]alpractice settlements are both good indicators of past negligence and good predictors of future claims. They are good indicators because both the likelihood and the size of payments correlate with the strength of the evidence of medical malpractice. They are good predictors because the number of past settlements correlates with the likelihood that more payments will be made.”

• “Settlements can serve as good proxies in these ways because, generally, liability insurers are willing to pay claimants and physicians are willing to consent to settlements only when good evidence of malpractice exists.”


• “We find a strong association between [adverse patient safety] rates and malpractice claim rates with extensive control variables and hospital fixed effects (in Florida) or county fixed effects (in Texas). Our results, if causal, provide evidence that malpractice claims leading to payouts are not random events. Instead, hospitals that improve patient safety can reduce malpractice payouts.”

• “We study here the association between rates of adverse patient safety events and rates for paid medical malpractice claims (below, simply “claims” or “malpractice claims”), using data from Florida and Texas, the only states with publicly available data on these claims. In Florida, we find evidence, with hospital fixed effects and extensive covariates, that adverse event rates predict malpractice claim rates. Our point estimates suggest hospitals can meaningfully reduce malpractice claims by investing in patient safety. An improvement from one standard deviation above to one standard deviation below the expected adverse event rate predicts a 32% drop in paid malpractice claims. In Texas, we have only county-level data on malpractice claim rates, but obtain similar point estimates, using county fixed effects.”
• “We find a strong positive association in Florida between adverse patient safety events in hospitals and the number of medical malpractice claims paid by these hospitals. Our results are both statistically strong and ‘economically’ meaningful: A one standard deviation reduction in PSI rates predicts a 16.2% fall in paid malpractice claims.”

❖ “TORT REFORMS” KEEP LEGITIMATE CASES FROM BEING FILED.

“Uncovering the Silent Victims of the American Medical Liability System,” Emory University Associate Professor of Law Joanna Shepherd, 2014.

After conducting a national survey of attorneys to determine medical malpractice victims’ access to the civil justice system, Shepherd found “evidence confirming that many legitimate victims of medical malpractice have no meaningful access to the civil justice system.” Among Shepherd’s conclusions from the survey results and additional analysis of empirical studies:

• “As a result of the high costs of medical malpractice investigation and litigation, many malpractice victims are left without legal remedy. …Unfortunately, most legislative reforms over the past several decades have only exacerbated the access-to-justice problem. Damage caps and other tort reforms that artificially reduce plaintiffs’ damage awards also reduce contingent fee attorneys’ expected recoveries. As a result, even fewer cases make economic sense for the attorneys to accept.”

• Private-industry claims data show that “95% of medical malpractice victims have extreme difficulty finding legal representation unless their damages are significantly larger than the typical damages for their types of injuries.”

• “Data also suggest that the problem of access to justice is worsening; half as many victims with low damage awards recovered in 2010 as they did twenty-five years earlier. The economic realities of the medical liability system are silencing a growing number of victims.”

• “Victims who cannot attain legal representation are effectively excluded from the civil justice system. Because of the complexity and expense of medical malpractice lawsuits, employing a lawyer is critical to a successful claim. Thus, without legal representation, most of these victims will not be compensated for the harm they suffer as a result of medical negligence.”
PHYSICIANS GREATLY MISPERCEIVE THE RISK AND CONSEQUENCES OF BEING SUED AND ULTIMATELY BELIEVE OUTCOMES ARE FAIR; PERSONAL ASSETS ARE NOT AT RISK.


- A majority – 61 percent – of doctors who were sued “believed the outcome of their lawsuit was fair.”

- “More than half of physicians who were sued reported that there were no attitude or career changes after the experience, which is consistent with results of prior surveys.”

Medical Malpractice Litigation: How It Works, Why Tort Reform Hasn’t Helped, Pritzker Law School and Kellogg School of Management Professor Bernard S. Black et al., 2021.

Six top medical malpractice researchers examined data about jury verdicts and insurance payouts and found the following.

- Health care providers often carry minimal medical malpractice insurance, likely knowing that if they purchase inadequate insurance and commit malpractice, injured patients are less likely to file a claim against them, there is little risk they will have to cover the difference personally if a jury rules against them, and even if they are on the hook for something, the amount will be “modest in size.”
  
  o Plaintiffs’ lawyers told the authors that it is so difficult for patients to collect anything exceeding policy limits that lawyers typically cannot afford to take cases when doctors are grossly underinsured, allowing negligent providers to get away with paying nothing and leaving victims with no compensation.

  o In only 0.6 percent of cases did physicians make any out-of-pocket payments, and most of these were “relatively small.”

  o Only 2 percent of damages paid beyond policy limits are covered by defendants, including so-called “deep pocket” institutional defendants like hospitals.

  o The authors “asked a number of Texas medical malpractice plaintiffs’ lawyers whether and when they try to collect above limits from physicians or other defendants. All agreed that they would not pursue a case against a physician if the physician’s policy limits were insufficient to justify bringing the claim. Absent unusual circumstances, they treated policy limits as a hard cap on recovery.”

- “[P]ayments rarely exceed primary carriers’ policy limits, even when jury verdicts establish that the legal value of plaintiffs’ claims is far higher.”

- “[W]hen the providers are independently employed physicians, insurers provide all but a minute fraction of the dollars that are paid.”

- “Even when injuries are large and the facts strongly indicate that negligence occurred, plaintiffs’ attorneys often decline requests for representation when providers carry little or no malpractice coverage.”

“Policy Limits, Payouts, and Blood Money: Medical Malpractice Settlements in the Shadow of Insurance,” University of Texas Law Professor Charles Silver et al., 2015.

- “[Out-of-pocket payments] OOPPs are rare, they rarely threaten physicians’ financial solvency, and they would be even rarer if all physicians bought the $1 million/$3 million policies that the conventional wisdom says they carry.”

- “No study has ever shown that malpractice claims threaten doctors in any state with a significant risk of insolvency.”

- “Although physicians loudly complain that they are one med mal claim away from bankruptcy, the empirical evidence paints a radically different picture. The risk of an OOPP is small – vanishingly so when a physician buys $1 million in malpractice coverage. Physicians who choose to buy smaller malpractice policies, and thus incur somewhat higher but still tiny OOPP risk, probably have only themselves to blame if they end up having to make an OOPP.”

“Five Myths of Medical Malpractice,” University of Illinois Professor of Law and Medicine David A. Hyman and University of Texas Law Professor Charles Silver, 2013.

- “Many physicians seem to believe that malpractice verdicts threaten to wipe out their savings. When assessing this fear, it is appropriate to start by observing that jury trials are uncommon and that plaintiff victories are even less common. …[M]ost malpractice cases are settled or dismissed; only about 2% of claims are tried, and at trial, providers win about 75% of the time.”

- “We also learned something that may surprise many readers. When payments above the policy limits were made, whether in tried or in settled cases, they almost always came from insurers. Out-of-pocket payments by physicians were extraordinarily rare, particularly when physicians had policy limits of ≥ $500,000. One might say, with only
the slightest exaggeration, that physicians have effectively no personal exposure on malpractice claims (other than the obvious and unavoidable side effects of litigation, eg, the emotional and time-related costs of being deposed). Why do plaintiffs’ lawyers not pursue personal assets? Years ago, a qualitative study documented a strong social norm among malpractice lawyers against seeking “blood money” from individual physicians. Our findings buttress that account. The only physicians who should worry about personal exposure are those who grossly underinsure, and even they should not worry too much.”74


“A bizarre aspect of the medical malpractice reform debate is the recognition that doctors grossly misperceive the system, accompanied by recommendations to change the system to cater to their misimpressions. Rather than educate doctors about reality, one reads of proposals to change the system to cater to physicians’ misperceptions (Hermer and Brody 2010). It seems preferable to include a reasonable medical education requirement focusing on how the legal system operates in medical malpractice cases rather than to curtail the current liability system that is widely recognized as underenforcing standard-of-care norms.”75

“Physicians’ Fears of Malpractice Lawsuits Are Not Assuaged by Tort Reforms,” Center for Studying Health System Change Senior Health Researcher Emily R. Carrier et al., 2010.

Doctors’ fear of lawsuits is “out of proportion to the actual risk of being sued” and enacting “tort reforms” have no impact on this phenomenon. Several explanations are suggested for this undue fear. One squarely blames the medical societies, which continuously hype the risk of lawsuits to generate a lobbying force to help them advocate for doctors’ liability limits. A second possible explanation is that doctors will “exaggerate their concern about being sued, using it as a justification for high-spending behavior that is rewarded by fee-for-service payment systems.” A third explanation relates to well-documented human tendencies to overestimate the risk of unfamiliar and uncommon events, such as a fear of plane crashes compared to much more common car crashes. The authors write, “Lawsuits are rare events in a physician’s career, but physicians tend to overestimate the likelihood of experiencing them.”76
COMPENSATION IS FOR SERIOUS INJURIES OR DEATH; HIGH VERDICTS ARE ALMOST ALWAYS SLASHED; AND PUNITIVE DAMAGES ARE EXTREMELY RARE.


High-severity injuries and death accounted for over 74 percent of all claims against medical hospitalists from 2012-2020, with deaths accounting for more than 53 percent of events.\(^{77}\)

A Call for Action: Insights from a Decade of Malpractice Claims, Coverys, 2020.

Closed claims data from 2010-19 show the following\(^{78}\):

- “High-severity injuries and death accounted for 33% of all claims during the 10-year period, with little variation from year to year.”
- “Deaths accounted for 23.8% of events and 37.5% of indemnity paid.”
- “Death and high-severity injury constitute 52% of [diagnostic error] events and 74% of indemnity paid. High-severity injury and death allegations are mostly attributable to missed or delayed cancer diagnoses.”
- Death and high-severity injury cases accounted for 43 percent of medical treatment (\textit{i.e.}, “non-surgical management and care of a patient to prevent or combat disease and disorders”) claims and 73 percent of indemnity paid. “The high percentage of medical treatment events resulting in death is concerning,” namely 36.5 percent.
- “Events resulting in death and medium-severity injuries accounted for 87% of indemnity paid for medication-related events. Death is the costliest severity category (52% of all indemnity paid) for medication-related events, and events resulting in death accounted for 32% of all medication-related events. Medium severity was recorded for 37% of events, and contributed to 35% of the indemnity paid on medication-related cases.”
- “Death and high-severity injury accounted for 55% of [obstetrics] events and 78% of indemnity.”
- “Death and high-severity injury levels comprised 42% of [emergency department-related] events and 75% of total indemnity.”
“Serious misdiagnosis-related harms in malpractice claims: The ‘Big Three’ – vascular events, infections, and cancers,” Johns Hopkins University School of Medicine Director of the Armstrong Institute Center for Diagnostic Excellence and Professor of Neurology, Ophthalmology and Otolaryngology David E. Newman-Toker et al., 2019.

Researchers analyzed over 55,000 malpractice claims and confirmed that “inaccurate or delayed diagnosis remains the most common, most catastrophic and most costly of medical errors.” More specifically, “They found that of the diagnostic errors causing the most harm, three quarters (74.1 percent) are attributable to just three categories of conditions: cancer (37.8 percent), vascular events (22.8 percent) and infection (13.5 percent). These severe cases resulted in $1.8 billion in malpractice payouts over the course of 10 years. The authors also showed that, collectively, the top five in each category account for nearly half (47.1 percent) of all the serious harms.”


- “Although occasional case results seem random or arbitrary, the primary determinant of financial damages in MPL cases is injury severity. High-severity injury cases closed more often with an indemnity payment, and those payments were, on average, four times higher than for medium and low severity cases.”

- “High-severity injuries are more likely to result in indemnity payment. The increasing cost of long term life-care plans are reflected in the average indemnity for patients with severe, but non-fatal outcomes of care.”

- “Over the 10-year study period, nearly two-thirds of obstetrics-related cases and 63% of those alleging a diagnostic error involved high-severity injuries.”

- “Indemnity was impacted most by injury severity and patient age. Death-related cases accounted for the largest amount of total indemnity, but severely-injured patients under age 40 received the highest average payment.”

- “MPL cases compensating future medical expenses for younger patients with severe permanent injuries drive indemnity costs.”

- “Patients with severe, permanent (non-fatal) injuries seek compensation – in addition to pain and suffering – to cover the health care costs and lost income of their remaining years (sometimes decades). Thus, for the 22% of cases involving a patient’s death, the average payment ($453K) was just over half the average payment for patients with permanent severe injuries.”
Emergency Department Risks: Through the Lens of Liability Claims, Coverys, 2019.

After analyzing over 1,300 closed medical malpractice claims filed against hospitals between 2014 and 2018 over emergency department care, the insurance provider found that 61 percent of claims involved serious injury, with more than one-third resulting in death.  


The insurer’s analysis of 472 obstetric-related closed claims across a five-year period (2013-2017) revealed the following:

- 80 percent of cases involved injuries with the “highest clinical severity: significant permanent (e.g., neonatal brachial plexus injury or maternal loss of fertility), major permanent (e.g., neonatal blindness or hearing impairment, maternal organ injury), grave (e.g., neonatal neurological/brain damage, hypoxic ischemic encephalopathy, or cerebral palsy), or death (of mother, baby, or both).”
- 24 percent of cases resulted in death of the baby, mother or both.
- The most common injury to mothers was future infertility (29 percent).
- The most common injury to babies was neurological/brain damage (41 percent), followed by injuries resulting in fetal demise (34 percent).
- The single largest cause of obstetrical claims was “alleged negligence during the management of labor – accounting for 40% of claims and 49% of indemnity paid.” Risks included failure to: “Recognize and act on nonreassuring fetal heart tracings”; “Monitor mother/fetus during administration of high-risk medications (e.g., oxytocin and magnesium sulfate)”; and “Recognize and act on obstetric emergencies.”


The med mal insurer examined over 1,200 pediatric patient claims filed against doctors that closed from 2008-2017 and found the following:

- “Brain injuries accounted for the highest percentage of claims for all age groups: neonates, 48%; first year, 36%; child, 15%; and teenager, 11.”
- “Children in the first-year category of the claims experienced the highest death rate at 30%.” Patient deaths occurred in 15 percent of claims filed for children ages one through nine, 13 percent for neonatal patients and 13 percent for teenage patients.
- 75 percent of neonate closed claims, 65 percent of first year closed claims, 44 percent of ages one through nine closed claims and 32 percent of teenage closed claims were for high-severity injuries.

- “[T]rial verdicts and settlement payments grow in size as injuries become more severe and the strength of the evidence of malpractice increases.”

- “[A] ‘death discount’ exists, meaning that payments tend to be larger when patients sustain grave, permanent injuries than when they die.”

- “Juries often send deserving plaintiffs home empty-handed, and severely injured plaintiffs frequently receive smaller payments than they deserve. The more grievous the injury, the more likely and the more serious the problem of under-compensation tends to be.”

“Five Myths of Medical Malpractice,” University of Illinois Professor of Law and Medicine David A. Hyman and University of Texas Law Professor Charles Silver, 2013.

- “[T]he outlandish jury verdicts that attract popular attention are not at all representative and often are slashed dramatically by judicial oversight or through other means. More broadly, the overwhelming majority (> 95%) of cases are resolved, and the overwhelming majority of payouts are made as a result of voluntary settlement.”

- “There is also a well-established severity gradient: Payments increase with injury severity, with the exception of a death discount (ie, those who die receive less than those who are severely and permanently injured). Unfortunately, most patients are undercompensated, and those with the most severe injuries suffer the biggest gap between provable injuries and the amounts they recover.”

- “Blockbuster verdicts dominate the press, but their coverage reflects their rarity. Reporters are interested in big verdicts for the same reason they are interested in airplane crashes: Both are unusual.”

- “We found that the larger the verdict, the more likely and larger the haircut because policy limits serve as a functional cap on patients’ recoveries. Stated differently, the portion of a jury award that exceeds the available insurance coverage is rarely collectible. Other studies have documented similar haircuts with large verdicts.”
**MEDICAL MALPRACTICE CASES ARE NOT CLOGGING THE COURTS; JURIES RESOLVE FEW CASES.**

“CSP STAT Civil: Trial Court Caseload Overview, Data Table – Malpractice Medical, Jury Trials and Jury Trial Rate,” National Center for State Courts, 2022.

- In 2021, juries resolved a low percentage of medical malpractice cases. Those rates ranged from 0.0 to 9 percent (with the exception of three outliers at 22.8 percent, 30.8 percent and 80 percent). In 2020, those rates ranged from 0.0 to 7.3 percent (with the exception of two outliers at 16 percent and 100 percent).

- Even before the pandemic, juries resolved a low percentage of medical malpractice cases. For example, in 2019, those rates ranged from 0.0 to 10.5 percent of cases (with the exception of two outliers at 16.4 percent and 100 percent). This rate has remained low for the past ten years.


According to a survey of over 4,300 doctors across 29 specialties conducted from May 21 through August 28, 2021, “Few claims ever reach trial. One third (33%) of physicians who were sued said the lawsuit was settled before trial, whereas just 2% said the case went to trial and the judge or jury decided for the plaintiff. These statistics have remained stable over the past 8 years.”

**EXPERTS SAY AND DATA SHOW THAT, EVEN WITH ITS PROBLEMS, THE MEDICAL MALPRACTICE SYSTEM WORKS.**

“Screening Plaintiffs and Selecting Defendants in Medical Malpractice Litigation: Evidence from Illinois and Indiana,” Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black et al., 2018.

After analyzing “comprehensive datasets from Illinois and Indiana, covering every insured med mal claim closed in Illinois during 2000–2010 and in Indiana during 1980–2015” and conducting interviews with med mal plaintiffs’ lawyers, researchers concluded the following:

- “Consistent with prior research, plaintiffs’ lawyers report turning away many of those seeking representation after a short initial meeting or phone call…. Plaintiffs’ lawyers also told us that they will also drop some defendants from a case if investigation indicates that these defendants did nothing wrong or at least that the marginal expected recovery from including them is outweighed by the incremental cost of doing so.”
• “Our data suggest, and our interviews confirm, that screening does not stop when a suit is filed. In some instances, postfiling investigation reveals the case is not worth pursuing, and the plaintiffs’ lawyer will drop the case.”

• “What about the common physician perception that plaintiffs’ lawyers often sue every physician with even a remote connection to the patient? In serious cases involving physicians only, physicians + institutions, and institutions only, there are an average of 1.5 defendants per case in Illinois and 1.8 defendants per case in Indiana. For these categories of defendants, only 4 percent of serious Illinois cases and 8 percent of serious Indiana cases have four or more defendants.”

“Could Mandatory Caps on Medical Malpractice Damages Harm Consumers?”
California State University, Northridge Economics Professor and Cato Institute Adjunct Scholar Shirley Svorny, 2011.

In an October 2011 study, Professor Svorny analyzed existing empirical data and found that the medical malpractice system works just as it should. As Svorny explained,"93

• “The medical malpractice system generally awards damages to victims of negligence and fails to reward meritless claims. Plaintiffs’ attorneys, paid on a contingency basis, filter out weak cases. Patients who file valid claims are likely to collect, generally through out-of-court settlements.”

• “The fact that settlement is common suggests courts are providing good signals as to when plaintiffs will prevail. Under these conditions, insurance companies assess the validity of claims and settle valid claims rather than go to court.”

• “Critics of the system point to the fact that many initial claims do not involve negligence. This can be explained by patients and their attorneys seeking to gather information about the level of negligence associated with an injury. Once discovery shows a small likelihood of success, many plaintiffs drop their claims.”

• “Critics of the medical malpractice system point to its high administrative costs. …Yet, as economist Patricia Danzon observes, the bulk of administrative costs are limited to the small fraction of cases that go to court. Meanwhile, the deterrent effect influences all medical practice.”
THE BEST WAY TO REDUCE MALPRACTICE LITIGATION IS TO REDUCE THE AMOUNT OF MALPRACTICE.


A study published in the *American Journal of Medical Quality* linked quality of care improvements with a reduction in medical malpractice claims. Researchers discovered that a “drop in malpractice claims corresponded with an increase in hospitals’ quality scores,” with the decrease in claims showing a “statistically significant correlation with the increase in quality scores based on 22 Medicare measures....” As one of the report’s co-authors explained, “Clearly, the evidence shows that if you do high quality care, it is well received by patients and decreases your medicolegal costs....”

“A comprehensive obstetric patient safety program reduces liability claims and payments,” Yale School of Medicine Associate Professor of Obstetric, Gynecology and Reproductive Sciences and Chief of Obstetrics Christian M. Pettker et al., 2014.

As reported online by the *American Journal of Obstetrics & Gynecology*, after comparing the five-year period before their patient safety program was implemented to the five-year period afterward (1998-2002 vs. 2003-2007, respectively), Yale School of Medicine researchers found “a strong association between introduction of a comprehensive obstetric patient safety initiative and a dramatic reduction in liability claims and liability payments.” Among their key findings:

- An estimated 95% reduction in direct liability payments and a savings of $48.5 million over a 5-year period.
- A “consistent pattern of statistically significant trends in reduced payments and in the variability of these payments.”
- “Furthermore, during this patient safety intervention there was a 53% reduction in liability claims and lawsuits compared with the 5 years prior.”
- “The mean number of annual cases consistently dropped over the 10-year period.”
- There were absolute decreases in the severity and types of cases in each category.
- “The results from this analysis document a third benefit of initiating a comprehensive obstetric patient safety effort: possible cost savings. Although the primary motivations driving patient safety efforts are improving quality of care and eliminating harm, these data are also important for demonstrating further downstream impacts patient safety projects can have.”
• “A reduction in liability claims is likely a hallmark of an environment with improved quality. In fact, coupling these results with our prior report demonstrating reduced adverse outcomes suggest a direct association, as others have reported.”


• “Our results showed a highly significant correlation between the frequency of adverse events and malpractice claims: On average, a county that shows a decrease of 10 adverse events in a given year would also see a decrease of 3.7 malpractice claims. Likewise, a county that shows an increase of 10 adverse events in a given year would also see, on average, an increase of 3.7 malpractice claims.”

• “We also found that the correlation held true when we conducted similar analyses for medical specialties – specifically, surgeons, nonsurgical physicians, and obstetrician/gynecologists (OB-GYNs). Nearly two-thirds of the variation in malpractice claiming against surgeons and nonsurgeons can be explained by changes in safety. The association is weaker for OB-GYNs, but still significant.”

• “These findings are consistent with the basic hypothesis that iatrogenic harms are a precursor to malpractice claims, such that modifying the frequency of medical injuries has an impact on the volume of litigation that spills out of them. Although this is an intuitive relationship, it is not one that has been well validated previously. It suggests that safety interventions that improve patient outcomes have the potential to reduce malpractice claiming, and in turn, malpractice pressure on providers.”

• “[N]ew safety interventions potentially can have positive effects on the volume of malpractice litigation – a desirable result to seek out, even beyond the immediate impact of medical injuries avoided.”

• “Presumably, the one thing that all parties to the debate can agree on is that reducing malpractice activity by reducing the number of iatrogenic injuries is a good idea. Arguments about the merits of statutory tort intervention will surely continue in the future, but to the extent that improved safety performance can be shown to have a demonstrable impact on malpractice claims, that offers another focal point for policymakers in seeking to address the malpractice crisis. Based on the results of the current study, we would suggest that that focal point may be more immediately relevant than has previously been recognized.”

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PART 2: MEDICAL MALPRACTICE, HEALTH CARE COSTS AND “DEFENSIVE MEDICINE”

❖ STRIPPING AWAY PATIENTS’ LEGAL RIGHTS WILL NOT LOWER (AND MAY INCREASE) HEALTH CARE COSTS; “TORT REFORM” DOES NOT REDUCE MEDICAL TESTS AND PROCEDURES (“DEFENSIVE MEDICINE”).

“Perspectives of Emergency Clinicians About Medical Errors Resulting in Patient Harm or Malpractice Litigation,” University of Massachusetts Medical School Associate Professor of Emergency Medicine Peter B. Smulowitz et al., 2022.

Contradicting prior research connecting heavy ordering of diagnostic exams with fear of malpractice charges – a.k.a. “defensive medicine” – the survey showed that emergency department attending physicians and advanced practice clinicians in acute care hospitals across Massachusetts were more focused on not harming patients than on not getting sued. As one of the researchers told MedPage Today, “When we look at defensive medicine, a lot of times people are really just focusing on a limited number of variables, and right at the top of the list, everyone thinks that doctors are ordering lots of tests because they’re afraid of malpractice. …And we’re saying, actually, you can imagine a doctor who is just really afraid of harming people – a lot of doctors are – and they don’t care that much about malpractice.”

Medical Malpractice Litigation: How It Works, Why Tort Reform Hasn’t Helped, Pritzker Law School and Kellogg School of Management Professor Bernard S. Black et al., 2021.

Data analyzed by six top medical malpractice researchers revealed that “tort reform” doesn’t reduce “defensive medicine” or health care costs. Instead, it likely increases costs. More specifically,

• The authors “provide strong evidence that tort reform does not reduce Medicare spending” and in fact leads to “modestly higher health care spending, at least for the Medicare population.”

• The researchers estimate that “tort reform” results in “a 4 to 5 percent rise in Medicare Part B spending” and a “2 to 3 percent and…sometimes statistically significant” increase in “combined Part A and B spending.”

• “The conventional wisdom is that damage caps reduce health care spending by reducing defensive medicine.” However, after Texas capped non-economic damages for injured
patients in 2003, which was considered “a major shock to Texas medical malpractice risk,” tests and procedures (“health care utilization”) did not drop and rather increased in some areas.

- “In our view, the accumulation of evidence finding zero or small declines in spending, or even – as we find – a rise in Part B spending, suggests that it is time for policymakers to abandon the hope that tort reform can be a major element in health care cost control.” But they call the arguments that “tort reform” reduces health care spending a “politically convenient myth” that, while false, is “hard to kill.”


Extensive review of direct physician surveys, clinical scenario studies and case data analyses led researchers to conclude that there is little support for the notion that the practice of “defensive medicine” pervades the American healthcare system. As the authors explain,100

- “[Serious researchers’] consensus belief is that, if defensive medicine exists, whatever its extent, the dollar cost of wasteful procedures attributable to defensive medicine is a thin shadow of what the industry’s campaigners argue it is. Consequently, reforms of tort law are unable to make much of a contribution to bringing down America’s unusually high healthcare costs.”

- “One of the most remarkable facts about defensive medicine is how successful the promoters of the notion have been in persuading legislators and the public of its existence, its seriousness, that it is key to solving the problem of exorbitant healthcare costs, and that the only cure for it worth discussing is to reduce the healthcare industry’s accountability. That, despite empirical evidence for the hypothesis which has been found contradictory and uncertain….Proponents of the defensive medicine hypothesis have put forward fantastic numbers, the most extreme of them approaching a trillion dollars annually, on air-thin bases. Even serious and sober studies have found their way to numbers at the high end of where the empirical evidence can take us.”

- “One of the most illuminating findings is that tort reforms have little impact on the perceptions of healthcare providers about the legal environment that they inhabit. If providers are insensitive to the specific tort rules under which they practice, if they do not know what the law is in their jurisdiction, then they cannot sensibly adjust their estimation of malpractice risk.”

Researchers examined Military Health System data on over one million births in military families from 2003 to 2013 to determine whether legal liability had any impact on C-section rates in two care options – military hospitals (where doctors have no liability) and private civilian hospitals (where doctors can be held accountable for medical negligence). What they found: “C-sections are about 4 percent more common during the deliveries at military hospitals, compared to the times when mothers in the Military Health System deliver at civilian hospitals.”¹⁰¹

“Defensive Medicine: A Case and Review of Its Status and Possible Solutions,”
Banner Estrella Medical Center Chief Medical Officer Eric D. Katz, 2019.

“A physician’s perception of malpractice rarely correlates with the stringency of their state’s tort system, overestimates their own risk, and overestimates the cost of defensive practices. While estimates are difficult to make, defensive medicine likely only accounts for 2.8% of total healthcare expenses.”¹⁰²

“Damage Caps and Defensive Medicine: Reexamination with Patient Level Data,”
Northwestern University Professor Bernard S. Black, George Washington University Associate Professor Stephen Farmer and George Washington University Assistant Research Professor Ali Moghtaderi, 2019.

- “An often proposed remedy [to “defensive medicine”] is caps on non-economic damages.... We report evidence, from a careful study with a large, patient level dataset, of a more complex and nuanced response to caps. Rates for cardiac stress tests and other imaging tests appear to rise, instead of falling, and overall as does Medicare Part B lab and radiology spending. Yet cardiac interventions do not rise, and likely fall. There is no evidence of a fall in overall Medicare spending and, consistent with a recent prior paper (Paik et al., 2017), some evidence of higher Part B spending.”

- “The heterogeneous effects from damage caps, and lack of evidence for lower overall healthcare spending, suggest that if the policy goal is to limit health-care spending, damage caps are simply the wrong tool. If the goal is to reduce physician incentives to engage in assurance behavior by ordering tests with little or no clinical value, damage caps are too blunt a tool to achieve that goal.”

- “[A] core message from our findings is that, writ large, the ‘adopt damage caps, reduce spending’ story lacks empirical support. Instead, measures to reduce overtreatment will need to be carefully targeted to particular areas of concern.”¹⁰³
“Fictions and Facts: Medical Malpractice Litigation, Physician Supply, and Health Care Spending in Texas Before and After HB4,” University of Texas at Austin Law School Professor Charles Silver, Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black and Georgetown University Law Professor David A. Hyman, 2019.

“[A]lthough the damage caps adopted in Texas and other states greatly reduced the volume of malpractice litigation and payouts to patients, neither in Texas nor in other states have damage caps moderated the growth of health care spending….“104


- The Congressional Budget Office (CBO) estimates that if Congress imposed an extreme menu of tort restrictions on every state, even those that are unconstitutional, federal health care savings would total a mere $28 billion over 10 years. This is nearly half its prior estimate of $54 billion in total health care savings.105 Both estimates amount to a tiny 0.5 percent in savings.

- There is no evidence that five of the six extreme tort restrictions examined by CBO106 have any impact whatsoever on health care spending.107

- One of the six tort restrictions – a cap on attorneys’ fees, which many states currently have – would have the opposite budgetary impact than proponents suggest. Not only would this provision have no impact on federal health care spending, it would cost the government money.108

- CBO accepts the finding of other recent studies showing that imaging and testing actually increase after a state enacts a cap.109

- Caps on non-economic damages are the only tort restriction that CBO is willing to even consider scoring. However, the effort to try to reach a precise “savings” number is convoluted. In CBO’s own words, many of its assumptions are variously described as “fundamentally untestable,” “theoretically ambiguous” and “imprecisely estimated.”110


- “Although about half the states in the Union have had non-economic damage caps in place for at least eight years, our aggregate data shows that women are just as likely to give birth by cesarean section in states with damage caps as in ones without such caps.”

- “This data shows that a woman is not less likely to give birth by cesarean section in a state with damage caps than in one without. Thus, either damage caps are insufficient to
address physicians’ concerns or other explanations better account for the overuse of the procedure.”

“Association of Medical Liability Reform with Clinician Approach to Coronary Artery Disease Management,” George Washington University Associate Professor of Medicine Steven A. Farmer et al., 2018.

- Researchers examined more than 36,600 doctors who evaluated patients for coronary artery disease in nine states that adopted medical malpractice damages caps between 2002 and 2005 and compared them with over 39,100 doctors in 20 states without malpractice caps.

- Among their chief findings? “Overall testing rates didn’t change,” and though “the kind of test doctors in new-cap states ordered did change” to less invasive ones, the “researchers do note that nationally, cardiologists were beginning to move away from more intensive procedures after a large study concluded that one of those procedures, cardiac revascularization, should not be done for people whose chronic chest pain is stable. That study and others could have influenced doctors’ choices in new-cap states toward the end of their study period, which ended in 2013.”

“Damage Caps and Defensive Medicine, Revisited,” Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black et al., 2017.

The authors examined health care spending trends in nine states that enacted caps during the last “hard” insurance market (2002 to 2005), compared these data to other “control” states and found the following:

- “[D]amage caps do not significantly affect Medicare Part A (hospital) spending. However, caps predict 4-5% higher Part B [physician] spending.”

- “A core policy argument used to support adoption of damage caps, is that caps will reduce defensive medicine and thus reduce healthcare spending. For the third-wave cap adoptions, we find evidence pointing, instead, toward higher Medicare Part B spending.”

- “There is, at the least, no evidence that caps reduce healthcare spending.”


After analyzing survey responses from members of the American Board of Neurological Surgeons, researchers concluded that “[s]tate-based medical legal environment is not a significant driver of increased defensive medicine associated with neurosurgical spine procedures.”
“Residents’ self-report on why they order perceived unnecessary inpatient laboratory tests,” University of Pennsylvania Hematology/Oncology Fellow Mina S. Sedrak et al., 2016.

Researchers surveyed internal medicine and general surgery residents at the Hospital of the University of Pennsylvania to learn why they ordered unnecessary tests. Among their findings117:

• “Of the 116 respondents, 105 (90.5%) said they ordered daily labs out of habit because that’s the way they were trained.”

• “Other frequent responses were that tests were ordered because residents weren’t aware of the costs (86.2%), discomfort with diagnostic uncertainty (82.8%), and as was the case in the previous paper, concern that the attending would ask for the lab results (75.9%).”


• “Do tort claims, or the fear of them, result in the adoption of practices aimed at protecting against tortious liability?… An analysis of empirical studies on defensive medicine raises doubts as to whether the assumption holds true. The findings indicate that the empirical evidence is weak and that, if there is a concern about defensive practices, it seems to exist primarily in physicians’ minds.”

• “The outcomes of these studies suggest that the evidence for defensive medicine is weak at best. This applies for both studies using tort reforms as a measure of liability risk and research that uses claims history.”

• “The idea that physicians do not or hardly ever practice defensive medicine is consistent with empirical research focusing on psychiatrists, firemen, the police, and financial regulators. Studies in those fields have also shown small or no effects resulting from tortious liability.”

• “An interesting observation is that survey research does tend to produce evidence of the practice of defensive medicine. This suggests that defensive medicine merely or predominantly exists in the minds of people. Consequently, the belief physicians have with respect to medical malpractice is not necessarily related to the actual number of claims or the actual malpractice risk. This suggests there may not be a need to call for legal reforms, at least not to tackle defensive medicine issues. Perhaps it would be more meaningful to look into possibilities to change physicians’ perceptions about tort liability exposure and its effects.”118
STUDIES ESTABLISHING “DEFENSIVE MEDICINE” ARE UNRELIABLE.


“In regards to defensive medicine, the evidence has unique limitations. These include lack of nationally representative samples (e.g., studies from a single or several insurers), reliance on proprietary data from malpractice insurers and therefore inability to reproduce results, under-reporting of malpractice events to the legally mandated National Practitioner Data Bank, lack of data specific to emergency medicine physicians, and use of data pulled from non-concurrent years for a single estimation.”


- “Survey respondents are quite capable of answering consequential questions strategically – often in line with their tribe’s current norms – rather than offering genuinely candid responses. In the research business, this is known as ‘social desirability bias.’ People want to look good to those whose opinions matter to them.

“These are the most obvious methodological weaknesses of self-report surveys. Others include: (1) low response rates, especially by busy professionals; (2) recall biases; (3) heuristic biases; and (4) questions that could not possibly elicit meaningful answers.”

- “Overall, ‘[i]n clinical scenario surveys designed specifically to elicit a defensive response, malpractice concerns were occasionally cited as an important factor in clinical decisions. However, physicians’ belief that a course of action is medically indicated was the most important determinant of physicians’ clinical choices.’ The contrast between the conclusions reached based on direct-ask surveys versus those from clinical scenarios illustrates how powerful an impact research design can have on what a study finds. A wholly different methodological approach is to stop asking doctors what they say they have done or what they say they would do, and to try to look at what they actually do.”

- “Inadequately controlled observational studies can result in dramatically erroneous conclusions, as medical researchers know all too well.”
“DEFENSIVE MEDICINE” IS MEDICARE FRAUD.

A doctor who bills Medicare or Medicaid for tests and procedures done for a personal purpose – e.g., possible lawsuit protection – as opposed to what is medically necessary for a patient, is committing fraud under federal and state Medicare/Medicaid programs.

- The Medicare law states: “It shall be the obligation of any health care practitioner and any other person…who provides health care services for which payment may be made (in whole or in part) under this Act, to assure, to the extent of his authority that services or items ordered or provided by such practitioner or person to beneficiaries and recipients under this Act…will be provided economically and only when, and to the extent, medically necessary.”[121] “[N]o payment may be made under part A or part B for any expenses incurred for items or services…which…are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”[122]

- Providers cannot be paid and/or participate in the Medicare program unless they comply with these provisions, and they impliedly certify compliance with these provisions when they file claims. Thus, if they are not in compliance, the certifications and the claims are false. Providers who do not comply and/or file false claims can be excluded from the Medicare program.[123]

- Perhaps more importantly, the Medicare claim form (Form 1500) requires providers to expressly certify that “the services shown on the form were medically indicated and necessary for the health of the patient.”[124] If the services are, to the doctor’s knowledge, not medically necessary, the claim is false.

THE REAL REASONS DOCTORS MAY ORDER TOO MANY TESTS AND PROCEDURES: WORKLOAD AND REVENUE.

“Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization,” Harvard Medical School Associate Professor of Health Care Policy and Medicine Zirui Song et al., 2022.

- “In general, private equity firms aim for annual returns exceeding 20% in a short investment period of 3 to 7 years. Although private equity acquisitions may bring technological and operational efficiencies into a practice, private equity’s short-term financial incentives and ownership models may have negative outcomes on health care access, quality, or spending.”

- The researchers examined changes in spending, utilization, and practice patterns following private equity acquisitions of dermatology, gastroenterology and ophthalmology physician practices from 2016 to 2020 and found increases in patient volume that “may reflect overutilization of profitable services and/or unnecessary or low-
value care, which could raise health care spending without commensurate patient benefits.”


- “Surgeries gone awry. Unnecessary procedures. Extra hardware implanted in patients’ bodies. Insurance companies and government insurance over-charged. All potential consequences critics point to when doctors own a stake in the devices they use in surgeries. The set-up is known as a physician-owned distributorship, or POD. In this type of arrangement, a surgeon might own a percentage of a company that distributes devices, such as the metal parts used in spinal fusions. That doctor could then have the hospitals they work at buy the hardware right from the POD – and implant that hardware in their own patients. Critics say that financial motive for installing equipment can cloud judgement and mean unnecessary surgeries for patients. ‘You have these egregious doctors that were throwing in hardware just for the sake of making money,’ said Dr. Scott Lederhaus, a California neurosurgeon who has spoken out against PODs for years.”

- “Some doctors have made extra money by cutting out big device companies and acting as their own middleman to funnel devices into their own operating rooms. One doctor is in prison after multiple complaints of surgical issues and unnecessary operations using products in which he invested…. Lederhaus said doctors may stand to make two to three times more money per surgery by using their own company’s devices.”


There is a “grim world of health-care fraud – specifically, the growing number of doctors who are accused of performing unnecessary procedures, sometimes for their own personal gain.” Among the examples cited:

- A pediatric neurologist in Michigan accused by hundreds of patients after “intentionally misreading their EEGs and misdiagnosing them with epilepsy in childhood, all to increase his pay”;

- A Kentucky hospital and cardiologist sued by nearly 400 former patients for “needlessly performing heart procedures to ‘unjustly enrich themselves’”;

- A Texas rheumatologist accused of “‘falsely diagnosing patients with various degenerative diseases including rheumatoid arthritis’”; and

- A Kentucky cardiologist “sentenced to 60 months in federal prison for, among other things, implanting medically unnecessary stents in his patients.”

- “[S]pending on urine screens and related genetic tests quadrupled from 2011 to 2014 to an estimated $8.5 billion a year more than the entire budget of the Environmental Protection Agency. The federal government paid providers more to conduct urine drug tests in 2014 than it spent on the four most recommended cancer screenings combined.”

- “Urine testing has become particularly lucrative for doctors who operate their own labs. In 2014 and 2015, Medicare paid $1 million or more for drug-related tests billed by health professionals at more than 50 pain management practices across the U.S. At a dozen practices, Medicare billings were twice that high.”

- “Thirty-one pain practitioners received 80 percent or more of their Medicare income just from urine testing, which a federal official called a ‘red flag’ that may signal overuse and could lead to a federal investigation.”


- “Fee-for-service or volume-based reimbursement, which by one estimate determines payments for nearly 90% of US physicians, provides incentives for physicians to order more and different services than those that match patient need. This can influence treatment mix, with less profitable treatments not selected in favor of more profitable ones, and can also lead to excessive use of the most profitable treatments.”

- “[P]hysicians who own or receive payments from third-party companies providing procedures as diverse as computed tomography scans, surgery, and orthopedic treatments are much more likely to order these services. Referrals for anatomic pathology services by dermatologists, gastroenterologists, and urologists substantially increase the year after physicians begin to self-refer these tests to their own laboratories.”

- Research finding large costs associated with excessive procedures “significantly understate the true financial and nonfinancial implications of these conflicts. Patients also experience nonmonetary costs from unneeded testing and procedures because nearly every medical procedure carries medical risks, has adverse effects, generates opportunity costs of patient time, and can carry psychological costs in the form of worry as well as anguish, depending on the results of the tests or procedures. These nonfinancial ancillary costs are likely several orders of magnitude greater than financial costs, yet are difficult to quantify.”
“Low-Cost, High-Volume Health Services Contribute the Most to Unnecessary Health Spending,” UCLA David Geffen School of Medicine Assistant Professor of Medicine and RAND Corporation Health Policy Scientist John N. Mafi et al., 2017.

- “A team led by UCLA researchers analyzed claims data on patients in Virginia that reflected nearly all public and private payment sources, including fee-for-service Medicare, Medicare Advantage, Medicaid, private insurance, as well as consumer out-of-pocket costs. … Researchers found that the 5.5 million people in the database received 5.4 million of the 44 services. Of that number, 1.7 million were low value, meaning that nearly one-third of the time they were medically unnecessary,” and “1.6 million (93%) were very low cost and low cost ($538 or less per service), compared with 119,000 (7%) that were high and very high cost ($538 or more).”

- “As president and CEO of the Virginia Center for Health Innovation and paper co-author Beth A. Bortz explained, ‘The current economic incentives in healthcare typically reward the provision of more services, regardless of their value to the patient....’”


- An exclusive analysis for Kaiser Health News – which analyzed records of 4,225 breast cancer patients treated in the first half of 2017 – found that “only 48 percent of eligible breast cancer patients today get the shorter [radiation] regimen, in spite of the additional costs and inconvenience of the longer type.”

- “Overzealous screening for cancers of the thyroid, prostate, breast and skin, for example, leads many older people to undergo treatments unlikely to extend their lives, but which can cause needless pain and suffering, said Dr. Lisa Schwartz, a professor at the Dartmouth Institute for Health Policy and Clinical Practice. ‘It’s just bad care,’ said Dr. Rebecca Smith-Bindman, a professor at the University of California-San Francisco, whose research has highlighted the risk of radiation from unnecessary CT scans and other imaging.”

- “In surveys, some doctors blame overtreatment on financial incentives that reward physicians and hospitals for doing more. Because insurers pay doctors for each radiation session, for example, those who prescribe longer treatments earn more money, said Dr. Peter Bach, director of Memorial Sloan Kettering’s Center for Health Policy and Outcomes in New York. ‘Reimbursement drives everything,’ said economist Jean Mitchell, a professor at Georgetown University’s McCourt School of Public Policy. ‘It drives the whole health care system.’”
Physician Owned Distributorships: An Update on Key Issues and Areas of Congressional Concern, U.S. Senate Finance Committee Majority Staff Report, 2016.

“Our analysis found that:

1. [Physician owned distributorships] (PODs) surgeons saw **significantly more** patients (24% more) than non-POD surgeons.
2. In absolute numbers, POD surgeons performed fusion surgery on **nearly twice as many patients** (91% more) as non-POD surgeons.
3. As a percentage of patients seen, POD surgeons performed surgery at a **much higher rate** (44% higher) than non-POD surgeons.
4. In absolute number, POD surgeons performed **nearly twice as many** fusion surgeries (94% more) as non-POD surgeons.

“These findings quantify, for the first time, the extent to which POD ownership influences the behavior of individual physicians.

“In view of the findings summarized in this report, the Senate Finance Committee staff has six primary concerns about PODs,” among them:

- “POD physicians face an inherent conflict of interest when they have a financial incentive to perform surgeries. This incentive may compromise a doctor’s medical judgment and place financial incentives at odds with the best interest of the patient.”
- “Overutilization may occur if physicians perform additional, more complex, or medically unnecessary surgeries to garner POD financial incentives. Analysis by the Committee and HHS OIG suggest that POD doctors are, in fact, overutilizing spinal implant products. Such overutilization results in higher costs for the entire health care system, and particularly for Medicare.”
- “As a result of potential conflicts of interest and overutilization, PODs compromise patient safety as patients receive high-risk treatment beyond what is medically warranted. Any unnecessary medical procedure increases the risk that the patient may be harmed. Committee staff has heard extremely troubling reports of POD surgeons performing revision surgery to replace previously implanted hardware with the same or nearly equivalent hardware sold by their own PODs. While surgeons may contend that they replace such hardware for purely medical reasons, they would receive a payout from installing the POD hardware. Our concerns about medically unnecessary services are especially acute in the case of seniors who, due to their age, are less physically capable of withstanding the rigors of complex, invasive spine surgery.”


- “Doctors’ charges – and the incentives they reflect – are a major factor in the nation’s $2.7 trillion medical bill. Payments to doctors in the United States, who make far more
than their counterparts in other developed countries, account for 20 percent of American health care expenses, second only to hospital costs.”

• “Many specialists have become particularly adept at the business of medicine by becoming more entrepreneurial, protecting their turf through aggressive lobbying by their medical societies, and most of all, increasing revenues by offering new procedures – or doing more of lucrative ones.”

• “In addition, salary figures often understate physician earning power since they often do not include revenue from business activities: fees for blood or pathology tests at a lab that the doctor owns or ‘facility’ charges at an ambulatory surgery center where the physician is an investor, for example.”


According to a comprehensive study financed by the American Society for Radiation Oncology (ASTRO) and published in the New England Journal of Medicine, doctors who have a financial interest in [intensity-modulated radiation therapy] IMRT are twice as likely to recommend it despite the absence of strong evidence that it would be better than less costly options.\textsuperscript{135} As reported by Reuters, “Federal law prohibits what is known as self-referral, when doctors send patients for tests or treatment from which the physician stands to gain financially, but makes an exception for ‘in house’ services.”\textsuperscript{136} Yet, “urologists are taking advantage of a loophole in federal law that doesn’t make it a conflict of interest for the doctors to benefit from such an arrangement,” the study’s author told Reuters.\textsuperscript{137} ASTRO’s Chairwoman agreed, saying in a news release that the “study provides clear, indisputable evidence that many men are receiving unnecessary radiation therapy for their prostate cancer due to self-referral,” adding that “[w]e must end physician self-referral for radiation therapy and protect patients from this type of abuse.”\textsuperscript{138}

“Physician Self-Referral: Frequency of Negative Findings at MR Imaging of the Knee as a Marker of Appropriate Utilization,” Duke University Medical Center Radiology Fellow Matthew P. Lungren et al., 2013.

After reviewing 700 referrals for knee M.R.I.s made by two physician groups (one with a financial interest in the machine, the other without), researchers found that “patients are more likely to have magnetic resonance imaging scans that indicate nothing is wrong if they are referred by a doctor who owns the machine. The scientists conclude that doctors with a financial interest in the machines may be more likely to order M.R.I.s even when clinical findings suggest they are unnecessary.”\textsuperscript{139}
PART 3: PHYSICIAN SUPPLY AND ACCESS TO HEALTH CARE

“TORT REFORM” DOES NOT IMPROVE ACCESS TO CARE; PHYSICIAN SHORTAGES RESULT FROM FACTORS HAVING NOTHING TO DO WITH LIABILITY.

See also PART 8: THE IMPACT OF COVID

Addressing the healthcare staffing shortage, Definitive Healthcare, 2022.

• “According to Definitive Healthcare data, an estimated 333,942 healthcare providers dropped out of the workforce in 2021.”

• “The driving forces behind the healthcare staffing shortage” are: “Population growth and aging is leading to increased demand for healthcare,” “Physicians are nearing retirement age”; and “Feelings of burnout.”

• “While being overworked contributes to physician burnout, it’s not the only factor. In fact, it’s not even the primary concern held among doctors and medical students. Three of the biggest reasons why healthcare professionals are burning out are:

  1. Too many administrative tasks
  2. Poor work-life balance
  3. Insufficient salary”

• “Three Strategies to Address the Staffing Shortage: Invest in telehealth – Confront burnout – Expand [Graduate Medical Education] programs.”

“Back from Burnout: Confronting the Post-Pandemic Physician Turnover Crisis,” Jackson Physician Search and Medical Group Management Association, 2022.

• “Physician burnout – the long-term, cumulative stress and depersonalization that doctors experience amid growing burdens in the practice of medicine – continues to pose a major threat to a healthcare industry that remains in dire need of clinical leaders.”

• “An Aug. 23, 2022, [Medical Group Management Association] MGMA Stat poll found that 40% of medical groups reported that a physician had retired early or left the organization due to burnout this year….”

• “These results come almost a year after a similar MGMA Stat poll found that one in three (33%) medical practices had physicians retire early or leave due to burnout in
2021 – a rate that grew from 28% in a March 2, 2021, MGMA Stat poll that asked about physicians retiring unexpectedly from the organization.”

**Physician and Provider Recruitment Benchmarking Study, Association for Advancing Physician and Provider Recruitment, 2022.**

- The annual report highlighted “the continuing physician shortage in the United States,” with organizations “searching for more physicians than ever before and amid one of the largest shortages.”

- The study “found that 48 percent of all physician searches in 2021 were to replace departing physicians” and “that 33 percent of physicians cited burnout as the reason for leaving their organization.”

“The doctor shortages are here – time to act, Drs. Harmon and Orlowski weigh in,” *AMA Moving Medicine, April 13, 2022.*

In an April 2022 podcast, American Medical Association President Dr. Gerald E. Harmon, stated:

“‘We’ve had data from AMA’s own polls that show, almost independent of the COVID pandemic, as many as 20% of physicians are planning on leaving the profession within the next 24 months and a substantial number are talking about reducing their access and hours.

“There are a couple of reasons that they offer to me. They’re burned out, a common thing. They’re fatigued both emotionally and physically, and they’re overwhelmed with the burden of practicing medicine, just the impediments that we face as practicing physicians every day, the barriers to delivering care in a quality manner from electronic records to prior authorization, to the cost of medications. It’s just an ongoing assault on all of us as providers and they’re really getting discouraged.’”

In that same podcast, Association of American Medical Colleges Chief Health Care Officer Dr. Janis M. Orlowski said the following:

- “The main two factors that are affecting this [doctor shortage] are, first of all, the growth in the U.S. population. So, we are using U.S. Census numbers. We see the growth in the U.S. population and that’s a big factor. And number two, right behind it is the aging of the population. So, we really have the baby boom. They’re in their sixties to seventies, maybe a decade plus or minus on either side. And we know that individuals consume more health care after the age of 60. So, we’ve got a very big generation that is moving over the age of 60. Those are the two biggest factors.”

- When respondents (i.e., newly trained physicians) “who had plans to leave New York were asked about the main reason for leaving, the most common reasons reported were proximity to family (27%), better salary offered outside New York (13%), better jobs in desire practice setting outside New York (10%), and better jobs in desired location outside New York (10%).”145 These reasons are consistent with previous annual surveys.146

- Only 1% of respondents cited the category “cost of malpractice insurance” as a principal reason for practicing outside New York State.147 And as in previous years, New York’s liability laws or legal environment were not even listed.148


- One of five physicians “are moderately likely or higher to leave their current practice within 2 years. Because multiple studies have demonstrated that intent to leave among physicians correlates with actual departures, these findings are of concern.”

- “Higher levels of burnout, stress, workload, fear of infection, anxiety/depression due to COVID-19, and years in practice are each associated with greater intention to reduce work hours and leave one’s current practice. In contrast, feeling highly valued by one’s organization is associated with lower such intentions.”149


- “By 2034, we project: A shortage of primary care physicians of between 17,800 and 48,000 [and] a shortage across the non-primary care specialties of between 21,000 and 77,100 physicians.”

- “Demographics – specifically, population growth and aging – continue to be the primary driver of increasing demand from 2019 to 2034. During this period, the U.S. population is projected to grow by 10.6%, from about 328.2 million to 363.0 million. The population under age 18 is projected to grow by 5.6%, which portends low growth in demand for pediatric specialties. The population aged 65 and older is projected to grow by 42.4% – primarily due to the 74.0% growth in size of the population age 75 and older. This trend portends high growth in demand for physician specialties that predominantly care for older Americans.”
“A large portion of the physician workforce is nearing traditional retirement age, and supply projections are sensitive to workforce decisions of older physicians. More than two of five currently active physicians will be 65 or older within the next decade. Shifts in retirement patterns over that time could have large implications for physician supply. Growing concerns about physician burnout, documented in the literature and exacerbated by COVID-19, suggest physicians will be more likely to accelerate than delay retirement.”

**Non-Clinical Careers Report 2021, Medscape, 2021.**

- “The pressures forcing physicians to rethink their careers are ongoing and systemic and predate the COVID-19 pandemic. Although COVID-19 has created challenges for physicians, only 7% put the blame for leaving clinical practice squarely on the pandemic. When asked why they sought to change careers, respondents shared their frustrations with the healthcare system. Much of this frustration involves billing and finances, but lack of agency and autonomy were cited as well.”

- “Roughly 1 in 5 (22%) of the [over 2,500] physicians surveyed said they were considering leaving their current jobs to pursue a nonclinical career; 58% of those said they planned to make the change within 3 years. Eight in 10 are actively exploring other options, and over half (53%) are looking online.”

- “Burnout was most often cited as the primary reason for considering a change; 34% gave this reason. Twenty percent said they wanted to work fewer hours.”

**Medical Malpractice Litigation: How It Works, Why Tort Reform Hasn’t Helped, Pritzker Law School and Kellogg School of Management Professor Bernard S. Black et al., 2021.**

Data analyzed by six top medical malpractice researchers revealed that “tort reform” doesn’t attract physicians to a particular location. More specifically,

- Whether “examining total physicians, high-risk specialties, primary care physicians, or rural physicians,” the authors found no evidence that physicians choose to practice in a state because that state caps damages, noting, “Physicians’ location decisions simply do not seem to respond very much to damage caps.”

- They discovered, “In Texas, the assertion by medical malpractice reform proponents that Texas experienced a pre-reform exodus of physicians followed by a sharp post-reform turnaround is doubly false. There was neither an exodus before reform nor a dramatic increase after reform.”

- As to ob-gyns, orthopedic surgeons or neurosurgeons, “three specialties that are generally seen as facing high risk and that figured prominently in the political campaign for tort
reform...there is no evidence that tort reform meaningfully affected [their numbers in Texas], relative to what one would expect based on national trends.”

- Regarding why physicians locate in particular areas, the researchers found this decision “appears to be primarily driven by factors other than liability risk, including population trends, location of the physician’s residency, job opportunities within the physician’s specialty, lifestyle choices, and demand for medical services, including the extent to which the population is insured.”

- The authors’ “bottom line is simple: it is time to bury the myth that damage caps have a meaningful effect on physician supply. Despite political rhetoric from cap proponents, other factors are more important in determining where physicians choose to practice.”


When surveyed about what would most help reduce their burnout, limiting medical malpractice lawsuits was not listed among the nine options from which physician respondents could choose.153


- “We continue to project that physician demand will grow faster than supply, leading to a projected total physician shortage of between 54,100 and 139,000 physicians by 2033.”

- “Demographics – specifically, population growth and aging – continue to be the primary driver of increasing demand from 2018 to 2033.”

- “A large portion of the physician workforce is nearing traditional retirement age, and supply projections are sensitive to workforce decisions of older physicians.”154


“Statewide, the availability of active medical staff with clinical privileges increased both pre- and post-tort reform. The available data indicates no statewide trends between medical malpractice insurance rates and the number of active medical staff with clinical privileges. …Without widespread trends, and access to detailed physician data, we could not measure the specific effects of tort reform on physician availability, including the specific effect of the venue change alone.”155
“Fictions and Facts: Medical Malpractice Litigation, Physician Supply, and Health Care Spending in Texas Before and After HB4,” University of Texas at Austin Law School Professor Charles Silver, Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black and Georgetown University Law Professor David A. Hyman, 2019.

- “HB 4 [a package of severe medical malpractice “tort reforms” enacted in Texas in 2003] had no measurable effect on the size of Texas’ physician population. The impact of HB 4 on Texans’ access to medical treatments is best described as both close to zero, and precisely estimated. Our findings are consistent with those from multi-state studies of the relationship between lawsuit restrictions and physician supply, including our own, which generally find no effect or small effects for particular sub-groups of physicians, such as those practicing in rural counties.”

- “[T]here was steady growth in Texas’ supply of DPC [direct patient care] physicians, both total and per capita, both before and after reform…. Texas’ supply of direct patient care physicians grew steadily, at similar rates, in both the pre- and post-reform periods, despite politician’s claims that physicians fled Texas before reform and flocked back thereafter….”

- “Texas had a lower ratio of physicians to population than most other states before reform, and has a lower ratio today.”

- “Whatever the explanation, the truth is obvious. The med mal liability insurance crisis that Texas experienced from 1999 to 2003 did not measurably stunt the growth of the state’s supply of DPC physicians, and there is no evidence that HB 4 led to a more rapid growth rate in subsequent years. Texans’ access to medical treatments, measured in terms of physicians per capita, has improved steadily both before and after reform, albeit somewhat more slowly than for the U.S. as a whole.”

- “Texas, like many other states, faces a challenge in attracting physicians to rural areas. But we found no evidence that tort reform lessened that challenge.”

- “The primary drivers of physicians’ location decisions appear to be population trends, location of the physician’s residency, job opportunities within the physician’s specialty, lifestyle choices, and local demand for medical services, including the extent to which the population is insured. Because Texas has a large uninsured population and large areas with low population densities, its difficulty in attracting physicians (relative to other states) is likely to continue.”

- “Labor market dynamics may also make it hard for Texas to attract doctors. When employers in one state seek to attract physicians from other states, employers in target states will react, to retain their own physicians. They may offer current employees and new applicants higher compensation, shorter work weeks, longer vacations, etc. These reactions may prevent the would-be poacher from achieving its goal.”

156

Data from the Centers for Medicare & Medicaid Services, board certification and self-reported information from approximately 43,000 full-time, board-certified OB-GYNs show that practitioners “continue to face high workload demands and compensation issues that are potentially contributing to a national shortage.”\textsuperscript{157}

2019 Women’s Health and Oncologist Workforce Analysis, Doximity, 2019.

Data from the Centers for Medicare & Medicaid Services, board certification and self-reported information from over 18,000 full-time, board-certified oncologists show that “an imminent wave of retiring oncologists,” coupled with a growing demand for cancer treatment, will cause a shortage of practitioners across the country.\textsuperscript{158}


The authors examined physician supply in nine states that enacted caps during the last “hard” insurance market (2002 to 2005)\textsuperscript{159} and compared these data to other “control” states. They found “no evidence that cap adoption leads to an increase in total patient care physicians, increases in specialties that face high liability risk (with a possible exception for plastic surgeons), nor increases in rural physicians.”\textsuperscript{160}


“For all specialty categories, physician retirement decisions are projected to have the greatest impact on supply, and over one-third of all currently active physicians will be 65 or older within the next decade. Physicians between ages 65 and 75 account for 11% of the active workforce, and those between ages 55 and 64 make up nearly 26% of the active workforce. Projected shortfalls for the Other Specialties category (which includes emergency medicine, neurology, pathology, and psychiatry) are particularly sensitive to retirement assumptions.”\textsuperscript{161}


The survey of over 17,000 physicians “identified low physician morale as the primary factor underlying the worsening shortage. The survey found that ‘physicians identify regulatory/paperwork burdens and loss of clinical autonomy’ as their primary sources of dissatisfaction. Physicians Foundation President Walker Ray commented that ‘by retiring, taking non-clinical roles or cutting back in various other ways, physicians are essentially voting with their feet and leaving the clinical workforce. This trend is to the detriment of
patient access. It is imperative that all healthcare stakeholders recognize and begin to address these issues more proactively, to support physicians and enhance the medical practice environment."
PART 4: MEDICAL MALPRACTICE INSURANCE

❖ PREMIUM SPIKES THAT DOCTORS ARE EXPERIENCING ARE UNJUSTIFIED PRICE-GOUGING AND ARE NOT CAUSED BY JUMPS IN LAWSUITS OR CLAIMS.

Volcanic eruptions in insurance premiums for commercial customers (including doctors) occurred in the mid-1970s, the mid-1980s and the early 2000s. These periods are known as “hard markets.” The nation is in the fourth such cycle although premium increases are not as high as in past hard markets. Insurance prices have been rising since 2019 without justification.163 These hikes are greatly adding to the bottom line of the medical professional liability (MPL) market. As always, but particularly now, medical malpractice insurers have extreme difficulty arguing that lawsuits warranted recent price hikes when the civil courts and juries were essentially shut down in 2020 and remain extremely backlogged. (See also PART 8: THE IMPACT OF COVID)


• “More than 6 in 10 medical groups report their doctors’ malpractice premiums have increased since 2020,” with the average increase being 14.3 percent. 47.8 percent reported an increase of 10-19 percent, while 15.6 percent reported an increase of 20-29 percent.

• “[A]lthough premiums have risen during this period, overall claims throughout the United States have dropped.”164


Direct written premiums for U.S. medical professional liability insurers increased 10 percent to $11.2 billion in 2021.165


• “The results show that while much of the U.S. was weathering a surge in COVID-19 infections due to the Omicron variant, the MPL industry quietly finished up a positive year as reflected in a variety of financial metrics. In short, the overall results for 2021 were better than many anticipated just 12 months ago.”
“The MPL industry’s top-line revenue growth last year was its strongest in nearly two decades, and a number of other metrics (including combined ratio and investment gains) rebounded from certain worrying trends we observed through 2020….”

“The composite’s total direct written premium for 2021 increased by 9.8% to $6.2 billion, its highest level since 2008…and largest increase since 2004.”

The composite “did record its second-consecutive year of combined ratio improvement.”

“The composite’s net income increased by approximately 32% last year and by nearly 90% from its recent low in 2019…. [R]ecent investment results have been buoyed by increases in net realized capital gains, which reached a new high for this dataset in 2021 at 10.1% of net earned premium.”


“Using almost thirty years of data on the medical malpractice insurance market, we report evidence inconsistent with a smoothly functioning, plausibly competitive market. These include: (i) insurer direct costs are a surprisingly weak predictor of premia; (ii) caps on non-economic damages predict a substantially higher Premium/Cost Ratio even when controlling for insurer costs; (iii) competitor premia predict premia much more strongly than measures of insurer cost; (iv) insurers earn consistently high profits, proxied by the Premium/Cost Ratio, from 2005 on, relative to earlier years.”

Prevalence of Medical Liability Premium Increases Unseen Since 2000s Continues for Third Year in a Row, American Medical Association, 2022.

After analyzing medical professional liability insurance premium data from the Medical Liability Monitor, the American Medical Association concluded:

“The main and most significant finding for three years in a row is that more premiums have increased than in any year since the 2000s.”

“Moreover, not only are premium increases of any size on the upswing, but there has also been a rise in large increases as well. In 2021, 7.5% of all premiums increased by 10% or more – up from 3.9% in 2018 and 3.6% in 2019.”


“Perhaps no commercial insurance policyholders have been bigger victims of the industry’s manufactured economic cycle crises than doctors.”
• “New evidence shows clearly that doctors were price-gouged during the last hard market (2002 to 2005). Doctors paid increasingly high premiums while paid claims actually dropped. Medical malpractice insurers were misrepresenting their actual losses by an incredible annual average of 33%.”

• “Over the last 20 years, insurers saw major loss reductions yet doctors’ premiums dropped only $1 for every $3 in reduced claim payments.”

• “[I]t is simply extraordinary that the industry may be trying to repeat history by hitting doctors with premium increases – despite incredible profits, no increase in claims payments, no trend suggesting any such increase – and blaming juries for this action. Fortunately … as of today the data do not indicate any significant rate hikes for doctors as of yet.”

“Fictions and Facts: Medical Malpractice Litigation, Physician Supply, and Health Care Spending in Texas Before and After HB 4,” University of Texas at Austin Law School Professor Charles Silver, Georgetown Law School Professor David A. Hyman and Northwestern University Law School and Kellogg School of Management Professor Bernard S. Black, 2019.

• “[W]e find no evidence that the ‘smoke’ of the insurance crisis that prompted [Texas’s 2003 medical malpractice] reforms was produced by an underlying “fire” of rising liability. Measured in a variety of ways, before and during the insurance crisis, the performance of the liability system was stable.”

• “[T]here were no major changes in the frequency of med mal claims, payout per claim, total payouts, defense costs, or jury verdicts that can explain the spike in premiums for med mal liability insurance that occurred in Texas in the years before the 2003 reforms….”

• “[W]e know from other studies that the biggest drivers of malpractice claims are the rate of medical mistakes and the severity of resulting injuries. These drivers depend on the volume and mix of medical services patients receive, patients’ characteristics and technological developments, all of which change slowly. There is no obvious reason why the error rate or the claim rate should spike for an entire state. We used the [Texas Closed Claims Database] to learn whether legislatures findings [of a major jump in the frequency and severity of claims] were accurate. After careful study, we concluded they were not.”


• “Total payouts over the last four decades have never spiked and have generally tracked the rate of inflation. Premiums, on the other hand, sharply increased for doctors three times over the last 40 years – in the mid-1970s, in the mid-1980s, and in the early 2000s.
Each time, these volcanic eruptions in medical malpractice insurance rates developed into liability insurance “crises” for doctors.”

- “[T]hose sudden “hard market” rate hikes did not track malpractice claims or payouts whatsoever. Instead, rates rose or fell in sync with the insurance “cycle,” dictated by the state of the economy and insurance industry profitability, including gains or losses experienced by the insurance industry’s bond and stock market investments.”

- “The data plainly show that “hard markets” are not caused by tort system costs. However, for political effect during each crisis period, the insurance industry falsely blamed lawsuits and the small number of injured patients who sue in court for the industry’s decision to impose severe rate hikes on doctors.”

“Five Myths of Medical Malpractice,” University of Illinois Professor of Law and Medicine David A. Hyman and University of Texas Law Professor Charles Silver, 2013.

- “Because the overwhelming majority of payments to plaintiffs are the result of voluntary settlements, one must study closed claims (rather than jury verdicts) to get a full picture of what is going on. Using both federal and state closed claims databases, studies have found that both the frequency of malpractice claiming and the payments per claim were either stable or declining during the period that preceded the latest malpractice crisis, which began in 1999 to 2000.”

- “The finding that the latest malpractice crisis was not caused by spikes in malpractice claims or payouts should not be surprising. Although hot spots can occur, the liability system primarily responds to (and lags) the frequency of serious medical injuries. Because the frequency of serious medical injuries changes slowly, the litigation rate should not be prone to dramatic spikes in claiming.”

**NEITHER “TORT REFORMS” NOR “CAPS ON DAMAGES” LOWER INSURANCE PREMIUMS FOR DOCTORS.**


- “We study how insurers price med mal insurance sold to physicians, using almost 3 decades of data on med mal premia, collected by Medical Liability Monitor (MLM). We assess the extent to which per-physician costs, caps on non-economic or total damages (‘damage caps’), and competition from other insurers predict affect premia for the three specialties for which MLM collects data: general surgery, internal medicine, and obstetrics and gynecology (ob-gyn).”
• “[W]e find evidence that the association between cap adoption and higher Premium/Cost Ratio is causal: as caps drive down insurer costs, premia do not fall in parallel with costs, leading to rising premia/cost ratios. These persist through the end of our sample period, well over a decade after the early 2000s wave of cap adoptions. We also find evidence for reverse causality, with a rising Premium/Cost Ratio predicting cap adoption.”

“The Impact of Medical Malpractice Reforms,” Georgetown University Law Professor David A. Hyman and East China University of Political Science and Law Associate Professor Jing Liu, 2020.

A comprehensive review of available data and scholarly literature led researchers to conclude that “because malpractice claiming does not appear to be the cause of med mal crises, litigation-focused remedies are likely to be incomplete, underpowered, and inefficient in addressing what is, in the end, a problem in the market for med mal insurance.”


• During the last hard market [2002-2006], “states that enacted new limits on patients’ legal rights in medical malpractice cases (caps on damages plus other traditional tort reforms) saw an average 22.7 percent decrease in pure premiums from 2002 to the present – but states that did nothing saw a larger average drop of 29.5 percent.”

• “What’s more, states that enacted only caps on damages saw an average 21.8 percent decrease in pure premiums from 2002 to the present – but the states that did nothing saw an even greater average drop of 28.9 percent.”

• “In sum, the data do not support any conclusion that limiting patients’ legal rights – including capping damages – results in lower premiums for doctors.”

 Industry Insiders Have Historically Said That Capping Damages Will Not Lower Insurance Rates.

• American Insurance Association: “[T]he insurance industry never promised that tort reform would achieve specific premium savings.”

• Sherman Joyce, President, American Tort Reform Association: “We wouldn’t tell you or anyone that the reason to pass tort reform would be to reduce insurance rates.”

• Victor Schwartz, General Counsel, American Tort Reform Association: “[M]any tort reform advocates do not contend that restricting litigation will lower insurance rates, and ‘I’ve never said that in 30 years.’”
• **State Farm Insurance Company (Kansas):** “[W]e believe the effect of tort reform on our book of business would be small. … [T]he loss savings resulting from the non-economic cap will not exceed 1% of our total indemnity losses…” 179

• **Aetna Casualty and Surety Co. (Florida):** After Florida enacted what Aetna Casualty and Surety Co. characterized as “full-fledged tort reform,” including a $450,000 cap on non-economic damages, Aetna did a study of cases it had recently closed and concluded that Florida’s tort reforms would not affect Aetna’s rates. Aetna explained that “the review of the actual data submitted on these cases indicated no reduction of cost.” 180

• **Allstate Insurance Company (Washington State):** In asking for a 22% rate increase following passage of tort reform in Washington State, including a cap on all damage awards, the company said, “[O]ur proposed rate would not be measurably affected by the tort reform legislation.” 181

• **Great American West Insurance Company (Washington State):** After the 1986 Washington tort reforms, the Great American West Insurance Company said that on the basis of its own study, “it does not appear that the ‘tort reform’ law will serve to decrease our losses, but instead it potentially could increase our liability. We elect at this point, however, not to make an upward adjustment in the indications to reflect the impact of the ‘tort reform’ law.” 182

• **Vanderbilt University:** A regression analysis conducted by Vanderbilt University Economics Professor Frank Sloan found that caps on economic damages enacted after the mid-1970s insurance crisis had no effect on insurance premiums. 183

❖ **STRONG INSURANCE REGULATORY LAWS ARE THE ONLY WAY TO CONTROL INSURANCE RATES FOR DOCTORS AND HOSPITALS.**

Comparing California and Illinois: Two states that enacted both severe caps on damages and strong insurance regulation.

**CALIFORNIA**

**Cap.** In 1975, California enacted a severe $250,000 cap on non-economic damages, the first in the nation. This cap has greatly reduced the number of genuine malpractice cases brought in California.

• Despite the reduction of legitimate cases, between 1975 and 1988, doctors’ premiums in California increased by 450 percent, rising faster than the national average. 184

• As a result of the cap, California’s medical malpractice insurance industry became so bloated that “as little as 2 or 3 percent of premiums are used to pay claims” and “the state’s biggest medical malpractice insurer, Napa-based The Doctors Company, spent
only 10 percent of the $179 million collected in premiums on claims in 2009.” Insurance Commissioner Dave Jones said that “insurers should reduce rates paid by doctors, surgeons, clinics and health providers while his staff scrutinizes the numbers.”

**Insurance regulation.** In 1988, California voters passed a stringent insurance regulatory law, Proposition 103 (Prop. 103), which ordered a 20% rate rollback, forced companies to open their books and get approval for any rate change before it takes effect, and allowed the public to intervene and challenge excessive rate increases.

- In the twelve years after Prop. 103 (1988-2000), malpractice premiums dropped 8 percent in California, while nationally they were up 25 percent.

- During the period when every other state was experiencing skyrocketing medical malpractice rate hikes in the mid-2000s, California’s regulatory law led to public hearings on rate requests by medical malpractice insurers in California, which resulted in rate hikes being lowered three times in two years, saving doctors $66 million.

- Prop. 103 has allowed the state Insurance Commissioner to take action and lower excessive insurance rates for doctors. According to an October 2012 news release issued by the California Department of Insurance,

  - “Insurance Commissioner Dave Jones today announced the second medical malpractice rate reduction this year for NORTAL Mutual Insurance Company’s physician and surgeon program. The company’s 6.9 percent reduction saves primarily Southern California doctors approximately $8.5 million annually. This company initiated rate reduction follows a Department ordered 7.1 percent decrease in March for an overall savings of $18 million this year alone for physicians and surgeons insured by NORTAL Mutual.”

  - “Last year Commissioner Jones ordered the top six medical malpractice insurance companies in California to submit rate filings to the Department of Insurance to justify their current rates. After a thorough review of those filings, Commissioner Jones called for rate reductions. As a result of the Commissioner’s rejection of excessive rates, all six companies lowered their medical malpractice rates,” amounts to “a total savings to medical providers of $52 million…."

  - “I’m pleased the medical malpractice rates are continuing to be decreased under the Department’s rate review process and authority,” said Commissioner Jones. “These medical malpractice rate reductions show the important role that Proposition 103, which authorizes the insurance Commissioner to reject excessive rate hikes for property and casualty insurance, including medical malpractice insurance, has played in curbing medical malpractice rates since it was passed in 1988.”
ILLINOIS

In 2005, Illinois enacted a non-economic damages cap on compensation for injured patients ($500,000 for doctors and $1,000,000 for hospitals) and a very strong insurance regulatory law. In February 2010, the Illinois Supreme Court struck down this cap as unconstitutional. Because of a non-severability clause, the insurance regulatory law was struck down, as well. In the five years these laws were in place, the following occurred:

**Cap.** The cap never really affected settlements or insurance rates in Illinois during the five years it existed. This was acknowledged in a May 2010 webinar sponsored by A.M. Best, where a Chicago-based insurance attorney said:

“It may be headlines in other places but here in Cook County [Illinois] I think that the Supreme Court’s decision in Lebron was fully anticipated and discounted. None of the settlements that I’ve been involved in for the last couple of years paid the slightest attention to the caps anymore. There was almost a universal acceptance that it would be overturned by the Supreme Court. In fact it was overturned in Cook County two years ago. Lebron was a Cook County case going up, so the caps haven’t been law here for quite some time.”

**Insurance regulation.** The strong insurance regulatory reforms did take effect and had an impact.

In October 2006, the Illinois Division of Insurance announced that an Illinois malpractice insurer, Berkshire Hathaway’s MedPro, would be expanding its coverage and cutting premiums for doctors by more than 30 percent. According to state officials and the company itself, this was made possible because of new insurance regulatory law enacted by Illinois lawmakers in 2005, and expressly not the cap on compensation for patients. The new law required malpractice insurers to disclose data on how to set their rates. This, according to Michael McRaith, director of the state’s Division of Insurance, allowed MedPro to “set rates that are more competitive than they could have set before.”

In February 2010, the Illinois Division of Insurance said:

“The 2005 Reform Laws imposed changes to the Illinois Insurance Code that improved insurer reporting and transparency requirements and enhanced the Department’s rate oversight authority. Since 2005, the Department has observed improvements in the medical malpractice insurance market. In particular, the Department observed:

- **A decrease in medical malpractice premiums.** Gross premium paid to medical malpractice insurers has declined from $606,355,892 in 2005 to $541,278,548 in 2008;
• **An increase in competition among companies offering medical malpractice insurance.** In 2008, 19 companies offering coverage to physicians/surgeons each collected more than $500,000 in premiums, an increase from 14 such companies in 2005; and

• **The entry into Illinois of new companies offering medical malpractice insurance.** In 2008, five companies collected more than $22,000,000 in combined physicians/surgeons premiums – and at least $1,000,000 each in premiums – that did not offer medical malpractice insurance in 2005.”
PART 5: PATIENT SAFETY

See also PART 8: THE IMPACT OF COVID

❖ MEDICAL ERRORS OCCUR IN ALARMING NUMBERS AND ARE EXTREMELY COSTLY.


• “During the study period (2018 through 2020), Healthgrades found that there were 170,231 potentially preventable patient safety events among Medicare patients in U.S. hospitals.”

• “Additionally, the analysis found that just four patient safety indicators accounted for 74% of all patient safety events:
  o In-Hospital fall resulting in hip fracture (22.2% of all patient safety events)
  o Collapsed lung resulting from a procedure or surgery in or around the chest (21.1% of all patient safety events)
  o Pressure sores or bed sores acquired in the hospital (15.3% of all patient safety events)
  o Catheter-related bloodstream infections acquired in the hospital (15.0% of all patient safety events)\(^{194}\)

*Hospital Safety Grade*, Leapfrog Group, 2022.

Using “more than 30 national performance measures from the Centers for Medicare & Medicaid Services (CMS), the Leapfrog Hospital Survey and information from other supplemental data sources” to determine “a hospital’s overall performance in keeping patients safe from preventable harm and medical errors,”\(^{195}\) Leapfrog found that 43 percent of the nearly 3,000 hospitals studied merited a C, D or F safety grade.\(^{196}\) This rate is consistent with Leapfrog data from previous years.\(^{197}\)


• “Each day, approximately one in 31 U.S. patients and 1 in 43 nursing home residents contracts at least one infection in association with their healthcare, underscoring the need for improvements in patient care practices in U.S. healthcare facilities.”

• “In 2021, the nation and the world continued to experience unprecedented challenges due to the COVID-19 pandemic, which impacted surveillance for and incidence of HAI. Compared to pre-pandemic years, hospitals across the nation experienced higher than
usual hospitalizations and shortages in healthcare personnel and equipment, which may have resulted in deterioration in multiple patient safety metrics since the beginning of the pandemic.”

*Patient Safety Component Manual, Healthcare Quality Promotion Division, Centers for Disease Control and Prevention, 2022.*

- **Central line-associated bloodstream infections (CLABSIs).** “[A]n estimated 30,100 central line-associated bloodstream infections (CLABSI) still occur in intensive care units and wards of U.S. acute care facilities each year. CLABSIs are serious infections typically causing a prolongation of hospital stay and increased cost and risk of mortality.”

- **Urinary tract infections (UTIs).** UTIs “are the fifth most common type of healthcare-associated infection, with an estimated 62,700 UTIs in acute care hospitals in 2015. UTIs additionally account for more than 9.5% of infections reported by acute care hospitals.” In addition, “[i]t has been estimated that each year, more than 13,000 deaths are associated with UTIs.”

- **Surgical site infections (SSIs).** “SSIs remain a substantial cause of morbidity, prolonged hospitalization, and death. It is reported, SSI accounts for 20% of all [reacquired infections] HAIs and is associated to a 2- to 11-fold increase in the risk of mortality…with 75% of SSI-associated deaths directly attributable to the SSI. SSI is the most costly HAI type with an estimated annual cost of $3.3 billion, and extends hospital length of stay by 9.7 days, with cost of hospitalization increased by more than $20,000 per admission.”

*Health and Health Care for Women of Reproductive Age, Commonwealth Fund, 2022.*

- “Among women of reproductive age in high-income countries, rates of death from avoidable causes, including pregnancy-related complications, are highest in the United States.”

- “When looking at all women, we found that those in the U.S. have the highest rate of avoidable deaths: nearly 200 in 100,000 deaths could have been prevented or treated with the right care provided at the right time.”

“Map: These 764 hospitals are facing Medicare HAC penalties in 2022,” Advisory Board, January 31, 2022.

- “The [Hospital-Acquired Condition] Reduction Program, which launched in October 2014, evaluates hospitals based on their rates of several avoidable complications.”
“As of 2021, the program has penalized 1,978 hospitals at least once since the program was established. Of those hospitals, 1,360 have been penalized at least twice, and 77 have been penalized each year the program has been in place.”


“The Hospital Readmissions Reduction Program has been a mainstay of Medicare’s hospital payment system since it began in 2012. Created by the Affordable Care Act, the program evaluates the frequency with which Medicare patients at most hospitals return within 30 days and lowers future payments to hospitals that had a greater-than-expected rate of return. Hospitals can lose up to 3% of each Medicare payment for a year.”

“[Centers for Medicare and Medicaid Services] evaluated 2½ years of readmission cases for Medicare patients who’d had heart failure, heart attacks, chronic obstructive pulmonary disease, coronary artery bypass grafts, and knee and hip replacements.” As a result of its analysis, 43 percent of the nation’s 5,236 hospitals face readmissions penalties for 2023.


OIG analyzed “medical records for a random sample of 770 Medicare patients who were discharged from acute-care hospitals during October 2018” and found the following.

- “Twenty-five percent of Medicare patients experienced patient harm during their hospital stays in October 2018. Patient harm includes adverse events and temporary harm events.”
- “Twelve percent of patients experienced adverse events, which are events that led to longer hospital stays, permanent harm, life-saving intervention, or death.”
- “Physician-reviewers determined that 43 percent of harm events were preventable, with preventable events commonly linked to substandard or inadequate care provided to the patient.”

Peer review of a report on strategies to improve patient safety, National Academies of Sciences, Engineering and Medicine, 2021.

“[T]he country is at a relative standstill in patient safety progress. Although the original To Err Is Human report (IOM, 2000) commanded national attention more than two decades ago, the country has not achieved the level of safety in daily patient care that we have come to expect from other industries, such as when we board an airplane. Continuing on the current trajectory is not likely to produce substantial improvements in patient safety.”

Analysis of 2,579 surgery-related closed malpractice claims across a five-year period (2014-2018) revealed that 29 percent of all surgical injuries were “permanent-significant” or worse, with 9 percent resulting in death.205


In 2017, hospital inpatients 18 years and older suffered approximately 2.55 million avoidable hospital-acquired infections (HAIs). Among the harms suffered: a bad reaction to medication, an injury from a procedure, a fall or an infection. According to the data, catheter-associated urinary tract infections, pressure ulcers/pressure injuries and surgical site infections continue to cause thousands of preventable inpatient deaths, with an estimated cost of over $2 billion.206

“Analysis of Human Performance Deficiencies Associated with Surgical Adverse Events,” Baylor College of Medicine Professor of Surgery and Surgery Department Chair Todd Rosengart et al., 2019.

- “Researchers collected data from three adult teaching hospitals over six months, during which time more than 5,300 surgical operations were performed. Out of these procedures, adverse events occurred in 188 cases. Adverse events included death, major complications (infection, bleeding, neurological outcome) or non-routine events, such as hospital readmission. Of the 188 adverse event cases, human performance deficiencies were identified in 106, or more than 50 percent of cases.”

- ““There are approximately 17 million surgical procedures performed in the United States each year…. If the adverse outcome rate is about 5 percent, and half of those are due to human error, as seen in our cohort and reported in other studies, it would mean that about 400,000 adverse outcomes could be prevented each year.””207

Lives Lost, Lives Saved: An Updated Comparative Analysis of Avoidable Deaths at Hospitals Graded by The Leapfrog Group, Johns Hopkins University School of Medicine’s Armstrong Institute for Patient Safety and Quality Assistant Professor Matt Austin and Jordan Derk, 2019.

Examination of Leapfrog quality ratings data revealed an estimated 161,250 avoidable deaths occurring in U.S. hospitals each year. Researchers explained that this number is likely an undercount.208
“Nurses’ and Patients’ Appraisals Show Patient Safety in Hospitals Remains a Concern,” Center for Health Outcomes and Policy Research Director and Nursing Professor Linda H. Aiken et al., 2018.

Researchers assessed safety by examining reports from over 53,000 RNs and more than 805,000 patients at 535 hospitals in four large states at two time points between 2005 and 2016. The results reflected little to no progress toward improving patient safety and preventing patient harm. Among the key findings:

- Over the past decade, “only 21 percent of hospitals substantially improved their clinical work environments; 71 percent made no improvements and 7 percent experienced deteriorating work environments.”

- “Where work environments deteriorated, fewer nurses (–19 percent) gave a favorable grade on patient safety.”

- “In the study, about 30% of nurses graded their own hospitals ‘unfavorably’ on measures of patient safety and infection prevention.”

- 55 percent of nurses “would not definitely recommend their hospital to a family member or friend who needed care.”

- “Patients also expressed concern about quality and safety with 30 percent reporting that they would not definitely recommend their hospital. Nearly 40 percent of patients said that they did not always receive help quickly from hospital staff, and nearly 40% reported that medications were not always explained before given.”


After analyzing how well the United States fared at preventing deaths from medical errors, Global health researchers gave the U.S. a 70 out of 100. More than 55 countries exceeded that score. These findings are consistent with data reported the previous year.

Americans’ Experiences with Medical Errors and Views on Patient Safety, NORC at the University of Chicago and IHI/NPSF Lucian Leape Institute, 2017.

A 2017 nationwide survey investigating Americans’ experiences with medical errors revealed the following:

- “Combined, 41 percent of adults in the United States have either experienced a medical error in their own care or were personally involved in a situation where a medical error was made in the care of someone close to them.”
• “One in 5 Americans say they have personally experienced a medical error while receiving health care...including 4 percent who experienced the error within the past year, 6 percent who experienced it within the past five years, and 11 percent who experienced it more than five years ago.”

• “Beyond personally experienced errors, 31 percent of Americans report that someone else whose care they were closely involved with experienced a medical error. This includes 6 percent who were involved with an error that occurred within the past year, 10 percent who were involved with an error that occurred within the past five years, and 15 percent who were involved with an error that occurred more than five years ago.”

• Sixty-seven percent who reported experiencing an error were not informed of the mistake by a health care provider or someone else at the facility where the error happened.

• “Twenty-seven percent of those with medical error experience say the error had a short-term effect on their physical health that lasted less than a month, 27 percent say the error had a long-term effect that lasted more than a month, and 30 percent say the error had a permanent effect on their physical health. Just 15 percent say the medical error had no effect on their physical health.”


• “The Joint Commission is the accrediting organization for almost 80% of U.S. hospitals, including those for veterans, the Federal Bureau of Prisons and the Indian Health Service, giving it a sweeping quasi-governmental role overseeing medical care.”

• “The Joint Commission revoked the accreditation of less than 1% of the hospitals that were out of Medicare compliance in 2014, the Journal found. In more than 30 instances, hospitals retained their full accreditation although their violations were deemed by CMS so significant they caused, or were likely to cause, a risk of serious injury or death to patients.”

• “A result is that hundreds of hospitals with safety problems could continue to display a ‘Gold Seal of Approval’ and promote their accredited status. The Joint Commission provides hospitals with an accreditation publicity kit, and a consulting arm of the organization sells ‘We Are Accredited!’ pins and stickers. A brochure it prepared for patients reads, ‘Whenever and wherever you receive health care, look for The Joint Commission Gold Seal of Approval.’”

• “The Journal found that not only did about 350 hospitals have accreditation while in violation of Medicare safety requirements in 2014, but 60% of them also had such violations in the preceding three years.”
• “In later years, when more than a third had Medicare deficiencies, these violations included instances of patients being shocked by medical equipment, sent away from emergency departments with untreated broken bones or dying after staff members didn’t respond for trauma surgery, according to a review of CMS inspection reports, state health-department data and information from HospitalInspections.org, a site run by the Association of Health Care Journalists.”\(^\text{213}\)

**Medication-related Malpractice Risks: CIRCO 2016 CBS Benchmarking Report, CRICO Strategies, 2017.**

An analysis of more than 28,000 medical malpractice cases asserted from 2010-2014 revealed the following\(^\text{214}\):

- “1 in 9 malpractice cases involves a medication-related problem.”
- “49% of all medication cases involve a high-severity injury or death.”
- “32% of medication-related malpractice cases involve a patient death, compared with 18% of all other cases.”
- In more than half the medication error cases that closed with a payment, “the patient suffered a permanent significant injury (18%) or died (34%).”
- Lastly, “a 10-year analysis of 48,483 cases with loss years from 2003–2012” found that the proportion of cases with medication errors is unchanged since 2003.

**Opioid Use in Acute Care, ECRI, 2017.**

- ECRI found that 35 percent of over 7,200 adverse events caused by opioids were linked to medication administration errors.
- “Issues linked to prescribing and patient monitoring were reported less frequently, but were more likely to cause patient harm, according to the report. Patient harm was reported in 1 in 5 cases that noted a level of harm.”\(^\text{215}\)

**Mirror, Mirror 2017: International Comparison Reflects Flaws and Opportunities for Better U.S. Health Care, Commonwealth Fund, 2017.**

In a study comparing U.S. health care to systems in 10 other countries, U.S. patients reported the second highest rate of medical, medication or lab errors over the past two years.\(^\text{216}\)
“Medical error – the third leading cause of death in the US,” Johns Hopkins University Professor of Surgery and Multidisciplinary Pancreatitis Center Surgical Director Martin A. Makary and Department of Surgery Research Fellow Michael Daniel, 2016.

- “Analyzing medical death rate data over an eight-year period, Johns Hopkins patient safety experts have calculated that more than 250,000 deaths per year are due to medical error in the U.S. Their figure…surpasses the U.S. Centers for Disease Control and Prevention’s (CDC’s) third leading cause of death – respiratory disease, which kills close to 150,000 people per year.”

- “10 percent of all U.S. deaths are now due to medical error.”

- “Medical errors are an under-recognized cause of death.”

“Patient Safety at the Crossroads,” National Patient Safety Foundation President and CEO Tejal K. Gandhi, Institute for Healthcare Improvement President Emeritus and Senior Fellow Donald M. Berwick and Toronto University Centre for Quality Improvement and Patient Safety Director Kaveh G. Shojania, 2016.

- “[I]t is now clear that medical errors and injuries have much broader effects than the [Institute of Medicine’s 1999] report addressed, causing morbidity as well as mortality and leading to harms in all health settings, not just hospitals.”

- “[R]ecent analysis suggests 13% of harms occurring in hospitals are substantial, requiring prolonged hospital stays or life-sustaining treatment or involving permanent harm or death. Moreover, harm during hospitalization likely only reflects a small proportion of harm because substantially more care is provided in the ambulatory environment.”

Patient Identification, ECRI, 2016.

- ECRI Institute Patient Safety Organization (PSO) “reviewed more than 7,600 wrong-patient events occurring over a 32-month period that were submitted by 181 healthcare organizations. The events are voluntarily submitted and may represent only a small percentage of all wrong-patient events occurring at the organizations.”

- “Most patient identification mistakes are caught before care is provided, but the events in this report illustrate that others do reach the patient, sometimes with potentially fatal consequences. About 9% of the events led to temporary or permanent harm or even death.”

- “More than half of the failures involved either diagnostic procedures (2,824 or 36.5%) or treatment (1,710 or 22.1%). Diagnostic procedures cover laboratory medicine, pathology, and diagnostic imaging. Treatment covers medications, procedures, and transfusions.”
• “In addition to their potential to cause serious harm, patient identification errors are particularly troublesome for a number of other reasons, including: Most, if not all, wrong-patient errors are preventable.”\(^{219}\)

**2016 National Patient Misidentification Report, Ponemon Institute, 2016.**

• “64% of respondents say that patient misidentification happens frequently or all the time in a typical healthcare facility, which means that the industry standard reporting of a 8-10% patient misidentification rate likely underrepresents the problem.”

• “86% of providers have witnessed or have known of a medical error due to misidentification.”\(^{220}\)


“The joint commission which accredits hospitals does keep track of items left inside surgical patients, telling the I-Team it happens roughly 2,000 to 4,000 times each year in the United States.”\(^{221}\)


“‘An estimated 200 to 650 surgical fires – fires that occur in, on or around a patient who is undergoing a medical or surgical procedure – occur in the U.S. annually,’ a Joint Commission spokeswoman told the I-Team.”\(^{222}\)

**Malpractice Risks in Communication Failures: 2015 Annual Benchmarking Report, CRICO Strategies, 2016.**

An analysis of more than 23,000 medical malpractice claims and suits filed from 2009-2013 in which patients suffered some degree of harm revealed the following\(^{223}\):

• “Hospitals and doctors’ offices nationwide might have avoided nearly 2,000 patient deaths – and $1.7 billion in malpractice costs – if medical staff and patients communicated better…”

• “[T]hree out of every 10 cases include at least one specific breakdown in communication.”

• “37% of all high-severity injury cases involve a communication failure.”

• “One-third of obstetrics-related malpractice cases involve communication errors. While a woman and her obstetrician or midwife may exchange considerable information leading up to labor, the preponderance of communication errors take place once labor has begun,”
often engaging caregivers new to the patient or unfamiliar with one another. Indeed, miscommunication among obstetrical team members is what most commonly leads to adverse outcomes and allegations of malpractice.”

- Among obstetrics cases, “56% resulted in a high-severity injury” and “23% resulted in death (maternal or fetal).” Top communication factors included: “miscommunication among providers re: patient’s condition” (37 percent), “poor documentation of clinical findings” (16 percent) and “inadequate informed consent” (8 percent).

- “Analysis of more than 7,500 surgery-related malpractice cases finds that 26 percent involved significant communication errors. In more than half of these cases, the surgical technique was not questioned, but the patient’s care was impacted by miscommunication within the surgical team – or more commonly, by inadequate communication with the patient.”

- Among surgery cases, “34% resulted in a high-severity injury” and “14% resulted in death.” Top communication factors included: “inadequate informed consent” (23 percent), “miscommunication among providers re: patient’s condition” (19 percent) and “unsympathetic response to patient complaints” (13 percent).

“Evaluation of Perioperative Medication Errors and Adverse Drug Events,” Massachusetts General Hospital Anesthesiologist and Harvard Medical School Assistant Professor Karen C. Nanji et al., 2015.

In a first-of-its-kind study measuring the incidence of medication errors and adverse drug events during the period immediately before, during and right after a surgical procedure, researchers found the following:

- “[S]ome sort of mistake or adverse event occurred in every second operation and in 5 percent of observed drug administrations.”

- “Of the almost 3,675 medication administrations in the observed operations, 193 events, involving 153 medication errors and 91 adverse drug events, were recorded either by direct observation or by chart review. Almost 80 percent of those events were determined to have been preventable.”

- “Of all the observed adverse drug events and medication errors that could have resulted in patient harm – four of which were intercepted by operating room staff before affecting the patient – 30 percent were considered significant, 69 percent serious, and less than 2 percent life-threatening; none were fatal.”

- “The most frequently observed errors were mistakes in labeling, incorrect dosage, neglecting to treat a problem indicated by the patient’s vital signs, and documentation errors.”
“Preventing falls and fall-related injuries in health care facilities,” Joint Commission, 2015.

- “Every year in the United States, hundreds of thousands of patients fall in hospitals, with 30-50 percent resulting in injury.”

- “Injured patients require additional treatment and sometimes prolonged hospital stays. In one study, a fall with injury added 6.3 days to the hospital stay.”

- “The average cost for a fall with injury is about $14,000.”

“Wrong-Site Surgery, Retained Surgical Items, and Surgical Fires,” RAND Corporation Behavioral Scientist and Pardee Graduate School Professor Susanne Hempel et al., 2015.

According to a comprehensive data review published in *JAMA Surgery*, every year there are an estimated 500 surgeries on the wrong body part and 5,000 surgical items unintentionally left in patients’ bodies, “which constitute too many events.”

“Adverse Events in Robotic Surgery: A Retrospective Study of 14 Years of FDA Data,” University of Illinois at Urbana-Champaign Engineering Professor Ravishankar K. Iyer et al., 2015.

After examining over 10,000 incident reports from the FDA spanning from 2000 to 2013, researchers found that robots used in minimally invasive surgery were involved in 144 patient deaths, 1,391 patient injuries and 8,061 device malfunctions. Among the errors reported – burnt or broken pieces of tools falling into the patient (14.7 percent), electrical sparking of instruments (10.5 percent) and robots making unintended movements (8.6 percent) – the last of which resulted in 52 injuries and two deaths. In addition, more errors were reported in complicated cardiothoracic and head and neck surgeries than during gynecology and urology procedures.


“Several studies show that hospital boards can improve quality and can make decisions associated with reduced mortality rates. But not all boards do so,” even though “boards, and other hospital management, can influence care in ways that individual physicians cannot.”

“In general, hospital boards do not view themselves as institutional champions of quality… Only half of boards view clinical quality as one of their top two concerns. In contrast, financial performance was a top priority for about three-quarters of hospital boards…. Troublingly, most hospitals boards can’t accurately assess their institution’s quality. There’s a Lake Wobegon effect: More than half of hospitals with low quality thought they were actually above average.”
STATE-SPECIFIC ERROR TRENDS ARE SIMILAR.

- **Connecticut.** A recent state Department of Public Health report[^229] on errors by acute care, chronic disease and mental hospitals plus non-hospital owned outpatient surgical facilities cited 376 reports of adverse events reported in 2018. Of those 376 adverse events reported, 52 percent were for pressure ulcers and 28 percent for falls resulting in death or serious injury. These two categories accounted for 80 percent of events reported and have been the top two reported errors year after year.[^230] The next most commonly reported event in 2018 was 28 reports of “retained objects after surgery,” including “sponge and packing (7), drain (4), guide wire (4), needle (2), and single mentions of different or unspecified items (11).”[^231]

- **Indiana.** The state Health Department revealed 134 reported medical errors in 2018, with 126 of those events occurring at hospitals. Since 2006, the average number of reported medical errors per year has been 108.5. The most common errors for 2018 were: stage 3 or 4 pressure ulcers acquired after admission (47 events); post-surgery retention of a foreign object (35 events); fall-related death or serious disability (21 events); and surgery on the wrong body part (18 events). Stage 3 or 4 pressure ulcers acquired after admission and post-surgery retention of a foreign object have always been in the top three reported events in all years of medical error reporting.[^232]

- **Iowa.** “Nearly one in five Iowans say they’ve had personal experience with medical errors, such as surgical mistakes, wrong diagnoses or incorrect medications, a new poll shows. In more than half of those cases, medical staff members did not inform the patients.” Among those who experienced medical errors, “59 percent said the mistakes happened in hospitals” and “29 percent said the mistakes happened in clinics….” In addition, “[s]ixty percent of those who experienced medical errors said the mistakes caused serious health consequences. Ninety percent believed the errors were preventable.”[^233]

- **Massachusetts.** As reported by the Betsy Lehman Center for Patient Safety, “Massachusetts faces the same patient safety challenges that persist throughout the nation.”[^234] Among the state agency’s chief findings[^235]:
  - “[A]t least 62,000 medical errors occur every year – 170 a day on average. Almost a third cause serious harm. And an additional 12% – many thousands every year – involve death.”
  - “The extra care required following medical injuries adds up to at least $617 million a year in excess health care costs. This number does ‘not come close to representing the full financial cost of medical care,’ the report says, because it doesn’t account for lost income, malpractice claims and other indirect costs.”
  - “Comparing these numbers to the Betsy Lehman Center’s last report on medical errors in Massachusetts nearly five years ago, it’s clear the problem hasn’t improved.”
• **Minnesota.** “In 2021, the total number of reported events increased to 508 (up from 382 in 2020). As in years past, pressure ulcers and falls were the most reported events, accounting for 60 percent of the reportable events. Of the reports submitted during this reporting period, 40 percent resulted in serious injury (207 events), while approximately two percent (14 events) led to the death of the patient. The number of reported events has increased, including those resulting in serious injury. Over the life of the reporting system, falls, medication errors and product/device malfunction have been the most common causes of serious patient injury. The pattern with deaths was similar in 2021 as well; six of the 14 deaths were associated with falls, two were associated with a product/device malfunction, three with the death of a neonate, one with wrong body part surgery/invasive procedure, one with a medication error and one after an elopement.”

• **New Jersey.** According to a recent state health department study, acute care hospitals reported 400 serious preventable adverse events in 2019. Among the consequences of those events for patients: additional lab testing or diagnostic imaging (212 events), increased length of stay (189 events), major surgery (118 events), disability-physical or mental impairment (107 events) and death (56 events). In aggregate, “care management ‘other,’” “intra-operative/post-operative coma, death or other,” “surgery-related ‘other’” and “fall” had “a total of 218 reportable events which represent 54.4 percent of all events reported. However, the total number of deaths associated with these four events was 49 and accounted for almost 88 percent (87.5%) of all deaths reported in 2019.”

• **Pennsylvania.** Between January 1, 2020 and December 31, 2020, Pennsylvania acute healthcare facilities reported 278,548 incidents, of which 8,368 of which were “serious” (i.e., “results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional healthcare services to the patient”) and 417 were “high harm” (i.e., “contributed to or resulted in permanent harm,” “resulted in a near-death event” or “contributed to or resulted in death”).

• **Washington.** In 2021, hospitals and other health care facilities reported a total of 1,018 adverse events, a 24 percent increase from the previous year. Among the errors cited: wrong site procedure (23 instances), wrong surgical procedure (9 instances), retained foreign object (41 instances), medication error (21 instances), fall resulting in death or serious injury (194 instances) and pressure ulcers (627 instances).
DIAGNOSTIC ERRORS ARE THE MOST COMMON AND COSTLY ERRORS.


- “Too many Americans have experienced the health-related consequences and anxieties that follow a diagnostic error – a diagnosis that is either delayed, poorly communicated, or just plain wrong.”

- “One in 20 adults annually experiences a diagnostic error in outpatient settings. An estimated 250,000 diagnostic errors occur annually in U.S. hospitals. Regardless of the setting, diagnostic errors can derail proper care and may lead to severe injury or death. These issues have been amplified by COVID-19 and its impact on caregivers and the healthcare delivery system.”

“Characteristics of Disease-Specific and Generic Diagnostic Pitfalls,” Brigham and Women’s Center for Patient Safety Research and Practice Associate Director and Harvard Medical School Associate Professor Gordon Schiff et al., 2022.

- “Combing through data from patient safety incident reports, malpractice claims, morbidity and mortality rounds (conferences that review patient deaths and complications), and focus group responses, researchers found 836 relevant diagnostic errors, which they used to identify the 10 most common missed or delayed diagnoses and explore what went wrong in the process. The findings highlight what experts say is a key safety issue in modern medical care.”

- “Colorectal cancer, lung cancer and breast cancer are the three most frequently missed diagnoses in outpatient clinics and academic medical centers…. Heart attack and prostate cancer round out the top five.” The remaining most common missed or delayed diagnoses are as follows: stroke, sepsis, bladder cancer, pulmonary embolism and brain hemorrhage.


- About 1 in 18 emergency department (ED) patients receive an incorrect diagnosis, with “1 in 50 suffering an adverse event, and 1 in 350 suffering permanent disability or death. These rates are comparable to those seen in primary care and hospital inpatient care.”

- “We estimate that among 130 million emergency department (ED) visits per year in the United States that 7.4 million (5.7%) patients are misdiagnosed, 2.6 million (2.0%) suffer an adverse event as a result, and about 370,000 (0.3%) suffer serious
harm from diagnostic error. Put in terms of an average ED with 25,000 visits annually and average diagnostic performance, each year this would be over 1,400 diagnostic errors, 500 diagnostic adverse events, and 75 serious harms, including 50 deaths per ED.”

- “Root causes of ED diagnostic errors were mostly cognitive errors linked to the process of bedside diagnosis. Malpractice claims associated with serious misdiagnosis-related harms involved failures of clinical assessment, reasoning, or decision making in about 90 percent of cases. Similar findings were seen in incident report data. These issues are not unique to the ED – they are seen across clinical settings, regardless of study method.”


- Over 20 percent of medical professional liability cases closed from 2010-2019 involved a diagnosis-related allegation.

- Internal medicine, family medicine, emergency medicine and radiology account for half of the more than 70,000 diagnosis-related MPL cases.

- “The universality of diagnostic pitfalls across all specialties and services is evident again in the list of contributing factors specific to the patient assessment process,” such as “[f]ailure to order a diagnostic test” and “[f]ailure to appreciate relevant sign/symptom/test result.”

A Call for Action: Insights from a Decade of Malpractice Claims, Coveys, 2020.

Analysis of 2010-2019 closed claims data revealed that “[d]iagnostic error is a primary contributor to healthcare-related patient harm.” More specifically,

- “Death and high-severity injury constitute 52% of events and 74% of indemnity paid. High-severity injury and death allegations are mostly attributable to missed or delayed cancer diagnoses.”

- Regarding emergency department-related events, “[d]iagnosis-related allegations account for 66% of indemnity paid.”
“Rate of diagnostic errors and serious misdiagnosis-related harms for major vascular events, infections, and cancers: toward a national incidence estimate using the ‘Big Three,’” Johns Hopkins University School of Medicine Director of the Armstrong Institute Center for Diagnostic Excellence and Epidemiology Professor David E. Newman-Toker et al., 2020.

- “[A]pproximately one in 10 patients (9.6%) in the United States with symptoms caused by major vascular events, infections or cancers will be misdiagnosed.”

- “Of the people with the most-commonly misdiagnosed major vascular events, infections and cancers, roughly half (53.9%) suffered permanent disability or die because of the error.”

- “Among the 15 diseases analyzed, spinal abscesses was the disease most often missed (62.1%). More than one-in-four aortic aneurysms and dissections have a critical delay in diagnosis (27.9%) and more than one in five (22.5%) lung cancer diagnoses are also meaningfully delayed.”

**Top 10 Patient Safety Concerns 2020, ECRI, 2020.**

“Missed and delayed diagnoses” ranked as the top patient safety concern for 2020. This was ECRI’s finding after examining patient safety data in conjunction with extensive expert input.

**“Diagnostic Errors: Why Do They Matter, and What Can You Do?” ECRI, 2019.**

According to a compilation of recent research:

- “Diagnostic errors that may have contributed to death have been found in 10% of autopsies. This extrapolates to 40,000 to 80,000 deaths annually.”

- “At least 1 in 20 adults experiences a diagnostic error annually, based on outpatient studies.”

- “12% of adults said they or someone close to them had experienced a misdiagnosis in the past 5 years, according to a phone survey.”

- Diagnostic errors were alleged in 29 percent of claims, accounted for 35 percent of payments and amounted to a mean payout of $390,000.

- Death occurred in 41 percent of diagnostic error claims.
Emergency Department Risks: Through the Lens of Liability Claims, Coverys, 2019.

After analyzing over 1,300 closed medical malpractice claims filed against hospitals between 2014 and 2018 over emergency department care, the insurance provider found that failure or delay in making a diagnosis accounted for over half the allegations. Moreover, a “staggering 44% of the Coverys cases that were classified as diagnosis-related identified the initial history and physical (H&P) and evaluation of the patient as the stage at which the diagnostic process broke down,” while problems related to ordering diagnostic/lab tests ranked as the second most common group of allegations, at 27 percent.252


- An analysis of 4,355 adverse events reported by ambulatory care settings between December 2017 and November 2018 revealed that diagnostic testing errors accounted for 47 percent of mistakes, making it the most frequent safety risk patients faced.

- A preliminary review of 13,429 claims and lawsuits closed between 2016 and 2018, as reported by the Medical Professional Liability Association, showed that: 1) 36 percent of closed claims alleged a diagnostic error; 2) more than half of the diagnostic error-related closed claims identified the diagnosis as incomplete or inaccurate; and 3) over one-quarter of diagnostic error-related closed claims paid an average indemnity of $494,000.253


An analysis of more than 1,800 closed medical malpractice claims brought against primary care doctors from 2013 to 2018 revealed not only that diagnostic errors were the leading cause of liability claims (46 percent) and accounted for the highest proportion of payouts (68 percent) but also that 45 percent of injuries in diagnostic-related cases resulted in a patient’s death.254

“Reflections on Diagnosis and Diagnostic Errors: A Survey of Internal Medicine Resident and Attending Physicians,” Yale Medical School Physical Examination Director, Clinical Reasoning Director and Instructor Thilan Wijesekera, Associate Professor of Medicine Lisa Sanders and Associate Professor of Medicine, Primary Care Residency Program Resident Research Director and General Internal Medicine Medical Education Fellowship Director Donna Windish, 2019.

A study analyzing responses from hundreds of residents and attending physicians at nine Connecticut internal medicine training programs – and published in the May 15, 2019 Journal of General Internal Medicine – revealed that “[a]lthough clinicians are often unsure of diagnoses, they tend to underestimate the rate of diagnostic errors and frequently fail to recognize how diagnostic testing affects patients….” More specifically, “despite the high rate
of diagnostic uncertainty among clinician respondents, most believed that diagnostic errors were uncommon. The majority thought they occurred once a month or less frequently (inpatient, 54%; outpatient, 60%). This is in stark contrast with findings in [a 2015 National Academy of Medicine report], which indicated that diagnostic errors arise in 10% to 15% of patient encounters….”

“Diagnosis,” Society to Improve Diagnosis in Medicine, 2018.

“[I]t’s estimated that roughly 40,000-80,000 deaths in U.S. hospitals each year can be attributed to an inaccurate or delayed diagnosis. Every nine minutes, a person dies in U.S. hospitals due to wrong or delayed diagnosis.”

“Learning from Patients’ Experiences Related to Diagnostic Errors Is Essential for Progress in Patient Safety,” Baylor College of Medicine Assistant Professor and Houston VA Medical Center for Innovations in Quality, Effectiveness and Safety Researcher Traber Davis Giardina et al., 2018.

Baylor College of Medicine researchers analyzed 465 written patient- and family-reported error narratives submitted between January 2010 and February 2016 and “identified 184 unique patient narratives of diagnostic error. Problems related to patient-physician interactions emerged as major contributors” to errors in 75 percent of the accounts. Among the behaviors cited:

- Physicians ignored or disregarded patients’ knowledge.
- Physicians disrespected patients by belittling, mocking and stereotyping.
- Physicians failed to communicate effectively or refused to speak with patients and family members.
- Physicians used fear to influence care decisions, misled patients or misinformed them.

Diagnostic Accuracy: Room for Improvement, Coverys, 2018.

Analysis of over 10,500 closed medical malpractice liability claims from 2013-2017 revealed the following:

- Misdiagnoses are the largest root cause of all medical liability claims, accounting for one-third of all claims and 47 percent of indemnity payments.
- Surgical/procedural failures are the second largest root cause of claims, accounting for nearly a quarter of all claims and 18 percent of indemnity payments.
- 53% of misdiagnosis claims include risk management issues involving poor clinical decision-making.
• 54% of misdiagnosis claims are high severity cases, and 36% result in death.

• 36% of misdiagnosis claims stem from outpatient (office setting) locations.


An analysis of 2017 National Practitioner Data Bank data revealed that error in diagnosis was the most common type of allegation in paid claims (34 percent), followed by surgical errors (22 percent) and errors related to treatment (19 percent).260

“Hospital transfers can leave diagnoses behind,” Minneapolis Star Tribune, July 28, 2018.

When analyzing data on patient transfers from one hospital to another, University of Minnesota doctors discovered discrepancies in lists of diagnoses in 85 percent of transfers. “Worse yet, they found that patients with inconsistent diagnostic records were more likely to die in hospital care.”261

Americans’ Experiences with Medical Errors and Views on Patient Safety, NORC at the University of Chicago and IHI/NPSF Lucian Leape Institute, 2017.

A 2017 nationwide survey investigating Americans’ experiences with medical errors revealed the following262:

“While a range of errors are reported in the survey, the most commonly reported type of error is related to diagnosis. Fifty-nine percent of those with medical error experience report that the patient experienced a medical problem that was not diagnosed, was diagnosed incorrectly, or that a diagnosis was delayed. …Forty-two percent say they received a diagnosis that didn’t make sense. Forty-six percent say a mistake was made during a test, surgery, or treatment,” while 28 percent say they were administered the wrong amount of medication or incorrect medication.

❖ ADDITIONAL CATEGORIES AND CAUSES OF UNSAFE CARE.

Care Transitions.

Care Transitions: Through the Lens of Malpractice Claims, Coverys, 2021.

• Care transitions include patient movements such as “office-to-office, emergency department-to-home, unit-to-unit within a hospital, and from hospital to post-acute care facility.”

• “Death and high injury severity accounted for 59% of [care transition] events and 66% of indemnity paid.” High injury “includes major permanent injury (like blindness in both
eyes, paraplegia, bowel injury requiring permanent colostomy) and grave injury (like severe cerebral palsy, vegetative state, or untreated and widespread metastatic cancer).”

- “Claims stemming from care transitions are 29% more costly than claims arising from other allegations.”

- “Just three medical specialties – general medicine, surgery, and emergency medicine – were implicated in 63% of events and accounted for 64% of care transition cases with indemnity paid.”

Childbirth.


- “Thousands of mothers are needlessly dying or sustaining life-altering injuries because of medical mistakes and poor care.”

- “Hospitals know how to protect mothers. They just aren’t doing it. About half of maternal deaths and injuries could be prevented or reduced with better medical care. For years, experts have recommended that doctors, nurses and hospitals follow safety practices known to save lives. But USA TODAY found that, at some hospitals, less than 15% of women experiencing childbirth emergencies quickly received recommended treatments.”

- Hemorrhage and high blood pressure “are among the leading killers of new moms, but they also are among the most preventable with better medical care. As many as 90% of hemorrhage deaths and 60% of hypertension deaths could be prevented.”

- “Moms suffer complications far more often at some hospitals. … About one of every eight hospitals – 120 in all – had rates double the norm.”


The insurer’s analysis of 472 obstetric-related closed claims across a five-year period (2013-2017) revealed the single largest cause of obstetrical claims was “alleged negligence during the management of labor – accounting for 40% of claims and 49% of indemnity paid.” Risks included failure to: “Recognize and act on nonreassuring fetal heart tracings”; “Monitor mother/fetus during administration of high-risk medications (e.g., oxytocin and magnesium sulfate)”; and “Recognize and act on obstetric emergencies.”
“Clinical capital and the risk of maternal labor and delivery complications: Hospital scheduling, timing and cohort turnover effects,” Colorado State University Departments of Economics and Epidemiology Associate Professor Sammy Zahran et al., 2019.

Researchers analyzed Texas Dept. of State Health Services data on more than two million cases from 2005 to 2010 and found that the quantity of delivery complications are substantially higher in teaching hospitals. More specifically,

- “Mothers delivering their infants in teaching hospitals are 2.2 times more likely to experience a delivery complication than mothers birthing at non-teaching hospitals.”

- “The risk also increases by a multiplicative factor of 1.3 at teaching hospitals in July, when new residents join the staff rotation. By June, after a full year of training and integration, the risk of a delivery complication at these same hospitals is statistically indistinguishable from chance.”

Children.


In February 2019, the medical association issued a policy statement outlining studies that reflect the extent to which children suffer avoidable medical errors. Among the research cited:

- “Errors in prescribing, dispensing, and administering medications represent a substantial portion of the preventable medical errors in children despite electronic prescribing.”

- “A study of hospitalized, pediatric, nonnewborn patients in the United States revealed a medication error rate of 1.81 to 2.96 per 100 discharges. Teaching hospitals and settings where patients had more complex medical needs showed significantly higher error rates….”

- “Other studies, including one in which a trigger tool was used, have revealed myriad nonmedication harms, with total rates as high as 40 harms per 100 patients. Harms reported include accidental extubation, pressure ulcers, patient misidentification, delays in diagnosis, intravenous infiltrates, and other adverse events attributed to communication, training, and systems failures.”

- “Pediatric errors in emergency department (ED) settings may be attributable to multiple factors, including incorrect patient identification, lack of experience of many ED staff with pediatric patients versus with adults, and challenges with performing technical procedures in and calculating medication doses for children. Other sources
of error include communication between prehospital and ED staff; among ED staff, particularly during change-of-shift sign off; between ED and inpatient staff; and between ED staff and family members.”

“U.N.C. Doctors Were Alarmed: ‘Would I Have My Children Have Surgery Here?’”

There are “concerns about the quality and consistency of care provided by dozens of pediatric heart surgery programs across the country…. At least five pediatric heart surgery programs across the country were suspended or shut down in the last decade after questions were raised about their performance.”

“Heartbroken,” *Tampa Bay Times, November 28, 2018.*

“*Times* reporters spent a year examining the All Children’s Heart Institute – a small, but important division of the larger hospital devoted to caring for children born with heart defects.” Among the findings:

- “All Children’s surgeons made serious mistakes, and their procedures went wrong in unusual ways. They lost needles in at least two infants’ chests. Sutures burst. Infections mounted. Patches designed to cover holes in tiny hearts failed.”

- “In just a year and a half, at least 11 patients died after operations by the hospital’s two principal heart surgeons. The 2017 death rate was the highest any Florida pediatric heart program had seen in the last decade.”

- “Parents were kept in the dark about the institute’s troubles, including some that affected their children’s care. [One] family didn’t know [their child] caught pneumonia in the hospital until they read her autopsy report. The parents of another child didn’t learn a surgical needle was left inside their baby until after she was sent home.”

“Adverse Events in Hospitalized Pediatric Patients,” *Children’s National Medical Center Critical Care Specialist David C. Stockwell et al., 2018.*

- “Incidence of adverse events in hospitalized pediatric patients showed no decline from 2007 to 2012….”

- Examination of 3,790 admissions revealed a total of 414 adverse events. “The most common were hospital-acquired infections (77 events), followed by intravenous line complications (60 events) and respiratory-related harms (53 events). Notably, a little over half of adverse events (n=210) were preventable….”

- A little over half of adverse events “contributed to or resulted in temporary harm to the patient and required intervention” and a little over a third were “contributed to or
resulted in temporary harm to the patient and required initial or prolonged hospitalization,” while 10 percent were life-threatening and “three caused or contributed to a patient’s death.”

“Parent-Reported Errors and Adverse Events in Hospitalized Children,” Harvard Medical School and Boston Children’s Hospital Researcher Alisa Khan et al., 2016.

- Roughly one in ten parents spotted safety incidents that their child’s physician did not.
- 62 percent of the safety incidents parents reported were medical mistakes.
- 30 percent of those medical mistakes caused harm and were preventable.
- Children suffering medical errors appeared to have longer hospital stays.
- “Parents identified communication problems as a contributing factor in a number of errors, including instances when day and night staff didn’t note a medication change and when written information for one patient was documented in a different patient’s medical record.”

Clinics/Doctors’ Offices/Surgery Centers.


The federal agency analyzed Medicare data on ambulatory surgery centers (ASCs) and found the following:

- “Just over three-fourths of the facilities inspected during 2013-2017 had at least one deficiency and 25% had serious deficiencies. The most common one were lapses in infection control, which made up about 20% of the deficiencies. ‘Serious deficiencies’ are those grave enough to indicate what the report called ‘pervasive noncompliance’ and posing ‘a serious threat to patient health and safety.’”
- “Of the 732 complaints that states received about ASCs during 2013-2017, nearly half were substantiated. They included a finding that the ASC ‘failed to properly assess patients pre-operatively, did not have medical records for some patients, and did not follow its own procedures.’”
- “Of the ASCs inspected, roughly a third had deficiencies in observing pharmaceutical requirements, environmental controls, or patient rights, and some failed to meet all three.”
“Serious misdiagnosis-related harms in malpractice claims: The ‘Big Three’ – vascular events, infections, and cancers,” Johns Hopkins University School of Medicine Director of the Armstrong Institute Center for Diagnostic Excellence and Professor of Neurology, Ophthalmology and Otolaryngology David E. Newman-Toker et al., 2019.

Researchers analyzed all 11,592 diagnostic error cases between 2006 and 2015 that were drawn from a list of open and closed U.S. malpractice claims documented in the national Comparative Benchmarking System (CBS) database and “found that most of the diagnostic errors (71.2 percent) associated with the malpractice claims occurred in ambulatory settings – either in emergency departments, where missed infections and vascular events were more of a concern, or outpatient clinics, where misdiagnoses were more likely to be cancer-related.”273


- An analysis of 4,355 adverse events reported by ambulatory care settings between December 2017 and November 2018 revealed that diagnostic testing errors and medication safety issues were the most frequent risks patients faced, accounting for 47 percent and 27 percent of mistakes, respectively.

- “Errors that occur during diagnostic testing in ambulatory care settings can have potentially devastating consequences for patients. Although such errors occur in all care settings, they are especially prevalent in ambulatory care: AHRQ estimates that about 40% of primary care patient visits involve some sort of medical test (AHRQ “Improving”), and a Coverys analysis of 10,618 medical professional liability claims closed between 2013 and 2017 found that diagnosis-related errors accounted for approximately 33% of claims and 47% of indemnity payments.”274


Data submitted by 1,141 hospital and 321 ambulatory outpatient surgery centers across the nation in 2019 revealed that275:

- “More than 1 in 3 outpatient surgery centers employ doctors who are not board certified in their respective medical specialty....”

- “[N]early 30% of providers who provide anesthesia at doctor-owned centers are not board certified....”
“Lax Oversight Leaves Surgery Center Regulators and Patients in The Dark,” USA TODAY Network, August 9, 2018.

“A Kaiser Health News and USA Today Network investigation found that surgery centers operate under such an uneven mix of rules across U.S. states that fatalities or serious injuries can result in no warning to government officials, much less to potential patients. The gaps in oversight enable centers hit with federal regulators’ toughest sanctions to keep operating, according to interviews, a review of hundreds of pages of court filings and government records obtained under open records laws. No rule stops a doctor exiled by a hospital for misconduct from opening a surgery center down the street.”

“As surgery centers boom, patients are paying with their lives,” Kaiser Health News/USA Today, March 2, 2018.

- “An investigation by Kaiser Health News and the USA TODAY Network has discovered that more than 260 patients have died since 2013 after in-and-out procedures at surgery centers across the country. Dozens – some as young as 2 – have perished after routine operations, such as colonoscopies and tonsillectomies.”

- “Reporters examined autopsy records, legal filings and more than 12,000 state and Medicare inspection records, and interviewed dozens of doctors, health policy experts and patients throughout the industry, in the most extensive examination of these records to date. The investigation revealed,” among other things:

  o “Some surgery centers are accused of overlooking high-risk health problems and treat patients who experts say should be operated on only in hospitals, if at all. At least 25 people with underlying medical conditions have left surgery centers and died within minutes or days. They include an Ohio woman with out-of-control blood pressure, a 49-year-old West Virginia man awaiting a heart transplant and several children with sleep apnea.”

  o “Some surgery centers risk patient lives by skimping on training or lifesaving equipment. Others have sent patients home before they were fully recovered. On their drives home, shocked family members in Arkansas, Oklahoma and Georgia discovered their loved ones were not asleep but on the verge of death. Surgery centers have been criticized in cases where staff didn’t have the tools to open a difficult airway or skills to save a patient from bleeding to death.”

- “Kaiser Health News and the USA TODAY Network found more than a dozen cases where the absence of trained staff or emergency equipment appears to have put patients in peril.”

- “Doctors in surgery centers may excel at the procedures they perform most often. But the centers aren’t always prepared and sometimes struggle in a crisis, according to a review of Medicare records and more than 70 lawsuits.”
“Analysis of Closed Claims Data in Ambulatory Surgical Centers,” Beth Israel Deaconess Medical Center Resident Joseph Foley et al., 2017.

- “Between 2007 and 2014, a total of 944 anesthesiology claims and lawsuits were filed. Of that total, 290 (30.7%) arose from events in ASCs [Ambulatory Surgical Centers].”

- “High-severity claims made up 19 percent of all ASC-related claims. About half of those high-severity claims involved patient deaths.”

- “The most common allegation – comprising 26% of all claims – was intubation-related damage to the teeth, followed by improper performance of an anesthetic procedure. ‘Injection of an anesthetic agent into a peripheral nerve was one of the most common procedures leading to the formation of a claim,’ Dr. Foley said. This was followed by intubation-related adverse events, such as injuries to the vocal cords and esophageal tears. ‘Finally, there were spinal – injection into the sympathetic nerve – and miscellaneous procedures, which included incorrect placement of an IV.’”

- “The next most common claim was for improper management of a patient under anesthesia, which comprised 20% of all ASC-related claims....”

Community Health Centers.


- “485 payouts [were] made nationwide involving community health centers from 2018 through 2021. The settlements and judgments totaled $410 million paid to the patients or their families, according to federal data released to KHN through a public records request.”

- “From 2018 through 2021, the median payment for malpractice settlements or judgments involving health centers was $225,000, according to the data from the Health Resources and Services Administration, which oversees the community health centers. In 68 of the 485 payouts, the total was at least $1 million.”

- “Many of the lawsuits against health centers involved allegations of misdiagnosis or dental errors. Most large awards were for birth injuries or cases involving children.”
Concurrent Surgeries.

“Association of Overlapping Surgery with Perioperative Outcomes,” Stanford University Medical School Assistant Professor of Anesthesiology, Perioperative and Pain Medicine and Health Services Research Eric Sun et al., 2019.

As explained by NPR’s Shots Blog, “The practice of double-booking the lead surgeon’s time seemed to put [high-risk] patients” (i.e., older patients, those with pre-existing medical conditions, and those undergoing coronary artery bypass graft surgery) “at significantly higher risk of post-op complications, such as infections, pneumonia, heart attack or death.”283


- “A Globe survey of 47 hospitals nationwide found that it is common for surgeons to start a second operation before the first is complete, often after the surgeries were deliberately scheduled to overlap briefly. However, some surgeons have operations that run simultaneously for longer periods. And few hospitals call on doctors to explicitly tell patients when their operations are double-booked.”

- Some “major hospitals either have no written concurrent surgery policy or declined to discuss the topic altogether. More than a dozen institutions, including Stanford Health Care, New York-Presbyterian Hospital, and the University of Pittsburgh Medical Center, refused to answer any questions.”

- “At Mass. General, the Globe found, a small group of medical staffers complained about at least 44 alleged problems involving concurrent surgeries in the last decade. They included cases where surgeons allegedly didn’t respond when an urgent need arose or didn’t show up, leaving the surgery to a resident or fellow; cases of patient complications, including the deaths of two elderly patients; cases where patients waited under anesthesia for the surgeon to arrive or return; and cases where operating room staff were confused about who would do the operation.”

- “Hospitals are fairly consistent on one thing: not requiring surgeons to explicitly tell patients when they will be caring for a second patient at the same time.”284

Do Not Resuscitate (DNR) Orders.

DNR Orders Can Lead to Worse Care & Increase Death Rates, e7 Health, 2021.

Analysis of 10 peer-reviewed studies found that the presence of DNR orders is “connected to elevated death rates, poorer medical care, and negative health outcomes.”285 More specifically:
• “DNR doubled the death rate for surgical patients: A Harvard Medical School study of patients undergoing elective procedures found that the presence of a DNR increased death rates despite no difference in disease rates. About 13 percent of patients with DNR orders in place died within the first 30 days after surgery compared to just under 6 percent for those without DNR orders, while DNR patients who survived had lower rates of most postoperative complications, including pneumonia, surgical site infection, and kidney failure.”

• “Death rates increased by 150 percent for DNR patients who had emergency vascular surgery: Those who had a DNR in place were more likely to experience graft failure (about nine percent vs. about two percent), while 35 percent died within 30 days of surgery compared to 14 percent without a DNR.”

• “Almost half of stroke victims who were designated DNR within the first 24 hours died in the hospital.”

• “Patients with DNR orders were seven percentage points less likely to have blood cultures drawn, 12 percentage points less likely to have a central IV line placed, and 12 percentage points less likely to receive a blood transfusion.”

• Another study on internal medicine residents “found that resident physicians were less likely to provide aggressive treatment to DNR patients like dialysis, surgical consultation, or transfer to intensive care despite not having specific guidance from patients or their family members.”

Emergency Rooms.

The hospital location with the highest proportion of negligent adverse events (52.6 percent) is the emergency department, where people without health insurance often go for primary care.


Researchers calculated the percentage of hospitals in each state that “have been cited for at least one ER-violation, as identified during the investigation of a complaint, since 2015.” These violations include “not properly assessing and treating patients, inadequate medical and nursing staff and not following ER policies and procedures.” Among the states with 30 percent or more of its hospitals cited for one or more violations: New York (53 percent), North Carolina (38 percent), Maryland (35 percent), Oregon (35 percent), Missouri (31 percent) and Pennsylvania (30 percent).

- Though the federal Emergency Medical Treatment and Labor Act (EMTALA) – which requires that emergency departments treat emergency patients regardless of ability to pay – “has been on the books for more than 30 years, hospitals are still violating it hundreds of times a year, sometimes with devastating results for patients.”

- “WebMD and Georgia Health News analyzed 10 years of EMTALA violations by hospitals around the United States from March 2008 to March 2018. The records, obtained under a Freedom of Information Act request, show cases where complaints were substantiated by investigators for the federal Centers for Medicare and Medicaid Services, meaning the hospital was found to be at fault.”

- Their investigation found:
  - “More than 4,300 violations from 1,682 hospitals in total over 10 years.”
  - “Violators represent about a third of the nation’s approximately 5,500 hospitals, according to statistics from the American Hospital Association.”
  - “Failure to do a thorough medical screening exam was the most common violation committed by hospitals, accounting for more than 1,300 citations, nearly twice as many as the second most common violation: transferring patients inappropriately.”
  - “In a deeper analysis of investigation reports from January 2016 to March 2018, at least 34 patients died during that period after emergency departments violated the law.”
  - “A medical condition often cited in these violations was pregnancy. About 1 in 12 involved women who were pregnant or in labor. About 1 in 7 involved patients who were having a mental health crisis, including having suicidal thoughts.”

- “Yet experts say the raw numbers belie both the scope and severity of the problems they see. That’s because enforcement of the law depends on someone filing a complaint. Although anyone can file a complaint, it’s most often a doctor, nurse, or hospital administrator.”

- According to Howie Mell, MD, an emergency doctor in Chicago and a spokesman for the American College of Emergency Physicians, “when you do see an EMTALA violation recorded in the system, it’s usually because something really serious happened. ‘They were either really egregious, or what you’re seeing is the tip of the iceberg’ for that hospital, Mell says.”

- “Patients are more likely to be misdiagnosed or experience treatment delays when emergency rooms are so crowded that they receive care in a hallway,” according to a 2015 survey of emergency room physicians.

- “Overall, nine in 10 doctors surveyed said they changed or shortened how they took patient medical histories when another person was present, and more than half of the physicians also altered how they did physical exams.”

“Early death after discharge from emergency departments: analysis of national US insurance claims data,” Harvard Medical School Health Care Policy Assistant Professor and Brigham and Women’s Hospital Emergency Medicine Assistant Professor Ziad Obermeyer et al., 2017.

- “Every year, a substantial number of Medicare beneficiaries die soon after discharge from emergency departments, despite no diagnosis of a life limiting illnesses recorded in their claims.”

- “In this national analysis, we found that over 10,000 Medicare beneficiaries each year died within seven days after being discharged from emergency departments, despite mean age of 69 and no obvious life limiting illnesses.”

- “For context, these deaths accounted for 1.7% of all non-hospice deaths in the Medicare fee for service population annually. Variability in mortality rates across hospitals was striking: hospitals with low patient volumes and lower admission rates had the highest rates of early death, and small increases in admission rates were linked to large decreases in risk – despite the fact that hospitals with low admission rates served emergency department populations with lower overall near term mortality.”

Hand-Off Communication.


“Inadequate hand-off communication is a contributing factor to adverse events, including many types of sentinel events. The Joint Commission’s sentinel event database includes reports of inadequate hand-off communication causing adverse events, including wrong-site surgery, delay in treatment, falls, and medication errors. A study released in 2016 estimated that communication failures in U.S. hospitals and medical practices were responsible at least in part for 30 percent of all malpractice claims, resulting in 1,744 deaths and $1.7 billion in malpractice costs over five years.”
High-Risk Surgeries.

*Safety in Numbers: Hospital Performance on Leapfrog’s Surgical Volume Standard Based on Results of the 2019 Leapfrog Hospital Survey, Leapfrog Group, 2020.*

The Leapfrog Group examined 2019 survey responses from over 2,100 hospitals nationwide, representing 70% of U.S. hospital beds – looking specifically at “whether hospitals are performing a sufficient volume of high-risk surgeries to safely do so, and whether the hospital grants privileges only to surgeons meeting the Leapfrog minimum volume standard. The report also records whether hospitals actively monitor to assure that each surgery is necessary.” Among the study’s findings:

- “The majority of hospitals are still electively performing high-risk procedures without the adequate, ongoing experience to do so.”
- “The bad news is the vast majority of hospitals performing these high-risk procedures are not meeting clear volume standards for safety. This is very disturbing, as a mountain of studies show us that patient risk of complications or death is dramatically higher in low-volume operating rooms….”
- “Of the eight high-risk procedures assessed in the report, esophageal resection for cancer and pancreatic resection for cancer are the two procedures where the fewest hospitals met the volume standard for patient safety – less than 3% and 8% respectively.”

Home Health Agencies.

“Hospital discharge: It’s one of the most dangerous periods for patients,” *Kaiser Health News, May 2, 2016.*

- A Kaiser Health News analysis of federal inspection records showed that medication errors are frequently missed by home health agencies. More specifically, between January 2010 and July 2015, “inspectors identified 3,016 home health agencies – nearly a quarter of all those examined by Medicare – that had inadequately reviewed or tracked medications for new patients. In some cases, nurses failed to realize that patients were taking potentially dangerous combinations of drugs, risking abnormal heart rhythms, bleeding, kidney damage and seizures.”
- In addition, “[o]ver the first half of this decade, 1,591 agencies – one in eight – had a defect inspectors considered so substantial that it warranted the agencies’ removal from the Medicare program unless the lapses were remedied.”
“Endgame: How the Visionary Hospice Movement Became a For-Profit Hustle,”
New Yorker and ProPublica, November 28, 2022.

- “Once a hospice is up and running, oversight is scarce. Regulations require surveyors to inspect hospice operations once every three years, even though complaints about quality of care are widespread.”

- “Because patients who enroll in the service forgo curative care, hospice may harm patients who aren’t actually dying. … [U]nitting recruits were denied kidney dialysis, mammograms, coverage for lifesaving medications or a place on the waiting list for a liver transplant.”

- “Some providers capitalize on the fact that most hospice care takes place behind closed doors, and that those who might protest poor treatment are often too sick or stressed to do so.”


- “Nearly all hospices that provided care to Medicare beneficiaries were surveyed at least once from 2012 through 2016. Eighty-seven percent of these 4,563 hospices had a deficiency during this 5-year period, meaning that they failed to meet at least 1 requirement (condition-level or standard level) for participating in the Medicare program. These requirements are intended to ensure the quality of care and services provided by hospices. Each year, 69 percent to 76 percent of surveyed hospices had at least one deficiency.”

- “Twenty percent (903 of 4,563) of hospices surveyed from 2012 through 2016 had at least one serious deficiency – a condition-level deficiency – which means that the hospice’s capacity to furnish adequate care was substantially limited, or the health and safety of beneficiaries were in jeopardy. The number of hospices with these deficiencies nearly quadrupled from 2012 to 2015 – going from 74 to 292 – then decreased somewhat in 2016.”


The nation’s 4,000-plus hospice agencies “pledge to be on call around the clock to tend to a dying person’s physical, emotional and spiritual needs. It’s a thriving business that served about 1.4 million Medicare patients in the U.S. in 2015, including over a third of Americans who died that year, according to industry and government figures.
“Yet as the industry has grown, the hospice care people expect – and sign up for – sometimes disappears when they need it most. Families across the country, from Appalachia to Alaska, have called for help in times of crisis and been met with delays, no-shows and unanswered calls, a Kaiser Health News investigation published in cooperation with TIME shows.

“The investigation analyzed 20,000 government inspection records, revealing that missed visits and neglect are common for patients dying at home. Families or caregivers have filed over 3,200 complaints with state officials in the past five years. Those complaints led government inspectors to find problems in 759 hospices, with more than half cited for missing visits or other services they had promised to provide at the end of life.

“Only in rare cases were hospices punished for providing poor care, the investigation showed.”


“[A]bout one in six U.S. hospice agencies, serving more than 50,000 of the terminally ill, did not provide either form of crisis care to any of their patients in 2012, according to an analysis of millions of Medicare billing records. The absence of such care suggests that some hospice outfits are stinting on nursing attention, according to hospice experts. Inspection and complaint records, meanwhile, depict the anguish of patients who have been left without care.”

Hospital “Off-Hours.”

“Clinical capital and the risk of maternal labor and delivery complications: Hospital scheduling, timing and cohort turnover effects,” Colorado State University Departments of Economics and Epidemiology Associate Professor Sammy Zahran et al., 2019.

“[T]he quantity of delivery complications in hospitals are substantially higher during nights, weekends and holidays, and in teaching hospitals.” This was the finding after researchers analyzed Texas Dept. of State Health Services data on more than two million cases from 2005 to 2010. More specifically,

- “The odds of a mother experiencing a delivery complication are 21.3 percent higher during the night shift, and that the odds of a delivery complication increase 1.8 percent with every hour worked within a shift.”

- “A mother delivering an infant on a weekend is 8.6 percent more likely to encounter a complication than a mother delivering on a weekday.”
• “Births occurring on holidays are particularly susceptible to labor or delivery complications, with holiday births being 29.0 percent more likely to have a complication.”\textsuperscript{301}

“Trends in Survival After In-Hospital Cardiac Arrest During Nights and Weekends,” Temple University Assistant Professor of Medicine and Geisinger Health System Critical Care Physician Uchenna R. Ofoma et al., 2018.

“Hospital patients who have a cardiac arrest may be more likely to die if it happens in the middle of the night or on a weekend than if it occurs on a weekday,”\textsuperscript{302} according to researchers examining data on over 151,000 adults who experienced cardiac arrest at 470 U.S. hospitals from 2000 through 2014.


Review of 2004-2013 data revealed that patients admitted to the hospital for a heart attack on the weekend were twice more likely to die than those hospitalized for a heart attack on a weekday.\textsuperscript{303}

“Association between day and month of delivery and maternal-fetal mortality: weekend effect and July phenomenon in current obstetric practice,” Baylor College of Medicine Obstetrics and Gynecology Professor Steven L. Clark et al., 2017.

• Researchers analyzed outcomes from over 45 million pregnancies in the United States between 2004 and 2014 and found that weekend delivery was “associated with differential maternal and neonatal morbidity, including increased ratios of perineal lacerations, maternal transfusions, neonatal intensive care admissions, immediate neonatal ventilation requirements, neonatal seizures and antibiotic use.”\textsuperscript{304}

• As the lead author explained, “‘Any system that shows this sort of variation in the most important of all system outcomes is, by definition, badly broken. Our data suggest that a part of the overall dismal U.S. obstetric performance may be related to this systems issue, that is, there may be a ‘spill over’ effect that is demonstrably worse on weekends but is also present on weekdays to a lesser extent. Our data does not allow us to go any further than this in terms of specifying what the problem is. However, we believe it is likely due to the fact that rarely is care of the pregnant inpatient the primary concern of the treating physician – it is almost always a distraction from office, surgery or personal activities.’”\textsuperscript{305}
“Incidence of ‘never events’ among weekend admissions versus weekday admissions to US hospitals: national analysis,” University of Southern California Medical School Neurosurgery Clinical Instructor Frank J. Attenello et al., 2015.

Researchers analyzed data from more than 350 million U.S. hospital admissions from 2002 to 2010 and found the following:

- “Even though most admissions – 81 percent – were on weekdays, preventable complications were more common on weekends. Hospital-acquired conditions occurred in 5.7 percent of weekend admissions, compared to 3.7 percent in people admitted on weekdays.”

- As the study’s lead author told Reuters, “‘This increased hospital-acquired condition rate is significant because we found presence of at least one hospital-acquired condition to be associated with an 83 percent likelihood of increased healthcare cost and a 38 percent increase in the likelihood of a prolonged hospital stay….’”


According to the study, published in the Journal of Pediatric Surgery, “even after controlling for sex, age, race, the type of surgery and other factors, patients having a procedure on the weekend were 40 percent more likely to sustain an accidental puncture or cut, 14 percent more likely to receive a transfusion, and 63 percent more likely to die.”

Hospital Transfers.

“Hospital transfers can leave diagnoses behind,” Minneapolis Star Tribune, July 28, 2018.

- In a 2017 study, Stanford University researchers “found that patients who move from one hospital to another experience longer stays, more medical mistakes and greater odds of dying in care.”

Intensive Care Units (ICUs).

“Prospective evaluation of medication-related clinical decision support over-rides in the intensive care unit,” Brigham and Women’s Hospital Outcomes Research and Pharmacy Informatics Fellow Adrian Wong et al., 2018.

- Clinical decision support (CDS) alerts in electronic medical records serve to “remind clinicians about everything from a patient’s drug allergies, to possible drug
interactions, to dosing guidelines, to lab testing guidance. Clinicians can either follow the alerts’ recommendations or override or ignore them."

- Researchers studying medication-related CDS alert over-rides among adults admitted to Brigham and Women’s ICUs between July 2016 and April 2017 found that nearly 20 percent of over-rides were inappropriate. Moreover, “inappropriate over-rides were six times as likely to be associated with potential and definite ADEs [adverse drug events], compared with appropriate over-rides.”

**Lower-Volume Hospitals.**

**Safety in Numbers: The Leapfrog Group’s Report on High-Risk Surgeries Performed at American Hospitals, Leapfrog Group, 2019.**

The Leapfrog Group examined 2018 survey responses from over 2,000 hospitals nationwide – looking specifically at “eight high-risk procedures to determine which hospitals and surgeons perform enough of them to minimize the risk of patient harm or death, and whether hospitals actively monitor to assure that each surgery is necessary” – and found “significant variation between urban and rural hospitals, with urban hospitals outperforming rural hospitals across all eight high-risk procedures. For five of the eight procedures, no rural hospitals are fully meeting Leapfrog’s volume standard.” Said Leapfrog president and CEO Leah Binder, “‘No hospital and no surgeon should do only one or two of these procedures a year ever. The evidence is abundant: that’s not safe for patients…’”


- “The analysis of four years of data from hospitals across the country indicates that 26 percent of deaths – more than 1 out of every 4 – that occur following surgery for the most severe heart defects could be prevented by having the operation performed at hospitals where surgical teams do the greatest numbers of procedures.”

- “In 4,000 of the most complex procedures performed, U.S. News found that 104 of 395 deaths could have been prevented if the patients – most of whom in such surgeries are children – had their operations in high-volume centers that treat 250 or more patients needing congenital heart surgery in a year. Nine hospitals studied, the data show, performed an average of just two or fewer of the riskiest and most challenging procedures per year.”


After analyzing Medicare data, the magazine found that “as many as 11,000 deaths nationally might have been prevented from 2010 through 2012 over the three years analyzed if patients who went to the lowest-volume fifth of the hospitals had gone to the
highest-volume fifth.” As *U.S. News & World Report* argued, large numbers of low-volume hospitals “continue to put patients at higher risk even after three decades of published research have demonstrated that patients are more likely to die or suffer complications when treated by doctors who only occasionally see similar patients rather than by experienced teams at hospitals with more patients and established protocols.”

**Multiple Step Medical Procedures.**

“All analysis of Physicians’ Probability Estimates of a Medical Outcome Based on a Sequence of Events,” Ohio State University Emeritus Psychology Professor and Berlin, Germany Harding Center for Risk Literacy Associate Hal R. Arkes, University of Utah Critical Care Pulmonologist Scott K. Aberegg and Travelers Insurance Forensic Specialist Kevin A. Arpin, 2022.

- “[P]hysicians tend to have unrealistic expectations of multiple step medical procedures,” where “inflated estimates of success could adversely influence treatment decisions and lead to unintended harm to patients.”

- The study “highlights a serious logical disconnect among physicians who fail to consider that each step in the process has its own risks that can diminish the chances of success for the desired medical outcome.”

**Neonatal Intensive Care Unit (NICU).**

“All risk of Wrong-Patient Orders Among Multiple vs Singleton Births in the Neonatal Intensive Care Units of 2 Integrated Health Care Systems,” Columbia University Assistant Professor of Medicine and New York Presbyterian/Columbia University Irving Medical Center Chief Patient Safety Officer Jason Adelman et al., 2019.

Researchers analyzed more than 1.5 million electronic orders placed for 10,819 infants in six NICUs within two NYC hospital systems and found that:

- “The risk of wrong-patient order errors was nearly doubled for [multiple-birth infants] compared with singletons.”

- “The risk grew with increasing number of siblings receiving care in the NICU: An error occurred in one in seven sets of twins and in one of three sets of triplets and quadruplets.”

- “The higher error rate was due to misidentification between siblings within sets of twins, triplets, or quadruplets.”
• “Our study suggests that the safeguards now commonly used to protect against medical errors in the NICU setting are not sufficient to prevent misidentification and medical errors among multiple-birth infants,” said the lead study author.

“Use of Temporary Names for Newborns and Associated Risks,” Montefiore Health System Patient Safety Officer and Hospital Medicine Assistant Professor Jason Adelman et al., 2015.

Researchers found that hospitals’ practice of assigning temporary, non-distinct first names such as Babyboy or Babygirl to newborns resulted in a high incidence of wrong-patient errors in the Neonatal Intensive Care Unit (NICU). According to the study, which was “designed to measure wrong-patient electronic orders, there are other types of misidentification errors in NICUs that may result from the use of non-distinct first names, such as reading imaging tests or pathology specimens for the wrong patient or administering blood products to the wrong patient. One particularly concerning wrong-patient error unique to NICUs and hospital nurseries is feeding a mother’s expressed breast milk to the wrong infant.”

Non-Teaching Hospitals.


Researchers analyzed 21 million hospitalizations of Medicare beneficiaries from 2012 through 2014 and found that “[o]lder adults treated at major teaching facilities are less likely to die in the weeks and months following their discharge than patients admitted to ‘non-teaching’ or community hospitals…” As the study’s lead author told Healthday, “‘[F]or every 84 patients treated at a major teaching hospital that otherwise would have gone to a non-teaching hospital, one fewer patient dies,’” or put another way, “If death rates at non-teaching hospitals were similar to major teaching facilities, there would be roughly 58,000 fewer deaths per year among these patients….”

Nursing Homes/Long-Term Care Facilities/Skilled Nursing Units.

See also, PART 8: THE IMPACT OF COVID


• “Our analysis of CMS data shows that seven of the eight key indicators of nursing home resident mental and physical health that we reviewed worsened at least slightly in 2020, the first year of the pandemic, compared to the years prior to the pandemic. Six of these key indicators continued to be worse in the second year of the pandemic than in the years prior to the pandemic.”
• “According to most of the state survey agency officials we interviewed and our review of IPC deficiency narratives written by state surveyors, nursing homes received IPC deficiencies during the pandemic for failing to follow basic IPC practices, such as proper handwashing and personal protective equipment usage, but some state survey officials noted that nursing homes also received IPC deficiencies for failing to follow COVID-19-specific practices such as failing to quarantine and isolate COVID-19 positive residents.”

The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff, National Academies of Science, Engineering and Medicine, 2022.

• “Nearly 1.3 million Americans reside in more than 15,000 certified nursing homes in the United States.”

• “The COVID-19 pandemic ‘lifted the veil,’ revealing and amplifying long-existing shortcomings in nursing home care such as inadequate staffing levels, poor infection control, failures in oversight and regulation, and deficiencies that result in actual patient harm. …The pandemic’s enormous toll on nursing home residents and staff drew renewed attention to the long-standing weaknesses that continue to impede the provision of high-quality nursing home care.”


“In Arizona, a nursing home resident was sexually assaulted in the dining room. In Minnesota, a woman caught Covid-19 after workers moved a coughing resident into her room. And in Texas, a woman with dementia was found in her nursing home’s parking lot, lying in a pool of blood.

“State inspectors determined that all three homes had endangered residents and violated federal regulations. Yet the federal government didn’t report the incidents to the public or factor them into its influential ratings system. The homes kept their glowing grades.

“A New York Times investigation found that at least 2,700 similarly dangerous incidents were also not factored into the rating system run by the federal Centers for Medicare and Medicaid Services, or C.M.S., which is designed to give people reliable information to evaluate the safety and quality of thousands of nursing homes.”

- Going to private equity-owned (PE) nursing homes “increases the short-term mortality of Medicare patients by 10%, implying 20,150 lives lost due to PE ownership over our twelve-year sample period. This is accompanied by declines in other measures of patient well-being, such as lower mobility, while taxpayer spending per patient episode increases by 11%. We observe operational changes that help to explain these effects, including declines in nursing staff and compliance with standards.”

- “We use the observed age and gender distribution of Medicare decedents to estimate the corresponding implied loss in life-years – 160,000. Using a conventional value of a life-year from the literature, this estimate implies a mortality cost of about $21 billion in 2016 dollars.”

**Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic, U.S. Government Accountability Office, 2020.**

GAO “reviewed [Centers for Medicare & Medicaid Services] guidance and analyzed data on nursing home deficiencies cited by surveyors in all 50 states and Washington, D.C., from 2013 through 2017 provided by CMS” and found the following:

- “[I]nfection prevention and control deficiencies were the most common type of deficiency cited in surveyed nursing homes, with most nursing homes having an infection prevention and control deficiency cited in one or more years from 2013 through 2017 (13,299 nursing homes, or 82 percent of all surveyed homes). Infection prevention and control deficiencies cited by surveyors can include situations where nursing home staff did not regularly use proper hand hygiene or failed to implement preventive measures during an infectious disease outbreak, such as isolating sick residents and using masks and other personal protective equipment to control the spread of infection.”

- “In each individual year from 2013 through 2017, the percent of surveyed nursing homes with an infection prevention and control deficiency ranged from 39 percent to 41 percent.”

- “[N]ursing homes owned by for-profit organizations, which comprised about 68 percent of all surveyed nursing homes, accounted for about 72 percent of nursing homes that had infection prevention and control deficiencies cited in multiple years, but nursing homes owned by for-profit organizations comprised only about 61 percent of nursing homes with no infection prevention and control deficiencies cited.”
“Falls prevention is everyone’s responsibility – from care team to C-suite, speaker says,” *McKnight’s Senior Living*, October 16, 2019.

A representative from medical malpractice insurer Constellation shared the following data with attendees at the American Health Care Association/National Center for Assisted Living’s 70th Annual Convention and Expo:

- “Falls continue to be a big issue in long-term care, accounting for 42% of medical malpractice claims recently examined by Constellation.”
- “Errors in clinical judgment were overwhelmingly associated with the claims, cited in 92% of them.”
- “Policies not being followed or not existing (47%) and communication breakdowns (36%) among staff members or between the staff and the resident/family members also were factors.”


“We identified 34,664 Medicare claims for our audit period that contained diagnosis codes indicating the treatment of injuries potentially caused by abuse or neglect of Medicare beneficiaries. We estimated 30,754 of these Medicare claims were supported by medical records that contained evidence of potential abuse or neglect. We further estimated that, of the claims in our population associated with incidents of potential abuse or neglect, 2,574 were allegedly perpetrated by a healthcare worker, 3,330 were related to incidents that occurred in a medical facility, and 9,294 were related to incidents that were not reported to law enforcement.”

“Association Between High Discharge Rates of Vulnerable Patients and Skilled Nursing Facility Copayments,” University of Pennsylvania General Internal Medicine Assistant Professor Paula Chatterjee et al., 2019.

As reported by *Reuters*,

- “Skilled nursing facilities in the U.S. often discharge Medicare patients before daily co-payments kick in,” suggesting that “some patients may be sent home for financial reasons before they’re medically ready to leave.”
- “Overall, a total of 220,037 patients were discharged on day 20, more than the 131,558 sent home on day 19 and the 121,339 released on day 21. Compared to patients discharged on days 19 or 21, those sent home on day 21 were more likely to suffer from multiple chronic medical conditions, live in poor neighborhoods, and be racial or ethnic minorities, the study found.”

• “Year after year, nursing homes around the country have failed to prevent bedsores and other infections that can lead to sepsis…. [A] federal report has found that care related to sepsis was the most common reason given for transfers of nursing home residents to hospitals and noted that such cases ended in death ‘much more often’ than hospitalizations for other conditions.”

• “Poor infection control ranks among the most common citations in nursing homes. Since 2015, inspectors have cited 72 percent of homes nationally for not having or following an infection-control program.”

• “A special analysis conducted for KHN by Definitive Healthcare, a private health care data firm, also suggests that the toll – human and financial – from such cases is huge. Examining data related to nursing home residents who were transferred to hospitals and later died, the firm found that 25,000 a year suffered from sepsis, among other conditions.”

• Inspectors have “cited 37 percent of the nation’s nursing homes” for “risks of pressure sores or failure to treat them properly…."

• Kaiser Health News “identified more than 8,000 suits filed nationwide from January 2010 to March [2018] that allege injuries from failing to prevent or treat pressure sores and other serious infections.”

“Off-Service” Placement.

“Capacity Pooling in Hospitals: The Hidden Consequences of Off-Service Placement,” University of Pennsylvania Wharton School Assistant Professor of Operations, Information and Decisions Hummy Song et al., 2019.

• “[A]pproximately 1 in 5 patients is placed ‘off service,’ or in a hospital ward designated for a different specialty of care than what they require.”

• “Off-service patient placement leads to a hospital stay that is 23% longer and a higher chance of having to be readmitted within 30 days after initial discharge.”

• “In this study, off-service placements contribute to nearly 4,000 additional patient-days per year in the studied hospital. This makes hospitals more crowded and patients worse off.”
Plastic Surgery.

“Women seeking discount plastic surgery paid with their lives at clinics opened by felons,” USA TODAY, April 23, 2019.

- “One man pleaded guilty to bank fraud. One was convicted of grand theft in a real estate scam. Two others admitted to elaborate Medicare schemes that siphoned millions from taxpayers. In Florida, one of the nation’s top destinations for plastic surgery, a felony conviction can bar someone from operating a massage parlor or a pawn shop. But not from running a cosmetic surgery clinic.”

- “Nearly a dozen miles from the iconic beaches of South Florida, the four convicted felons ran facilities that became assembly lines for patients from across the country seeking the latest body sculpting procedures at discount prices. And at those businesses, at least 13 women have died after surgeries. Nearly a dozen others were hospitalized with critical injuries, including punctured internal organs.”


A recent Doctors’ Company analysis of 1,438 claims against plastic surgeons closed from January 2007 through June 2015 found that “technical performance” (e.g., “performing a procedure on an incorrect body site, misidentifying an anatomical structure, and using poor technique”) contributed to patient harm in 42 percent of claims. Among the most common injuries suffered: emotional trauma (35 percent), scarring (23 percent), cosmetic injury (14 percent), infection (12 percent), burns (6 percent), ongoing pain (6 percent), tissue necrosis (4 percent), nerve damage (4 percent) and death (3 percent).

Rehabilitation Hospitals.


After reviewing a nationally representative sample of medical records of Medicare beneficiaries discharged from rehab hospitals in March 2012, OIG found the following:

- “An estimated 29 percent of Medicare beneficiaries experienced adverse or temporary harm events during their rehab hospital stays, resulting in temporary harm; prolonged stays or transfers to other hospitals; permanent harm; life-sustaining intervention; or death. This harm rate is in line with what we found in hospitals (27 percent) and in [skilled nursing facilities] (33 percent).”

- “Physician reviewers determined that 46 percent of these adverse and temporary harm events were clearly or likely preventable.”
• “Nearly one-quarter of the patients who experienced adverse or temporary harm events were transferred to an acute-care hospital for treatment, with an estimated cost to Medicare of at least $7.7 million in one month, or at least $92 million in one year, assuming a constant rate of hospitalization throughout the year.”

Resident Hand-Off.

“Increased Mortality Associated with Resident Handoff in a Multi-Center Cohort,” University of Colorado Pulmonary and Critical Care Fellow Joshua Denson et al., 2016.

• Researchers reviewed thousands of internal medicine patient discharges from ten Veterans Administration hospitals between 2008 and 2014 and found that the “risk of patient death significantly increases when medical residents leave their monthly clinical rotations and turn their patients’ care over to other residents….”

• More specifically, for patients experiencing a transition in care from an intern (a first-year medical resident), resident or both an intern and resident there was a 64-95 percent increase in in-hospital mortality, a 76-82 percent increase in 30-day mortality and a 72-84 percent increase in 90-day mortality.

• “Researchers also noted that the highest mortality risk occurred among handoffs to only an intern, which suggests that level of training is a contributing factor.”

Stress/Burnout/Depression.

“Associations of physician burnout with career engagement and quality of patient care: systematic review and meta-analysis,” National Institute for Health Research Greater Manchester Centre for Primary Care Senior Research Fellow Alexander Hodkinson et al., 2022.

After examining the results of 170 observational studies, 45 percent of which were conducted in the U.S., researchers found that physician burnout was “associated with double the risk of patient safety incidents,” “more than twofold decreases in professionalism” and “up to threefold decreases in patient satisfaction.” In addition, the association between burnout and patient safety incidents “was found to be larger in younger physicians” (e.g., ages 20-30) as well as those “working in emergency medicine and intensive care settings.”


“It’s no surprise healthcare workers are suffering from burnout, but according to a new report over the last three months, physicians are struggling the most: 1 in 7 (14%)
physicians admit to consuming alcohol or controlled substances at work. More than 1 in 5 (21%) say they consume alcohol or controlled substances multiple times per day. 17% say they consume alcohol or controlled substances at least once daily. These statistics are troublesome for healthcare workers, but they also highlight a dangerous threat to quality patient care.”333

“Association Between Physician Depressive Symptoms and Medical Errors,” University of Michigan Psychiatry Department Researcher Karina Pereira-Lima et al., 2019.

A study of multiple surveys revealed that “depressive symptoms were associated with nearly twice the rate of self-reported medical errors, like prescribing the wrong medication.”334

“Acute mental stress and surgical performance,” Columbia University Data Science Institute Master's Candidate Peter Dupont Grantcharov et al., 2019.

The study, published in the British Journal of Surgery, “reveals that during stressful moments in the operating room, surgeons make up to 66 percent more mistakes on patients. Using a technology that captured the electrical activity of a surgeon’s heart, researchers found that during intervals of short-term stress, which can be triggered by a negative thought or a loud noise in the operating room, surgeons are much more prone to make mistakes that can cause bleeding, torn tissue, or burns.”335


The Mayo Clinic-Rochester “longitudinal Internal Medicine Resident Well-Being (IMWELL) Study found that higher levels of burnout were associated with increased odds of reporting a major medical error in the subsequent 3 months. Self-perceived major medical errors were also associated with worsening burnout, depressive symptoms and decrease in quality of life, suggesting a bidirectional relationship between medical errors and distress. …Other studies have found that increased emotional exhaustion levels of physicians working in intensive care units are associated with higher standardized patient mortality ratios,” plus “[i]increased physician depersonalization levels have been shown to relate to longer recovery times for hospitalized patients postdischarge.”336

“Physician Burnout, Well-being, and Work Unit Safety Grades in Relationship to Reported Medical Errors,” Stanford University Medical School Pediatric Critical Care Instructor Daniel Tawfik et al., 2018.

A Stanford University Medical School survey of physicians in active practice across the United States revealed the following337:
• 55 percent of doctors reported symptoms of burnout, with over 10 percent also reporting that they’d made at least one major medical error during the three months prior to being surveyed.

• 78 percent of doctors reporting errors had symptoms of burnout.

• Physicians with burnout were more than twice as likely to make a medical error.

• “[H]ealth care facilities where doctor burnout was seen as a common problem saw their medical error risk rate triple, even if the overall workplace environment was otherwise thought to be very safe.”

• The most common medical errors made were errors in medical judgment, errors in diagnosis and technical mistakes during procedures.

• More than five percent of physician errors led to permanent health problems, while 4.5 percent resulted in a patient’s death.

• “An unsafe work environment was found to triple to quadruple the risk for committing a medical error.”

• “Physician burnout is at least equally responsible for medical errors as unsafe medical workplace conditions, if not more so….”

• “‘The key finding of this study…is that both individual physician burnout and work-unit safety grades are strongly associated with medical errors.’”

“Pediatric Resident Burnout and Attitudes Toward Patients,” Harvard Medical School Department of Medicine Physician Tamara Elizabeth Baer et al., 2017.

• “A large number of pediatricians in training may already be experiencing burnout, a recent U.S. study suggests, and those who do are more likely to make errors or take shortcuts during treatment.”

• “Burned out residents were seven times more likely to make treatment or medication errors that were not due to inexperience or lack of knowledge, compared with residents who were not burned out.”

• “Residents reporting burnout were 3.5 times more likely not to fully discuss treatment options or answer a patient’s questions and four times more likely to discharge a patient to make the service more manageable.”
Surgeon’s Birthday.

“Patient mortality after surgery on the surgeon’s birthday: observational study,” UCLA Assistant Professor of Medicine Yusuke Tsugawa, Harvard Medical School Associate Professor of Health Care Policy Anupam B. Jena and UCLA Postdoctoral Fellow Hirotaka Kato, 2020.

“30-day mortality rates are approximately 23% higher for patients 65 and older who are treated on a surgeon’s birthday.”

Work Shift Timing.

“Association of Primary Care Clinic Appointment Time with Clinician Ordering and Patient Completion of Breast and Colorectal Cancer Screening,” Perelman School of Medicine Assistant Professor and Penn Medicine Center for Innovation Director of Operations Shivan J. Mehta et al., 2019.

Researchers examined two years of data on patient visits from 33 primary care practice sites at the University of Pennsylvania Health System and found greater risks to patient health if doctors examined them toward the end of the morning and afternoon shifts. More specifically, “[D]octors ordered fewer breast and colon cancer screenings for patients later in the day, compared to first thing in the morning. All the patients were due for screening, but ordering rates were highest for patients with appointments around 8 a.m. By the end of the afternoon, the rates were 10 percent to 15 percent lower. The probable reasons? Running late and decision fatigue.”

HOSPITALS PROFIT BY PROVIDING UNSAFE MEDICAL CARE.

“Association of the Hospital Readmissions Reduction Program Implementation with Readmission and Mortality Outcomes in Heart Failure,” Brigham and Women’s Hospital and Vascular Center Cardiovascular Research Fellow Ankur Gupta et al., 2017.

- “Federal policymakers five years ago introduced the Hospital Readmission Reduction Program to spur hospitals to reduce Medicare readmission rates by penalizing them if they didn’t. A new analysis led by researchers at UCLA and Harvard University, however, finds that the program may be so focused on keeping some patients out of the hospital that related death rates are increasing.”

- “In a study of 115,245 fee-for-service Medicare beneficiaries at 416 hospitals, implementation of the reduction program was indeed linked to a decrease in readmissions at 30 days after discharge and at one year after discharge among people hospitalized for
heart failure. But it was also linked to an increase in mortality rates among these groups of patients.”

• “‘To avoid the penalties, hospitals now have incentives to keep patients out of hospitals longer, possibly even if previously some of these patients would have been readmitted earlier for clinical reasons,’ said first author Dr. Ankur Gupta, cardiovascular research fellow at the Brigham and Women's Hospital, Harvard Medical School. ‘Therefore, this policy of reducing readmissions is aimed at reducing utilization for hospitals rather than having a direct focus on improving quality of patient care and outcomes.’”


Researchers examined data from Florida and Texas to determine the connection between adverse patient safety events in hospitals and paid medical malpractice claim rates. Among their discoveries:

“We find large variation in [adverse event] rates, both across counties and across hospitals within counties. This suggests that many adverse hospital events are avoidable at reasonable cost, since some hospitals are avoiding them…. Why then don’t more hospitals devote more effort to this important task? Here we can only speculate, but in big picture, hospital financial incentives for increasing patient safety, including those incentives provided by malpractice liability, are weak.”

“Medicare Payment Policy Creates Incentives for Long-Term Care Hospitals to Time Discharges for Maximum Reimbursement,” UCLA School of Public Health Health Policy and Management Department Chair and Professor Jack Needleman et al., 2015.

Long-term-care hospitals, which specialize in treating people with serious conditions who require prolonged care, “discharge a disproportionately large share of Medicare patients during a window when they stand to make the most money from reimbursements under the federal program,” not because of patients’ needs or their best interests. Based on this money-making discharge approach, “Medicare had spent $164 million in excess reimbursements on the ventilator patients over the five-year period,” for example.


• After analyzing Medicare claims paid from 2008 to 2013, the WSJ found that “long-term hospitals discharged 25% of patients during the three days after crossing thresholds for
higher, lump-sum payments. That is five times as many patients as were released the three days before the thresholds.”

- “Long-term-hospital executives sometimes pursued that goal for financial reasons rather than medical ones, say doctors, nurses and former long-term-hospital employees interviewed by the Journal.”

- “More than 400 long-term, acute-care hospitals in the U.S. received about $30 billion in Medicare payments from 2008 through 2013,” the WSJ reported.

- “The pattern of discharging patients at the most lucrative juncture is ‘troubling and disturbing,’ says Tom Finucane, a doctor and professor at Johns Hopkins University School of Medicine, after learning of the Journal’s findings. ‘The health-care system should serve the patients and try to improve their health, and any step away from that is a corruption.’ Dr. Finucane and other medical experts say longer-than-necessary hospital stays increase risks for medical errors, infection and unnecessary care. Discharges that come too early can mean patients don’t get care they need.”

THE SITUATION IS FAR WORSE BECAUSE MAJOR ERRORS GO UNREPORTED AND PATIENT SAFETY INFORMATION IS KEPT SECRET; LIABILITY LIMITS CAN RESULT IN SECRECY.


“The nation’s 1,375 federally qualified health centers, which treat 30 million low-income Americans, are mostly private organizations. Yet they receive $6 billion annually in federal grants, and under federal law their legal liabilities are covered by the government, just as those of the U.S. Department of Veterans Affairs and the Indian Health Service are. That means the centers and their employees can receive immunity from medical malpractice lawsuits and the federal government pays any settlements or court judgments.

“As a result, the public is often unaware of malpractice allegations against those centers. The health centers and their employees are not named as defendants in the lawsuits, and the government does not announce when it pays to settle cases or court judgments.”

“Discipline for addicted physicians who relapse is often lenient, secretive,” InvestigateTV, November 28, 2022.

An analysis of records from every state medical board across the country revealed:

- “A secretive treatment and oversight process for physicians struggling with substance abuse that critics say protects doctor reputations while leaving patients in the dark.”
• “Time lags in informing medical boards and the public about significant issues involving addicted doctors.”

• “Lenient, delayed punishments for physicians who have put people at risk while battling their own addictions.”


• “*InvestigateTV* and the Arnolt Center for Investigative Journalism at Indiana University contacted all medical boards across the country, asking how many licensed physicians each had referred to the state’s Physician Health Program [PHP] since January 1, 2020.” Only 20 states provided information. “At least 1,000 physicians from those states have been referred to PHPs by their medical boards since the start of 2020. Those referred included doctors whose discipline records show have been charged with DUI on the way to work, some who tested positive for drugs, one found slurring and stumbling on the job, and another who admitted to drinking daily while working with patients.”

• “[T]he identities of physicians are ‘zealously’ protected in these confidential programs across the country, *InvestigateTV* found. Websites for programs in several states indicate written permission would be needed from the doctors being treated to release any information, even if the organization was subpoenaed. Those restrictions on the release of information remain even when doctors are being routinely drug screened and monitored, and actively practicing with a list of conditions following treatment. As many of the program websites show, the PHPs often have no obligation to report doctors and won’t always notify the medical board when doctors don’t follow the rules. The only firm and universal exception *InvestigateTV* found is when a physician poses an immediate threat to safety or specific patient harm.”

• “‘Why wait until someone has been harmed? The imminent danger almost always means someone’s been harmed, damaged, or killed in some cases because you didn’t catch them earlier on,’” Dr. Sidney Wolfe, founder of Public Citizen’s Health Research Group, told *InvestigateTV*. “‘Why are the rehab organizations not automatically notifying the medical board? That’s because the state medical associations don’t like the idea.’ State medical associations or state medical societies, as Dr. Wolfe points out, are physician-funded lobbying organizations that play a powerful role in shaping the policies that determine how physicians are licensed, monitored, and policed. *InvestigateTV* discovered those groups run or have strong ties to at least 17 of the PHPs across the nation, something Dr. Wolfe finds problematic.”

“Fear of punishment makes healthcare professionals reluctant to report errors. While they fear for patients’ safety, they also dread disciplinary action, including the fear of losing their jobs if they report an incident. Unfortunately, failing to report contributes to the likelihood of serious patient harm. Many healthcare institutions have rigid policies in place that also create an adversarial environment. This can cause staff to hesitate to report an error, minimize the problem, or even fail to document the issue. These actions or lack thereof can contribute to an evolving cycle of medical errors.”


- “The American Medical Association initially estimated the database would receive 10,000 annual clinical privilege reports from hospitals per year. But since it opened in 1990, the highest number of reports on medical physician privileges revoked or investigated was in 1991, with 889 reports. In 2021, there were 592 reports. The vast majority of the 1.1 million adverse action reports in the data bank relate to nurse licensure action reports.”

- “‘There’s sort of this conspiracy of silence in which everything goes along pell-mell, merrily business as usual,’ said Dr. Vikas Saini, president of the Lown Institute, which publishes research on unnecessary procedures. ‘Hospitals have no incentive to say, ‘are you sure everything we’re doing is needed?’ Hospitals are in the business of collecting revenue, and so it’s not that they’re deliberately engaging in ripping off communities, it’s that they have no incentive to try to be better, and they have plenty of disincentives.’”

“After ‘Dr. Death,’ disciplinary records still a secret, despite state law,” KXAN, March 16, 2022.

- “The NPDB is a confidential clearinghouse containing things a patient would want to know in order to make informed treatment decisions – such as whether a surgeon is banned from operating at a hospital and any medical malpractice settlements or disciplinary records.”

- “Digging through thousands of physician disciplinary records from more than a dozen states, a KXAN investigation found nearly 50 doctors who have been disciplined or had their medical licenses suspended or revoked in other states who are still practicing in Texas, or able to, with ‘clean’ records. More than a dozen of them were issued Texas medical licenses after facing disciplinary actions elsewhere.”

- “No medical or osteopathic board website in the country included one piece of critical information for the public: the number and type of complaints received about a doctor. It is noteworthy when a member of the public or a fellow health professional takes the time and effort to file a complaint about a physician.”356

- “Only 14 (22%) of the state medical board Profiles we reviewed included a plain English summary of this information.”357

- “Eighteen (28%) of the Profiles on medical board websites provided information about actions taken in other states against a doctor, while most states did not. …This is particularly important as a recent report by the [Federation of State Medical Boards] noted that almost a quarter (23%) of physicians hold two or more active licenses.”358

- “Only about a third (36%) of Physician Profiles had any information about malpractice settlements or judgments. Those that did varied in the degree to which they provided complete information. For the states that included some type of information about medical malpractice settlements or judgments, few provided detailed information:
  
  o Seven state medical boards (11%) provided all medical malpractice payouts/settlements.
  
  o Four (6%) provided the exact amounts of the malpractice payouts/settlements

  …. Several states had long disclaimers for users seemingly designed to discourage or limit the impact of the malpractice information by suggesting the information was not connected to quality of care.”359

- “‘Would you want to know if your doctor has been disciplined and why? Whether they had malpractice settlements? Whether they could no longer practice at a hospital because of some safety concern by the hospital? Or, whether they had a criminal record?’ asked [Patient Safety Action Network] Board Chair Lisa McGiffert. ‘The reality is that most states only provide a sliver of this pertinent information that may tell a doctor’s history of harming or putting patients at risk.’”360

“Assessing the Quality of Public Reporting of US Physician Performance,” University of Michigan School of Public Health Ph.D. Candidate Jun Li et al., 2019.

There is an egregious lack of information regarding the safety records of individual doctors providing care to Medicare enrollees. Researchers came to this conclusion after looking at the scarce amount of data on 1 million U.S. doctors made available online by the U.S.
Centers for Medicare and Medicaid Services. Among the study’s more troubling discoveries:

- Three quarters of clinicians have no information about their quality of care.
- 99 percent of those in the online system have no data tied to their individual job performance, “making it hard for patients to know who might be a better or worse choice among several physicians at one clinic.”
- “Doctors who did share individual level outcomes tended to have very high quality scores, suggesting that physicians may only opt into the voluntary reporting system when they know the results will make them look good…”
- “Clinicians also aren’t required to report data on outcomes for every patient, and they may choose only to submit information for cases that turned out well…”


- “Hospitals often won’t say whether they follow key safety practices. Many maternity hospitals refused to answer basic questions about whether or not they are following specific safety protocols…. [W]hen USA TODAY repeatedly contacted 75 hospitals in 13 states, half would not disclose whether they are doing [basic safety] things.”
- “Safety data about maternity care is kept secret. Even though pregnancy and childbirth is the No. 2 reason for hospitalization in this country, the federal government doesn’t require hospitals to tell the public how often mothers die or suffer from childbirth complications. … USA TODAY’s investigation for the first time published rates of severe childbirth complications at hundreds of hospitals. It’s a number that many hospitals and experts use privately – but don’t think should be shared publicly.”
- “Many states fail to track and study moms’ deaths. USA TODAY further revealed that state maternal death review committees across the country often avoid scrutinizing medical care that occurred in the days and hours before mothers’ deaths – instead focusing on women’s lifestyle choices or larger societal problems, like obesity, smoking and seatbelt use. Some states didn’t study mothers’ deaths at all.”


- Hospitals infrequently report information to the National Practitioner Data Bank (NPDB) and use a tactics like the “corporate shield” to avoid reporting. “One study found that more than two-thirds of the hospitals examined reported no adverse events to the NPDB
over a 5-year span. Another estimated that 75% of ‘potentially reportable actions’ and 60% of ‘unquestionably reportable actions’ went unreported.”

- “Providers’ use of the so-called ‘corporate shield’ impairs the NPDB’s completeness too. The shield is employed when ‘the medical corporation for which the doctor works is named in the suit, and the doctor is either not originally named or is released specifically for the purpose of avoiding a report to the NPDB.’ Although the extent to which this tactic reduces the number of payments that are reportable to the NPDB is not known, some authors believe that one-half of otherwise reportable adverse events are deflected by this means.”

- “The University of Michigan Health System avowedly uses the corporate shield, and its settlements are generally in the institution’s name. … [H]ence under this approach ‘reporting of individual caregivers in medical malpractice claims in the National Practitioner Data Bank is rare. However, full claims histories are maintained and reported for each involved caregiver, as required.’ … Even though it rarely reports medical malpractice payments, it still actively reports adverse actions on a provider’s privileges or credentials to the NPDB.”


- “An exclusive WEWS-TV investigation reveals the culture of secrecy surrounding medical malpractice. Investigators found hospitals carefully track medical mistakes but often keep detailed information about errors hidden from patients and the public.”

- “‘People who are injured as a result of medical malpractice are almost never told that has happened by their doctors or by hospitals where it’s happened,’ said Maxwell Mehlman, the Director of the Law-Medicine Center at Case Western Reserve University.”

- The news investigation also discovered “how difficult it can be for patients to find out the truth about medical mistakes.”

🌟 LITIGATION, SETTLEMENTS AND INSURANCE PLAY CRITICAL SAFETY ROLES WHILE “TORT REFORM” LAWS HARM PATIENT SAFETY.

“The California Malpractice Cap on Noneconomic Losses: Unintended Consequences and Arguments for Reform,” UCLA Fielding School of Public Health Professor and Health Policy and Management Department Chair Jack Needleman, 2022.

- California’s $250,000 noneconomic losses cap, “by lowering the risk of suit for malpractice, also weakens the deterrent effect of risk of suit on physician efforts to avoid malpractice. The best available research suggests imposing caps is associated with a 16% increase in adverse events. … The estimated additional costs due to loss of
deterrence are a significant offset to the potential costs of higher and more frequent
claims were the cap to be eliminated or raised to reflect inflation.”365

• “The key argument for a cap on malpractice awards is that the caps lower malpractice
risk and premiums. The lower premiums and lower risk reduce practice costs, reduce the
incentive for defensive medicine such as unneeded diagnostic testing (which increases
overall health care costs), and reduce the incentive for physicians to leave practice. But
imposing a cap on awards also reduces the incentive to avoid malpractice. If the incentive
to reduce malpractice is weakened, and malpractice rates increase, this raises the potential
costs to patients and insurers as well as increasing potential noneconomic losses for
patients.”366

• “[I]t is likely that repeal of a cap on noneconomic damages would increase attention to
patient safety and lead to reduction of adverse patient events. These changes would be
associated with cost savings to payers and patients, and reduced economic and
noneconomic damages that improve the life and health of patients.”367

• In 2018, over a quarter of a million Medi-Cal patients experienced a “never event” (i.e., a
serious incident that is wholly preventable or avoidable, such as an object left in a patient
after surgery, a mismatched blood transfusion or hospital-acquired pressure ulcer), with
the state spending “approximately $1.5 billion on these cases. Many of these costs could
be avoided if California’s malpractice cap was lifted or substantially raised. A 16%
reduction in adverse events could mean savings to the state as much as $245 million
annually,” according to the study.368

_Lifesavers, Center for Justice & Democracy, 2021._

Numerous other medical practices have been made safer only after the families of sick and
injured patients filed lawsuits against those responsible. In addition to anesthesia procedures,
these include catheter placements, drug prescriptions, hospital staffing levels, infection
control, nursing home care and trauma care. As a result of such lawsuits, the lives of
countless other patients have been saved.369

“_The Deterrent Effect of Tort Law: Evidence from Medical Malpractice Reform,”_
_Northwestern University Law School and Kellogg School of Management Professor
Bernard S. Black and Bates White Competition and Antitrust Consultant Zenon
Zabinski, 2019._

• “We examine whether caps on non-economic damages in medical malpractice cases
affect in-hospital patient safety. We use Patient Safety Indicators (PSIs) – measures of
adverse events – as proxies for safety. In difference-in-differences (DiD) analyses of five
states that adopt caps during 2003-2005, we find that patient safety gradually worsens
after cap adoption, relative to control states.”
• “We find a broad increase in adverse patient safety events following damage cap adoption, across both most individual PSIs and across composite measures that combine related PSIs, both for individual states and pooled across states. In Texas, for example, PSI rates are generally stable or declining, relative to control states prior to reform. After reform, most PSI rates rise: 18 of the 21 measures have positive DiD coefficients; nine of these increases are statistically significant, while none of the three declines are statistically significant. This is consistent with hospitals reducing investments in patient safety. Across states and PSIs, we find a mean increase of about 15% in adverse events after reform.”

• “We find evidence that state adoption of caps on non-econ damages in medical malpractice lawsuits predicts higher rates of preventable adverse patient safety events in hospitals. To the best of our knowledge, our study is the first, either for medical malpractice or indeed, in any area of personal injury liability, to find strong evidence consistent with classic tort law deterrence theory: Liability for harm induces greater care and relaxing liability leads to less care. The drop in care quality occurs gradually over a number of years following adoption of damage caps.”

• “We find a gradual rise in rates for most PSIs after reform, consistent with a gradual relaxation of care, or failure to reinforce care standards over time. The decline is widespread, and applies both to aspects of care that are relatively likely to lead to a malpractice suit (e.g., PSI-5; foreign body left in during surgery), and aspects that are unlikely to do so (e.g., PSI-7; central-line associated bloodstream infection). The broad relaxation of care suggests that med mal liability provides “general deterrence” – an incentive to be careful in general – in addition to any “specific deterrence” it may provide for particular actions.”

• “[O]ur results lend additional support for the conclusion that standards of care affect the behavior of healthcare provider. Higher standards can lead to higher healthcare quality; reduced liability pressure can lead to lower quality. … Our results suggest that one should be cautious about relaxing tort liability without providing a substitute source of incentives.”


• “[M]edical liability insurers exist, and therefore do everything that they do, only because injured patients have the right to legal recourse. Moreover, we know what we know about the landscape of adverse medical events largely because of medical malpractice claims. This is obviously the case for the many important studies that use insurance company closed claim files as the data source. However, people often forget that the most important, large-scale, hospital-based studies of adverse medical events had their origins in efforts by the medical profession to prove there was a better way to address patient injuries than tort litigation. While the studies failed to achieve that goal, they did achieve
something important: documenting that serious adverse medical events are a major public health problem.”

- “[I]nsurers protect patients by providing compensation that helps insurers deal with the consequences of medical mistakes…. [I]t would be a mistake to view policy limits only as caps on injured patients’ recoveries because the existence of insurance coverage is what enables patients to obtain compensation. Insurers are the bankers for the tort system. Without them, the liability system as we know it could not function.”


- “Doctors are learning valuable new lessons from past malpractice cases about mistakes that could put their patients at risk and expose them to lawsuits.”

- “Malpractice insurers and medical specialty groups are mining thousands of closed claims from suits that have been tried, dismissed or settled over the past few years. Their goal is to identify common reasons that doctors are sued and the underlying issues that threaten patient safety. They are sharing those insights with doctors and hospitals, which in turn are using them to develop new safety protocols and prevention strategies.”

“Uncovering the Silent Victims of the American Medical Liability System,” Emory University Associate Law Professor Joanna Shepherd, 2014.

- “Damage caps and other tort reforms that artificially reduce plaintiffs’ damage awards also reduce contingent fee attorneys’ expected recoveries. As a result, even fewer cases make economic sense for the attorneys to accept. … Victims who cannot attain legal representation are effectively excluded from the civil justice system. Because of the complexity and expense of medical malpractice lawsuits, employing a lawyer is critical to a successful claim. Thus, without legal representation, most of these victims will not be compensated for the harm they suffer as a result of medical negligence. In turn, the medical liability system will fail to provide adequate precautionary incentives for healthcare providers.”

- “Empirical evidence suggests that the lack of victim compensation has, in turn, reduced the liability system’s deterrent effect by blunting incentives for the medical community to improve care; most studies find that malpractice liability does not influence physician behavior.”


After conducting in-depth interviews and a nationwide survey of those responsible for risk management, claims management and quality improvement in hospitals around the country, Acting UCLA Law Professor Joanna C. Schwartz found that malpractice lawsuits enhance
patient safety. As Schwartz explained in an August 2012 study, “malpractice lawsuits are playing an unexpected role in patient safety efforts: as a source of relevant information about medical error. The vast majority of interviewees and survey participants report that their hospitals review legal claims, the information developed during the course of discovery, and closed claims for patient safety lessons.” Moreover, “litigation data has proven useful to hospital patient safety efforts. Lawsuits reveal allegations of medical negligence and other patient safety issues about which hospital were previously unaware; depositions and discovery materials surface previously unknown details of adverse events; analyses of claim trends reveal problem procedures and departments; and closed claims files serve as rich teaching tools.”

“FEAR OF LITIGATION” IS NOT THE MAIN REASON DOCTORS FAIL TO REPORT ERRORS.


A January 2012 report from the U.S. Department of Health and Human Services (HHS) found that massive error underreporting at hospitals is caused by widespread employee failure to recognize patient harm. According to the HHS Inspector General, “[T]he problem is that hospital employees do not recognize ‘what constitutes patient harm’ or do not realize that particular events harmed patients and should be reported. In some cases, he said, employees assumed someone else would report the episode, or they thought it was so common that it did not need to be reported, or ‘suspected that the events were isolated incidents unlikely to recur.’”
PART 6: SPECIAL PROBLEMS FOR VETERANS, ACTIVE-DUTY Servicemembers AND MILITARY FAMILIES

The Department of Veterans Affairs’ Veterans Health Administration operates one of the largest health-care systems in the nation, serving over 9 million veterans annually.376


- “The Department of Veterans Affairs (VA) is the only federal entity that oversees all 153 state veterans homes, which provide nursing home care to roughly 14,500 veterans. … Our analysis of VA’s annual inspection data for 2019 and 2021 found increases in both the number of deficiencies and the number of deficiencies that were classified as causing actual harm, including immediate jeopardy.”

- “Specifically, we found that the number of deficiencies increased from 424 in 2019 to 766 in 2021. Similarly, the average number of deficiencies cited per inspection increased from 2.8 in 2019 to 6.2 in 2021. Further, 36 state veterans homes had no deficiencies in 2019; in 2021 all homes had at least one deficiency that caused no actual harm but had the potential for more than minimal harm.”

- “[W]e found that deficiencies that caused actual harm or immediate jeopardy — the most severe ratings – increased as a share of total deficiencies from 8 percent in 2019 to 20 percent in 2021. Further, the percent of state veterans homes with at least one deficiency that caused actual harm increased from 9 percent in 2019 to 63 percent in 2021. About 79 percent of all deficiencies in 2021 with a severity rating of actual harm resulted from non-compliance with standards associated with preventing accidents; preventing and treating pressure sores (i.e., bedsores); and providing the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.”377


- “The Defense Health Agency [DHA] is responsible for ensuring the quality and safety of health care delivered by individual providers at its military medical treatment facilities. However, GAO found that four selected facilities and the Defense Health Agency did not always adhere to the agency’s clinical quality management procedures in part because they were unclear.”

- “GAO reviewed documentation for 100 providers from four selected facilities and found that the facilities did not always adhere to the Defense Health Agency’s procedures for
credentialing and privileging,” which “are intended to help ensure that providers are qualified and competent. Specifically, the four selected [military medical treatment facilities] MTFs did not always verify all medical licenses, conduct providers’ performance assessments, or query national databases before granting providers privileges, in accordance with requirements in the DHA procedures manual.” For example, “for about one-sixth of providers reviewed, the facilities did not verify all medical licenses before granting privileges. Additionally, for almost half of the providers reviewed, the facilities did not obtain clinical references from appropriate individuals such as the program director, as required.”

**Veterans Community Care Program: VA Should Improve Its Ability to Identify Ineligible Health Care Providers, U.S. Government Accountability Office, 2022.**

- “GAO found vulnerabilities in the controls used by the Veterans Health Administration (VHA) and its contractors to identify health care providers who are not eligible to participate in the Veterans Community Care Program (VCCP), resulting in the inclusion of potentially ineligible providers.”

- “Of over 800,000 providers assessed, GAO identified approximately 1,600 VCCP providers who were ineligible to work with the federal government, were reported as deceased, or had revoked or suspended medical licenses. For example, GAO identified a provider eligible for referrals in the VHA system but whose medical license had been revoked in 2019. Licensing documents stated that the provider posed a clear and immediate danger to public health and safety.”

**“The Feres Doctrine: The Fight to End a Systemic Miscarriage of Military Justice,” Vanity Fair, November 10, 2022.**

- In December 2019, the SFC Richard Stayskal Military Medical Accountability Act of 2019 became law, which allows active-duty military members to file claims for medical malpractice caused by military or civilian doctors in military hospitals and clinics. “According to information the DOD Office of General Counsel included in a presentation this past February, as of December 31, 2021, the total number of Stayskal Act claims filed in the Air Force was 105; in the Navy, 101; in the Army, 149. Only two settlement offers had been accepted by claimants. Both of those were Air Force: one for $20,000 and another for $10,000. …[N]o claims had yet been paid. Under the Stayskal Act, non-economic (pain and suffering) compensation is capped at $600,000.”

- “The compensation cap is just one of the things that Stayskal doesn’t love about the act that bears his name. He is proud of the work he did to get it passed, but he will be the first to tell you this new process is not nearly the justice active-duty service members deserve. That, he said, will only happen when the Feres doctrine is abolished. What troubles Stayskal and victims like him and their families most is that without the ability to sue, there is no discovery process to compel the DOD or the government to produce documents or information; and without that, there can be no accountability; and without accountability, there can be no justice.”
“Military Approving 2% of Medical Malpractice Claims Filed by Service Members,” Military.com, October 26, 2022.

- “U.S. service members are seeing little success in making claims for medical malpractice against military hospitals and physicians under a law passed in 2020 that allowed them to file compensation claims. Data provided by the services to Military.com shows that troops have filed 448 claims with the Departments of the Army, Navy and Air Force seeking more than $4 billion in damages. But of those, just 11 have been settled, an approval rate of 2%, while more than one-quarter have been denied.”

- “According to data from the services, the Navy has received 146 claims from sailors, Marines or their families, seeking $1.1 billion in compensation. The Navy has denied 58 claims and settled one, for $250,000.” The Army “said it had 184 claims alleging damages up to $1.65 billion. It has approved six and denied 36, while another 73 cases received an initial denial and are in the appeals process. The remaining 69 are under investigation. … The Air Force has received 118 claims worth up to $1.3 billion. The service has settled four cases and denied 23 without the chance of an appeal. Six additional cases were appealed to the Defense Health Agency, which denied five and is still considering one remaining case. The Air Force did not answer questions about how much it had paid out to date.”


GAO reviewed data from July 1, 2016 to September 2020 and found that the Department of Veterans Affairs (VA) had been endangering veterans by exposing them to treatment from 363 providers “who lost a license for violating medical license requirements in any state or who VA removed from employment for quality of care concerns or [were] otherwise suspended from VA employment.” According to GAO, there is “a continued risk” to patients since the VA “stated that it has no plans” to review 227 of the providers GAO identified as problematic.


“GAO analyzed VA data on deficiencies cited in [VA-owned and -operated community living centers] CLCs from fiscal years 2015 through 2019” and determined that:

- “[I]nfection prevention and control deficiencies were the most common type of deficiency cited in inspected CLCs, with 95 percent (128 of the 135 CLCs inspected) having an infection prevention and control deficiency cited in 1 or more years from fiscal year 2015 through 2019.”
• “The percentage of inspected CLCs with an infection prevention and control deficiency cited each fiscal year ranged from 46 percent to 70 percent. Deficiencies related to infection prevention and control included situations where CLC staff did not regularly use proper hand hygiene or wear personal protective equipment – such as gowns and gloves – to prevent the spread of infection or failed to clean reusable medical items.”

• “[O]ver the time period of its review, a significant number of inspected CLCs – 62 percent – had infection prevention and control deficiencies cited in consecutive fiscal years, which may indicate persistent problems. An additional 19 percent had such deficiencies cited in multiple, nonconsecutive years.”

• “Furthermore, 40 of the 135 CLCs (30 percent) had these deficiencies cited in at least 3 consecutive fiscal years, 13 of these 40 CLCs (10 percent of the 135 inspected) had these deficiencies cited in at least 4 consecutive fiscal years, and five of these 40 CLCs (4 percent of the 135 inspected) had these deficiencies cited in all 5 fiscal years.”

**VA Needs to Continue to Strengthen Its Oversight of Quality of State Veterans Homes, U.S. Government Accountability Office, 2020.**

In fiscal year 2019, over 20,000 veterans received nursing home care from state veterans homes (SVH) that were permitted to operate with lax government oversight. More specifically, GAO discovered that:

• “VA does not require its SVH contractor to identify all failures to meet quality standards during its inspections as deficiencies.”

• “VA is not conducting all monitoring of its SVH contractor.”

• “VA does not share information on the quality of SVHs on its website.”


• VA medical centers “overlooked or were unaware” of National Practitioner Data Bank information that some providers’ licenses had been revoked or surrendered for cause. As a result, 57 providers, who should’ve been disqualified under VHA policy, were hired or retained by the VA.

• Despite being required to do so, five VA medical centers didn’t report eight of nine providers to the NPDB or any of the nine to state licensing boards. “These nine providers either had adverse privileging actions taken against them – actions that limit the care providers can deliver at a facility or prevent the providers from delivering care altogether
– or resigned or retired while under investigation before such an action could be taken.”

“How Veterans Affairs failed to stop a pathologist who misdiagnosed 3,000 cases,”

- Veterans Affairs’ “sprawling network of 167 hospitals and 1,000 clinics has long struggled to police problem doctors, audits and internal investigations show.”

- The Inspector General’s Office “in recent years has identified multiple VA physicians who continued to practice even after they were found to have compromised patient care. A report this year by the Government Accountability Office found weak systems for ensuring that problems are quickly addressed when a physician’s quality of care to veterans is compromised.”

_Veterans Health Administration: Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care, U.S Government Accountability Office, 2019._

After examining how allegations of VA employee misconduct are investigated and resolved, GAO learned the following:

- “Some veterans seeking care at the Veterans Health Administration have been seen by providers who should have been disqualified from working for the massive veterans health care system,” GAO discovered. More specifically, the government watchdog “found that VHA has hired ineligible medical staff because it missed disqualifying information in a national database, like when a provider has been disciplined by a licensing board, or because hiring staff didn’t know providers with valid licenses were ineligible if they surrendered a license or got one revoked in another state. In one case, VHA hired a nurse whose license was revoked for patient neglect, the report noted, although the nurse has since resigned.”

- In addition, “GAO found that some facility officials were not aware of VHA employment policies. Specifically, GAO found that officials in at least five facilities who were involved in verifying providers’ credentials and hiring them were unaware of the policy regarding hiring a provider whose license has been revoked or surrendered for professional misconduct or incompetence, or for providing substandard care. As a result, these five VHA facilities hired or retained some providers who were ineligible.”

- A yearlong review of 33,902 pathology results from a single doctor – who had twice worked while drunk and was ultimately fired – revealed 3,029 errors, including 30 missed diagnoses posing serious health risks to patients.389

- The data reflected “an error rate of 8.9% compared with a pathology practice average of 0.7%”; in other words, “an error rate more than 12 times the average, figures show.”390

- In 2018, VA investigators undertook an initial review of 14,000 of the pathologist’s 33,000 cases and uncovered 1,119 cases with medical errors. Eleven of those errors had resulted in serious harm, including three deaths.391


“Our review of [the VA’s Office of Accountability Review] Legacy Referral Tracking List identified 70 out of 1,245 closed cases involving officials where misconduct was either substantiated, or partially substantiated, but no disciplinary action was recommended. One case involved three allegations of poor dental care provided to patients by three different senior officials. One physician cut underneath a patient’s tongue with the bur of a hand-piece drill (substantiated), another administered medication the patient was allergic to (partially substantiated), and the final senior official extracted the wrong tooth (substantiated). We did not find any evidence in the PAID system that these senior officials received disciplinary action. Further, OAR did not provide documentation to show that any disciplinary action had been proposed or taken. The physician that cut underneath a patient’s tongue received performance pay totaling $15,000 approximately 6 days after the investigation had concluded that misconduct was substantiated. As of March 2018, two of these senior officials received performance pay, and appear to still be employed at VA.”392

*Comprehensive Healthcare Inspection Program Review of the Memphis VA Medical Center, Office of Inspector General, Department of Veterans Affairs, 2018.*

OIG review of the Memphis VA Medical Center found a multitude of avoidable medical errors from October 1, 2015 through September 30, 2017, among them395:

- “Sixteen surgical inpatients with serious treatable conditions died while receiving care at the Facility. In each of these cases, Facility review processes had determined that high-risk patients had known pre-existing, complex, and comorbid health conditions that had not been optimized prior to being selected and/or cleared for surgery. Facility leaders identified a serious breakdown in communication/consultation with all providers involved in the patients’ overall care….“
• “Two patients developed central venous catheter related bloodstream infections, and 19 patients developed postoperative sepsis. Facility leaders stated this was directly attributable to a deficient number of acute care nursing staff, inefficient nursing staff training, and a lack of infection control/prevention protocols and follow up.”

• “Nine patients developed pressure ulcers while being hospitalized at the Facility. Nursing leaders initially attributed this to a deficient level of nurse training and staffing in acute care.”

• “In addition, six patients sustained a perioperative hemorrhage or hematoma, two patients developed an acute injury post-operatively that required dialysis, five patients developed postoperative respiratory failure, 12 patients developed pulmonary embolism or deep vein thrombosis, and one patient had unrecognized abdominopelvic accidental puncture/laceration. All 26 patients had comorbid and complex health conditions prior to being cleared for surgery; and, again, Facility leadership attributed inefficient provider communication/consultation processes, lack of rigorous surgical case review/selection, and lack of surgical case decision protocols to these patient complications and poor outcomes.”

“Secret data: Most VA nursing homes have more residents with bed sores, pain, than private facilities,” Boston Globe/USA TODAY, June 25, 2018.

• “An analysis of internal documents shows residents at more than two-thirds of Department of Veterans Affairs nursing homes last year were more likely to have serious bedsores, as well as suffer serious pain, than their counterparts in private nursing homes across the country.”

• “The analysis suggests large numbers of veterans suffered potential neglect or medication mismanagement and provides a fuller picture of the state of care in the 133 VA nursing homes that serve 46,000 sick and infirm military veterans each year.”

• “More than 100 VA nursing homes scored worse than private nursing homes on a majority of key quality indicators, which include rates of infection and decline in daily living skills, according to the analysis of data withheld by the VA from public view but obtained by USA TODAY and The Boston Globe.”


VA nursing homes serve 46,000 veterans annually in 46 states, D.C. and Puerto Rico, operating with little public scrutiny of the substandard health care they provide patients. As discovered through a joint Boston Globe/USA TODAY investigation:

• The VA “has tracked detailed quality statistics on its nursing homes for years but has kept them from public view, depriving veterans of potentially crucial health care
information. Nearly half of VA nursing homes nationwide—60—received the agency’s lowest ranking of one out of five stars as of Dec. 31, 2017, according to documents obtained by USA Today and The Boston Globe.”

- “The worst-performing VA nursing homes in the ratings were scattered across 32 states, including Pennsylvania, which had five one-star facilities, as well as Texas and California, which had four each. The VA facility in Bedford and another in Brockton were the only one-star nursing homes out of six in New England.”

- “The VA quality tracking found that its nursing home residents were five times more likely to report being in pain than private nursing home residents” and six times more likely to have a “catheter left in their bladder, which can lead to urinary or blood infections and other complications.”

**Critical Deficiencies at the Washington DC VA Medical Center, Office of Inspector General, Department of Veterans Affairs, 2018.**

“Although the OIG did not identify patients who suffered death or other adverse clinical outcomes as a result of the identified problems, veterans were put at risk because important supplies and instruments were not consistently available in patient care areas.”\(^{396}\) In addition, the OIG found:

- “More than 300 patient safety events involved a reported problem with supplies, instruments, or equipment from January 1, 2014, through September 6, 2016, with more than 100 of these events not reported to the VHA National Center for Patient Safety as required by VHA policy; and

- The Patient Safety Manager failed to accurately and effectively track and trend patient safety events, resulting in the Medical Center missing opportunities to conduct Aggregated Reviews of supply, instrument, or equipment issues to identify and correct problems.”

**“Investigative Findings Related to the VA Medical Center Manchester,” U.S. Office of Special Counsel, January 25, 2018.**

Four whistleblowers disclosed that 100 out of approximately 170 patients treated in the VAMC Manchester Spinal Cord Unit “developed serious spinal cord disease as a result of clinical neglect at the VA”; that the former Chief of the Spinal Cord Unit “improperly copied and pasted patient chart notes for over 10 years”; and that the operating room “has repeatedly been infested with flies.”\(^{397}\)
“Illegal VA policy allows hiring since 2002 of medical workers with revoked licenses,”
USA TODAY, December 21, 2017.

• “The Department of Veterans Affairs has allowed its hospitals across the country to hire
health care providers with revoked medical licenses for at least 15 years in violation of
federal law, a USA TODAY investigation found.”

• Among the doctors allowed to treat veterans despite having a revoked license: a
neurosurgeon “who had revealed in his application that he had numerous malpractice
claims and settlements and Wyoming had revoked his license after a patient death. He
still had a license in Montana.”
PART 7: STATES THAT CAP DAMAGES

Caps on Medical Malpractice Compensatory Damages

- The following six states have total caps (i.e., caps encompassing economic and non-economic damages, although some exempt future medical care): Colorado, Indiana, Louisiana, Nebraska, New Mexico and Virginia.

- The following 23 states have non-economic damages caps: Alaska, California, Colorado, Hawaii, Iowa, Indiana, Massachusetts, Maryland, Michigan, Missouri, Mississippi, Montana, North Carolina, North Dakota, Nevada, Ohio, South Carolina, South Dakota, Tennessee, Texas, Utah, West Virginia and Wisconsin.

- Nine states had caps that were later found to be unconstitutional; legislatures haven’t repassed them. They are: Alabama, Florida, Georgia, Illinois, Kansas, New Hampshire, Oklahoma, Oregon and Washington.

PART 8: THE IMPACT OF COVID

❖ LITIGATION IS DOWN.


According to a survey of over 4,300 doctors across 29 specialties conducted from May 21 through August 28, 2021:

- “U.S. physicians saw a decline in malpractice lawsuits during the pandemic, likely the result of performing fewer procedures during lockdown…” More specifically, primary care physicians experienced a 10 percent decrease in lawsuits from 2019, while specialists saw a 6 percent decrease compared to 2019.

- Failure to diagnose and treatment complications were the leading reasons for lawsuits, similar to survey results in prior years.

- When asked whether they’d been sued for a COVID-related allegation, 100 percent of respondents said no.

❖ PATIENT SAFETY PROBLEMS MOUNT.

Diagnostic Errors.


The doctors identified diagnostic errors that they were seeing during the pandemic, including: “Missed or delayed COVID-19 diagnosis in a patient who presents with respiratory symptoms”; “Missed or delayed COVID-19 diagnosis in a patient who presents with nonrespiratory symptoms”; “Missed or delayed non–COVID-19 diagnosis because it was assumed to be COVID-19”; and “Missed or delayed non–COVID-19 or secondary diagnosis in a patient being treated with known COVID-19 disease.”

Healthcare-Associated Infections.


- “In 2021, the nation and the world continued to experience unprecedented challenges due to the COVID-19 pandemic, which impacted surveillance for and incidence of
Compared to pre-pandemic years, hospitals across the nation experienced higher than usual hospitalizations and shortages in healthcare personnel and equipment, which may have resulted in deterioration in multiple patient safety metrics since the beginning of the pandemic.

Nationally, among acute care hospitals, between 2020 and 2021

- There was a 7 percent increase in central line-associated bloodstream infections (CLABSIs), with the largest increase in ICUs (10 percent).
- There was a 5 percent increase in catheter-associated urinary tract infections (CAUTI) between 2020 and 2021, with the largest increase in ICUs (9 percent).
- There was a 12 percent increase in ventilator-associated events (VAE), with a 12 percent increase in ICUs and a 16 percent increase in non-ICUs.
- There was an 11 percent increase in abdominal hysterectomy surgical site infections (SSIs).
- There was a 14 percent increase in hospital onset MRSA bacteremia, one of the more severe forms of MRSA infection.

On the state level compared to itself from 2020 to 2021

- Only three states performed better on at least two infection types; no state performed better on at least three infection types.
- Nine states performed worse on two or more infection types. Of these, six performed worse on at least three infection types while three performed worse on at least four infection types.

State performance compared to 2021 national infection-specific standardized infection ratio (SIR)

- 30 states performed worse on two or more infection types. Of these, 13 performed worse on at least three infection types while four performed worse on at least four infection types.


Data from the National Healthcare Safety Network, the nation’s largest health care-associated infection surveillance system, revealed the following:
• “Compared with 2019, the study uncovered major increases in four HAIs in 2020 – [central line-associated bloodstream infections] CLABSIs, catheter-associated urinary tract infections (CAUTIs), ventilator-associated events (VAEs) and MRSA bacteremia. The largest increases occurred in CLABSIs, which were around 46% to 47% higher in the third and fourth quarters of 2020 compared with 2019.”

• “According to the study, there also were dramatic increases in the frequency and duration of ventilator use and rates of VAEs, which rose by around 45% in the fourth quarter of 2020 compared with 2019. The Society for Healthcare Epidemiology of America noted in a press release that the sharp increases in [standardized infection ratios] SIRs indicate that the increase in infections was not simply a reflection of more devices being used.”

• “CAUTIs increased by around 19% in the fourth quarter in 2020 compared with 2019, and MRSA rates were 22% to 34% higher in the third and fourth quarters than the previous year.”

Nursing Homes.


According to the most recent data, as of the week ending December 18, 2022, more than 1.42 million nursing home residents had contracted COVID-19 and over 161,000 residents had died from COVID-19.418


• “Our analysis of CMS data shows that seven of the eight key indicators of nursing home resident mental and physical health that we reviewed worsened at least slightly in 2020, the first year of the pandemic, compared to the years prior to the pandemic. Six of these key indicators continued to be worse in the second year of the pandemic than in the years prior to the pandemic.”

• “Our analysis of CMS data shows that the percentage of nursing homes cited for infection prevention and control deficiencies in 2020 and 2021 was generally consistent with the years prior. Specifically, about 44 percent of nursing homes were cited for at least one [infection prevention and control] IPC deficiency in 2020, which decreased to about 37 percent in 2021. Prior to the pandemic, in 2018 and 2019, about 43 percent of nursing homes were cited for at least one IPC deficiency. We also previously reported that, in each year from 2013 through 2017, the percent of all nursing homes inspected by state surveyors with an IPC deficiency ranged from 39 to 41 percent.”
“According to most of the state survey agency officials we interviewed and our review of IPC deficiency narratives written by state surveyors, nursing homes received IPC deficiencies during the pandemic for failing to follow basic IPC practices, such as proper handwashing and personal protective equipment usage, but some state survey officials noted that nursing homes also received IPC deficiencies for failing to follow COVID-19-specific practices such as failing to quarantine and isolate COVID-19 positive residents. … When examining the severity of the deficiencies cited, we found that in 2018 and 2019, only 1 percent of IPC deficiencies were classified at a high severity where the surveyor determined that residents were harmed or in immediate jeopardy of being harmed. However, during the pandemic in 2020 and 2021, this increased to about 8 and 4 percent, respectively.”

The National Imperative to Improve Nursing Home Quality: Honoring Our Commitment to Residents, Families, and Staff, National Academies of Science, Engineering and Medicine, 2022.

“The COVID-19 pandemic ‘lifted the veil,’ revealing and amplifying long-existing shortcomings in nursing home care such as inadequate staffing levels, poor infection control, failures in oversight and regulation, and deficiencies that result in actual patient harm. …The pandemic’s enormous toll on nursing home residents and staff drew renewed attention to the long-standing weaknesses that continue to impede the provision of high-quality nursing home care.”

Staffing/Doctor Shortages.


Forty-five percent of the over 1260 primary care clinicians surveyed “personally know clinicians who have retired early/quit; 29% know practices that have closed.” In addition, 21 percent of those surveyed are “unable to hire clinicians for open positions; 54% are unable to hire staff for open positions.”


A July 2020 survey found the following based on over 3,500 responses:

• “8 percent of physicians have closed their practices as a result of COVID-19,” which “would entail the potential loss of more than 16,000 medical practices.”

• “[F]our percent of physicians surveyed said they plan to close their practices within the next 12 months. This represents a potential 8,000 additional practice closures, a development that would further inhibit access to physicians.”
• The survey “suggests that 16 percent of the physician workforce, or approximately 134,000 physicians, may change their practice patterns in such a way as to at least temporarily disrupt continuity of patient care, by changing practices, by no longer treating patients or by working temporary (locum tenens) assignments.”

• “COVID-19 is likely to exacerbate physician shortages in the long-term. More primary care physicians will be needed to test for the virus, treat those who have it and coordinate the care of those whose health has been affected by it. Additional primary care physicians also will be needed to provide preventive and other care to the backlog of patients who skipped care during the pandemic. More specialists also will be needed, to treat the various body parts and systems negatively affected by COVID-19.”

• “43 percent of physicians have reduced staff due to COVID-19,” while 18 percent indicated that they planned to reduce staff between July 2020 and June 2021 as a result of COVID.

State Medical Board Inaction.


• “Only a handful of physicians have been disciplined for spreading COVID-19 misinformation since MedPage Today first reported on this issue [in August 2021] – and none of them were on our original list of the 20 most vocal physicians spreading COVID falsehoods.”

• “Just three additional physicians were sanctioned by their state medical boards for actions related to COVID-19 misinformation, even though the Federation of State Medical Boards (FSMB) has issued a stern warning that doctors’ licenses could be at risk if they deliberately misinform.”

• Some doctors “closely tied to COVID disinformation campaigns…remain free to continue to misinform their patients and the public, even as the Omicron variant surges.”

• “Some of the physicians on our list even renewed their license during the last 5 months.”

• “MedPage Today followed up with the 10 boards that licensed the 20 physicians named in the August story, but only five boards responded as of press time (California, Idaho, Illinois, North Carolina, and Ohio) and none had taken any action against these licensees.”


Radiology B

Caseload Overview


3 Thirty states plus Puerto Rico reported publishable data for total incoming tort and medical malpractice cases in 2021. Their rates were as follows: Alabama (1.98 percent), Alaska (2.32 percent), Arizona (3 percent), Arkansas (6.18 percent), Connecticut (1.57 percent), Delaware (2.59 percent), Florida (2.6 percent), Hawaii (3.02 percent), Iowa (5.6 percent), Kentucky (3.43 percent), Maine (8.02 percent), Maryland (2.82 percent), Massachusetts (5 percent), Michigan (3.09 percent), Minnesota (0.53 percent), Nebraska (7.22 percent), Nevada (2.01 percent), New Hampshire (5.43 percent), New Jersey (2.17 percent), New York (4.84 percent), North Carolina (2.6 percent), Oregon (2.23 percent), Pennsylvania (4.42 percent), Puerto Rico (9.29 percent), Rhode Island (1.38 percent), South Carolina (5.45 percent), Tennessee (3.62 percent), Texas (1.72 percent), Utah (6.42 percent), Vermont (3.91 percent) and Wisconsin (1.73 percent). National Center for State Courts, “CSP STAT Civil: Trial Court Caseload Overview, Data Table – Malpractice Medical, Incoming Cases,” https://www.courtstatistics.org/court-statistics/interactive-caseload-data-displays/csp-stat-nav-cards-first-row/csp-stat-civil (data as of July 8, 2022); National Center for State Courts, “CSP STAT Civil: Trial Court Caseload Overview, Data Table – Total Tort, Incoming Cases,” https://www.courtstatistics.org/court-statistics/interactive-caseload-data-displays/csp-stat-nav-cards-first-row/csp-stat-civil (data as of July 8, 2022).


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Doctors who

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courts; 2.4 percent in limited jurisdiction courts

https://www.courtstatistics.org/court
STAT Civil: Trial Court Caseload Overview, Data Table

percent), Vermont (0.7 percent), Michigan (0.4 percent) and Wisconsin (9 percent). Regarding the three outlier rates, juries resolved 33 medical malpractice cases in Arkansas, four in Minnesota and four in Utah. National Center for State Courts, “CSP
STAT Civil: Trial Court Caseload Overview, Data Table – Malpractice Medical, Jury Trials and Jury Trial Rate,”

Eighteen states reported publishable data for medical malpractice dispositions and jury trials. Their rates were as follows: Arkansas (22.8 percent), Connecticut (0.6 percent), Florida (0.8 percent), Hawai‘i (0.0 percent), Michigan (0.7 percent), Minnesota (30.8 percent), Nebraska (7.1 percent), Nevada (2.9 percent), New Jersey (0.9 percent), New York (1.9 percent), North Carolina (0.4 percent), Oregon (1.9 percent), Rhode Island (2.9 percent), Tennessee (1.4 percent), Texas (0.6 percent in general jurisdiction courts; 2.7 percent in limited jurisdiction courts), Utah (80 percent), Vermont (0.0 percent) and Wisconsin (9 percent). Regarding the three outlier rates, juries resolved 33 medical malpractice cases in Arkansas, four in Minnesota and four in Utah. National Center for State Courts, “CSP
STAT Civil: Trial Court Caseload Overview, Data Table – Malpractice Medical, Jury Trials and Jury Trial Rate,”

Twenty states reported publishable data for medical malpractice dispositions and jury trials. Their rates were as follows: Alaska (0.0 percent), Arkansas (16 percent), Florida (1.1 percent), Georgia (7.3 in general jurisdiction courts; 2.4 percent in limited jurisdiction courts), Hawai‘i (4.2 percent), Michigan (0.4 percent), Minnesota (0.0


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percent), Nebraska (1 percent), Nevada (5.4 percent), New Jersey (1.7 percent), New York (2 percent), North Carolina (0.4 percent), Oregon (3.2 percent), Rhode Island (1.9 percent), South Carolina (3.3 percent), Tennessee (0.9 percent), Texas (1.1 percent), Utah (100 percent), Vermont (0.0 percent) and Wisconsin (2.4 percent).

Regarding the two outlier rates, juries resolved 16 medical malpractice cases in Arkansas, whereas all Utah’s medical malpractice cases – two total – were resolved by jury trial. National Center for State Courts, “CSP STAT Civil: Trial Court Caseload Overview, Data Table – Malpractice Medical, Jury Trials and Jury Trial Rate,” https://www.courtsstatistics.org/court-statistics/interactive-caseload-data-displays/csp-stat-nav-cards-first-row/csp-stat-civil (data as of July 8, 2022).

92 Twenty-two states reported publishable data for medical malpractice dispositions and jury trials. Their rates were as follows: Alaska (0.0 percent), Arkansas (16.4 percent), Connecticut (5 percent), Florida (3.6 percent), Georgia (10.5 percent in general jurisdiction courts; 2.8 percent in limited jurisdiction courts), Hawai’i (0.0 percent), Michigan (5.1 percent), Minnesota (6.3 percent), Nebraska (5.9 percent), Nevada (4.5 percent), New Jersey (6 percent), New Mexico (0.2 percent), New York (5.6 percent), North Carolina (2.5 percent), Oregon (6.3 percent), Rhode Island (10.2 percent), South Carolina (2.8 percent), Tennessee (3.2 percent), Texas (3.9 percent in general jurisdiction courts; 2.7 percent in limited jurisdiction courts), Utah (100 percent), Vermont (9.5 percent) and Wisconsin (7.5 percent). Regarding the two outlier rates, juries resolved 22 medical malpractice cases in Arkansas, whereas all Utah’s medical malpractice cases – two total – were resolved by jury trial. National Center for State Courts, “CSP STAT Civil: Trial Court Caseload Overview, Data Table – Malpractice Medical, Jury Trials and Jury Trial Rate,” https://www.courtsstatistics.org/court-statistics/interactive-caseload-data-displays/csp-stat-nav-cards-first-row/csp-stat-civil (data as of July 8, 2022).


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The six tort restrictions examined by CBO are: 1) a $250,000 cap on non-economic damages; 2) a $500,000 cap or two times the amount of economic damages; 3) repeal of the collateral source rule; 4) one-year date of discovery statute of limitations (3 years for children); 5) repeal of joint and several liability; and 6) newly added to the analysis – a percentage cap on attorneys’ fees, which grows higher the larger the award.

CBO says, “Few studies estimate the effect of other liability laws on spending, and studies that do so find zero or inconsistent evidence of an effect on spending.” The impact of these measures is also described as having “no measurable effect on liability pressure,” “no consistent evidence” and “would not affect the deficit.”

CBO says, “[B]ecause caps on attorneys’ fees would reduce attorneys’ taxable income, revenues would be reduced under proposals that include that policy. Capping attorneys’ fees would not affect federal spending.”

CBO puts it this way: “[A]lthough both theory (Frakes 2015) and anecdotal evidence indicate that laws that lower malpractice liability, such as noneconomic damage caps, would be expected to (weakly) reduce utilization of imaging and testing services, CBO estimates modest increases in the utilization rates of those services after the enactment of noneconomic damage caps (estimates not shown).” Indeed, as other researchers have said, “An often proposed remedy [to so-called ‘defensive medicine’] is caps on non-economic damages. … We report evidence, from a careful study with a large, patient level dataset, of a more complex and nuanced response to caps. Rates for cardiac stress tests and other imaging tests appear to rise, instead of falling, and overall as does Medicare Part B lab and radiology spending. Yet cardiac interventions do not rise, and likely fall. There is no evidence of a fall in overall Medicare spending and, consistent with a recent prior paper (Paik et al., 2017), some evidence of higher Part B spending.” Bernard S. Black, Steven Farmer and Ali Moghtaderi, “Damage Caps and Defensive Medicine: Reexamination with Patient Level Data,” Northwestern Law & Econ. Research Paper No. 16-xx, June 13, 2018, http://ssrn.com/sol3/papers.cfm?abstract_id=2816969

As one example, “CBO must therefore rely on empirical estimates to determine both the direction and magnitude of the effect of those laws on spending, with the expectation that the effects may differ depending on the type of care and patient population. Empirical studies cannot easily characterize the interpretation of the effect – that is, how much of a change in treatment is appropriate or inappropriate – because spending data do not include enough information on patient health and quality of treatment delivered.”


Florida, Georgia, Illinois, Mississippi, Nevada, Ohio, Oklahoma, South Carolina and Texas.


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Colorado also has a separate non-economic damages cap.

Colorado also has a separate “total” cap.

Cap applies to “pain and suffering” only. Other kinds of non-economic damages are not capped.

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One cap was found unconstitutional but another cap is still law.

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