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Richard F. Daines, M.D., Commissioner
Department of Health
Corning Tower, Empire State Plaza
Albany, NY 12237

Eric R. Dinallo, Superintendent
State Of New York
Insurance Department
One Commence Plaza
Albany, New York 12257

Dear Commissioner Daines and Superintendent Dinallo:

The following information is submitted to the medical malpractice task force in answer to several questions raised in the workplan for October 29, 2007. As is obvious, the best way to reduce medical malpractice deaths, injuries, claims and lawsuits is to reduce medical malpractice, which has been at epidemic proportions for years.

In setting forth the material below dealing with this medical malpractice plague, CJ&D, as an organization dedicated to consumers and patients, stands ready and eager to assist in devising and implementing solutions that address this topic, which is the true crisis we face here in New York State. In order to devise solutions, it is first necessary to fully understand the nature and extent of the problem. Thus, we will first give a brief overview of the problem, and then below we offer suggestions for solutions. We look forward to working with all parties on these or any other real solutions addressed to real and not contrived problems.

In 1999, the National Academy of Sciences Institute of Medicine released a now famous study entitled *To Err is Human; Building a Safer Health System*, (Kohn, Corrigan, Donaldson, Editors; Institute of Medicine, National Academy Press, Washington, DC, 1999.). Here are the major findings:

- **DEATHS IN HOSPITALS DUE TO MEDICAL ERRORS.** The report's findings are based on two large studies, one conducted in Colorado and Utah, which corroborated the seminal Harvard Medical Practice Study of New York hospitals.¹ The 1990 Harvard

¹ Brennan, Troyen A.; Leape, Lucian L.; Laird, Nan M.; et al, Incidence of adverse events and negligence in hospitalized patients. Results of the Harvard Medical Practice Study, N Engl J Med 324:370-376, 1991. Thomas,

Medical Practice study found that medical negligence in New York hospitals results in 27,000 injuries and 7,000 deaths every year.² When the findings of these studies are “extrapolated to the over 33.6 million admissions to U.S. hospitals in 1997, the results of the study in Colorado and Utah imply that at least 44,000 Americans die each year as a result of medical errors. The results of the New York study suggest the number may be as high as 98,000. Even when using the lower estimate, deaths due to medical errors exceed the number attributable to the 8th leading cause of death. More die in a given year as a result of medical errors than from motor vehicle accidents (43,458), breast cancer (42,297) or AIDS (16,516).” Pages 1, 22, 25-26.

- **COSTS OF PREVENTABLE MEDICAL ERRORS THAT RESULT IN INJURY.** “Total national costs (lost income, lost household production, disability and health care costs) of preventable adverse events ... are estimated to be between \$17 billion and \$29 billion, of which health care costs represent over one-half.”³ Page 1, 22, 34. “In 1992, the direct and indirect costs of adverse events were slightly higher than the direct and indirect costs of caring for people with HIV and AIDS.” Pages 22-23, 35.
- **EMERGENCY ROOMS:** The hospital location with the highest proportion of negligent adverse events (52.6 percent) is the emergency department. Page 30.
- **UNDERESTIMATION OF FIGURES.** “These figures offer only a very modest estimate of the magnitude of the problem since hospital patients represent only a small percentage of the total population at risk, and direct hospital costs are only a fraction of the total costs.” Page 2, 26. (“More is known about errors that occur in hospitals than in other health care delivery systems.” Page 23.) Not included in these studies are medical errors resulting from care provided in ambulatory settings, outpatient surgical centers, physician offices and clinics, home care, retail pharmacies and nursing homes. Page 2.
- **MEDICATION ERRORS.** “Medication errors alone (accidental poisoning by drugs, medicaments and biologicals, occurring either in or out of the hospital), are estimated to account for over 7,000 deaths annually, compared with less than 3,000 people in 1983, almost a 3-fold increase.”⁴ Generalizing the results of a prior study,⁵ “the increased hospital costs alone of preventable adverse drug events affecting inpatients are about \$2 billion for the nation as a whole.” Page 1-2, 27-28. Moreover, these estimates are low because “many errors go undocumented and unreported.” Page 29. “It has been estimated that for every dollar spent on ambulatory medications, another dollar is spent to

Eric J.; Studdert, David M.; Burstin, Helen R.; et al. Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado. *Med Care* forthcoming Spring 2000.

² Harvard Medical Practice Study, *Patients, Doctors and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York* (1990).

³ Thomas, Eric J.; Studdert, David M.; Newhouse, Joseph P.; et al. Costs of Medical Injuries in Utah and Colorado, *Inquiry* 36:255-264, 1999. See also, Johnson, W.G.; Brennan, Troyen A.; Newhouse, Joseph P.; et al. The Economic Consequence of Medical Injuries, *JAMA* 267:2487-2492, 1992.

⁴ Phillips, David P.; Christenfeld, Nicholas; and Glynn, Laura M; Increase in US Medication-Error Deaths between 1983 and 1993, *The Lancet*, 351:643-44, 1998.

⁵ Bates, David W.; Spell, Nathan; Cullen, David J.; et al., The Costs of Adverse Drug Events in Hospitalized Patients, *JAMA* 277:307-311, 1997.

treat new health problems caused by medications.”⁶ And “for every dollar spent on drugs in nursing facilities, \$1.33 is consumed in the treatment of drug-related morbidity and mortality, amounting to \$7.6 billion for the nation as a whole, of which \$3.6 billion as been estimated to be avoidable.”⁷ Page 35.

- **TYPES OF ADVERSE EVENTS.** “Patient safety problems of many kinds occur during the course of providing health care. They include transfusion errors and adverse drug events; wrong-side surgery and surgical injuries; preventable suicides; restraint-related injuries or death; hospital-acquired or other treatment-related infections; and falls, burns, pressure ulcers, and mistaken identity.” Page 30.
- **INATTENTION TO SAFETY.** “Health care is a decade or more behind other high-risk industries [like aviation] in its attention to ensure basic safety.” Page 4. “The likelihood of dying per domestic jet flight is estimated to be one in eight million. Statistically, the average passenger would have to fly around the clock for more than 438 years before being involved in a fatal crash.⁸ ...Some believe that public concern about airline safety, in response to the impact of news stories, has played an important role in the dramatic improvement in safety in the airline industry.” By comparison, “Americans have a very limited understanding of health care safety issues.” Page 36.

There has been some push back from the medical community over IOM’s definition of preventable or negligent “adverse events.” This is not warranted. IOM made clear that it considered only injuries caused by treatment itself and not an underlying condition, and IOM used stringent criteria in choosing which adverse events to consider. The report notes, “some maintain these extrapolations likely underestimate the occurrence of preventable adverse events because these studies: 1) considered only those patients whose injuries resulted in a specified level of harm; 2) imposed a high threshold to determine whether an adverse event was preventable or negligent (concurrence of two reviewers; and 3) included only errors that are documented in patient records.” **In other words, the IOM authors made special care to ensure that only incidents that were preventable or negligent were examined, and confirmed that if anything, the figures underestimate the extent of the problem.**

There are many subsequent polls and studies that not only back up the IOM findings, but suggest an even worse situation.

In July 2004, HealthGrades, a health care quality rating agency, released a study, based on Medicare data from all fifty states, estimating that an average of 195,000 people a year died from preventable medical errors in U.S. hospitals in 2000, 2001, and 2002.⁹

⁶ Alliance for Aging Research, When Medicine Hurts Instead of Helps, Washington DC: The Alliance for Aging Research; 1998.

⁷ Bootman, J. Lyle; Harrison, LTC Donald L., and Cox, Emily, The Health Care Cost of Drug-Related Morbidity and Mortality in Nursing Facilities, Arch Intern Med. 157(18):2089-2096, 1997.

⁸ Federal Aviation Administration, Office of System Safety. Aviation Safety Reporting System (ASRS) Database [Web Page] 1999. Available at: http://nasdac.faa.gov/safety_data.

⁹ Health Grades Quality Study, Patient Safety in American Hospitals. 2004. http://www.healthgrades.com/media/english/pdf/HG_Patient_Safety_Study_Final.pdf.

Another recent government study of 18 specific types of medical errors finds that they cause tens of thousands of deaths and cost billions of dollars each year. The federal government's Agency for Healthcare Research and Quality recently found that 18 categories of medical errors, such as postoperative infections, accidental reopening of surgical wounds, and medical objects left inside patients, result in 32,500 hospital deaths, cost \$9.3 billion in additional hospital charges, and lead to over 2.4 million extra days spent in hospitals.¹⁰ The study, published in the *Journal of the American Medical Association*, found that even these figures greatly underestimate the problem since many medical complications were not analyzed for this study.¹¹ Dr. Chunliu Zhan, study's lead researcher, said, "The message here is that medical injuries can have a devastating impact on the health care system."¹²

Another recent survey found, "[e]ighty percent of U.S. doctors and half of nurses surveyed said they had seen colleagues make mistakes, but only 10 percent ever spoke up." Moreover, "fifty percent of nurses said they have colleagues who appear incompetent" and "[e]ighty-four percent of physicians and 62 percent of nurses and other clinical care providers have seen co-workers taking shortcuts that could be dangerous to patients." Doctors and nurses do not talk about these problems because "people fear confrontation, lack time or feel it is not their job."¹³

A poll in November, 2004 found that 34 percent of the American public say that they or a close family member have experienced a preventable medical error. Of those, only 11 percent report they or their family member sued the health care professional or institution. 70 percent of those who have experienced a medical error said that their doctor did not tell them a mistake had been made.¹⁴

What may seem like a recent epidemic of medical malpractice is, unfortunately, nothing new. Consider that in 1985 the director of Maternal/Fetal Medicine at Pasadena's Huntington Memorial Hospital told the American College of Obstetrics and Gynecology: "The greatest cause of malpractice is malpractice. You must understand that some of the malpractice out there is so grievous, offensive and implausible as to beggar the imagination."¹⁵ This kind of information led *Business Week* to write in its August 3, 1987 issue, during New York's last liability insurance crisis, "So what can we do? Start by facing up to what the problem is not. It is not a malpractice insurance crisis. Nor, contrary to popular mythology, is the problem a lawsuit crisis. The real crisis is the degree of malpractice itself."¹⁶

¹⁰ Julie Bell, "Study of Medical Errors Puts Tentative Price Tag on Impact: Hospital Charges Alone Boosted \$9.3 Billion a Year," *Baltimore Sun*, Oct. 8, 2003.

¹¹ Lindsey Tanner, Associated Press, "Preventable Complications Cost More Than \$9 Billion," *Deseret News*, Oct. 8, 2003.)

¹² Press Release, Agency for Healthcare Research and Quality, *Injuries in Hospitals Pose a Significant Threat to Patients and a Substantial Increase in Health Care Costs*, Oct. 7, 2003, <http://www.ahrq.gov/news/press/pr2003/injurypr.htm>.

¹³ "Survey: 80 percent of doctors witness mistakes; But only 10 percent report errors or poor judgment," *Reuters*, January 26, 2005. <http://www.msnbc.msn.com/id/6872715/>.

¹⁴ Kaiser Family Foundation, "National Survey on Consumers' Experiences With Patient Safety and Quality Information," 2004

¹⁵ Letter from Ralph Nader to Florida Speaker Mills and Senate President Vogt (1988).

¹⁶ Christopher Farrell, "Let The Free Market End Malpractice Warfare," *Business Week*, August 3, 1987.

GOOD DOCTORS PAYING FOR THE MALPRACTICE OF A FEW

Following the IOM study, several newspapers ran extensive series on the degree and cost of malpractice in their states, including New York. In March 2000, a *New York Daily News* week-long investigative series found that “hundreds of New York State doctors, dentists and podiatrists – ranging from modest practitioners to prominent surgeons – have amassed extensive hidden histories of malpractice yet continue to treat patients.” Moreover, “making even three malpractice payments is rare – only 1% of the nation’s doctors have crossed that line, according to the national database. But those doctors account for 24% – or \$5.6 billion – of the money paid to aggrieved patients.... The effect of failing to crackdown on the tiny percentage of doctors with the worst malpractice records is stunning, because they are a powerful driving force behind medical misfeasance nationwide.”¹⁷

These conclusions are similar to those found by Public Citizen’s Health Research Group, which found that just 7 percent of New York’s doctors are responsible for 68 percent of malpractice payouts, according to the group’s examination of National Practitioner Data Bank data.¹⁸

More recently, an investigation by the *New York Post* found, “Some of [New York City’s] most frequently sued doctors are still practicing with the blessing of the state Health Department.” They include doctors sued for “such offenses as possibly setting off an outbreak of hepatitis C and botching boob jobs and face lifts.”¹⁹

In one case, “the Health Department never took disciplinary action against anesthesiologist Dr. Marvin Chiumento - although a city Health Department probe in 2002 found that his faulty ‘infection-control practices’ during injections likely caused an outbreak of the potentially deadly hepatitis C virus in a Brooklyn clinic.... The agency lists Chiumento as in good standing, [despite] at least 41 medical-malpractice suits.”

Clearly, the lack of action by the state’s Office of Professional Medical Conduct is a large part of this problem. An audit released in September by the New York State Comptroller Thomas DiNapoli found that while “OPMC is thorough in its investigation of cases of potential misconduct, and generally does effectively track complaints.... OPMC management concentrates little effort on proactively identifying cases of potential misconduct or ensuring that they have received all complaints from the various outside and internal reporting sources. In addition, OPMC needs to improve the timeliness of some of its investigations.”²⁰ The audit also found,

¹⁷ Russ Buettner and William Sherman, “The 15 Most Sued Doctors In New York; Operating In The Dark,” *New York Daily News*, March 5, 2000.

¹⁸ “Just 7 Percent of New York’s Doctors Are Responsible for Two-Thirds of Malpractice Payouts, Study Shows,” March 10, 2003.

¹⁹ Carl Campanile, “State Oks ‘Scandal’ Docs; Still In Practice Despite Lawsuits Galore,” *New York Post*, April 4, 2007.

²⁰ Office Of The New York State Comptroller, Division Of State Government Accountability, Department Of Health, Office Of Professional Medical Conduct, Complaints And Investigations Process, Report 2005-S-21.

- “OPMC is not proactive in seeking to identify instances of potential misconduct, but instead relies primarily on referrals from other entities. For example, the Medicaid and Medicare programs maintain listings of providers who committed an action which is sufficient to exclude them from participating in these programs. We determined that OPMC does not routinely review these listings as a source of potential misconduct cases. We identified licensees that appeared on these listings that OPMC did not investigate....
- “We found that for the period April 1, 2003 through July 31, 2005, OPMC did not open an investigation for 177 licensees who met the criteria for malpractice investigation. We also found the malpractice database that OPMC maintains is incomplete when compared to similar information maintained by the Office of Court Administration (OCA). As a result, OPMC does not have complete information for cases involving potential malpractice that may require investigation....
- “In New York, there is no legal requirement to investigate licensees who have a high incidence of malpractice judgments or settlements to determine whether these actions constitute medical misconduct. Some states initiate an investigation when a licensee has more than three malpractice payments during a five-year period. Applying a similar criterion to OPMC’s malpractice database, we identified 12 licensees who had 3 or more malpractice payments during the period April 1, 2003 through July 31, 2005. OPMC did not initiate an investigation for 3 of these 12 licensees....
- “We also found that OPMC has not developed formalized time standards for completing its investigations. We identified approximately 340 cases which have taken over one year to investigate, and the investigation still remained opened at the time of our testing. In addition, we found another 429 cases which were open and closed during our audit period, but took over one year to complete. When investigations are not completed timely, the public is at risk of receiving substandard care....

HOW LITIGATION IMPROVES PATIENT SAFETY

When regulation fails, as is clearly true when it comes to medical malpractice, litigation becomes the last line of defense to protect patients. Numerous 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.²¹ As a result of such lawsuits, the lives of countless other patients have been saved.

The academic literature confirms this. David A. Hyman, Professor of Law and Medicine at the University of Illinois College of Law, and Charles Silver of the University of Texas at Austin School of Law, have researched and written extensively about medical malpractice. They confirm, “No study has shown that liability exposure causes health care quality to decline overall. Instead, the best available evidence shows that liability makes a modest positive

²¹ Meghan Mulligan & Emily Gottlieb, *Lifesavers: CJ&D’s Guide to Lawsuits that Protect Us All*, Center for Justice & Democracy (2002), Hospital and Medical Procedures, A-36 *et seq.*, B-12 *et seq.*

contribution to patient safety despite the definitive and unqualified claims to the contrary”²²
 The field of surgical anesthesia, where anesthesiologists adopted practice guidelines to reduce deaths, injuries, claims and lawsuits, is a strong case in point. Hyman and Silver write,

“[T]wo major factors forced their hand: malpractice claims and negative publicity.... Anesthesiology [malpractice] premiums were ... among the very highest—in many areas, two to three times the average cost for all physicians. By the early 1980s, anesthesiologists recognized that something drastic had to be done if they were going to be able to continue to be insured.... Anesthesiologists worked hard to protect patients *because* of malpractice exposure, not in spite of it.”²³

“The authors of the Harvard [Medical Practice Study] study acknowledged this themselves: ‘[T]he litigation system seems to protect many patients from being injured in the first place. And since prevention before the fact is generally preferable to compensation after the fact, the apparent injury prevention effect must be an important factor in the debate about the future of the malpractice litigation system.’”²⁴

As we noted in our October 4, 2007 letter to the task force, on May 11, 2006, the *New England Journal of Medicine* published a recent article confirming this point: that litigation against hospitals improves the quality of care for patients.²⁵ Highlights of this article include:

- “In the absence of a comprehensive social insurance system, the patient’s right to safety can be enforced only by a legal claim against the hospital. ... [M]ore liability suits against hospitals may be necessary to motivate hospital boards to take patient safety more seriously.”
- “The major safety-related reasons for which hospitals have been successfully sued are inadequate nursing staff and inadequate facilities.” For example, the Illinois Supreme Court found that a hospital was at fault for failing to provide enough qualified nurses “to monitor a patient, whose leg had to be amputated because his cast had been put on too tight.”
- In a 1991 Pennsylvania Supreme Court case, the court listed four areas from which hospital safety obligations should flow: “the maintenance of safe and adequate facilities and equipment, the selection and retention of competent physicians, the oversight of medical practice within the hospital, and the adoption and enforcement of adequate rules and policies to ensure the quality of care for patients.”

²² David A Hyman and Charles Silver, “The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?,” 90 Cornell L. Rev. 893, 917 (2005).

²³ *Ibid* at 920, 921.

²⁴ Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 47, citing Paul C. Weiler, Joseph P. Newhouse, & Howard H. Hiatt, A Measure Of Malpractice: Medical Injury, Malpractice Litigation, And Patient Compensation 133 (1993).

²⁵ George J. Annas, J.D., M.P.H., “The Patient’s Right to Safety – Improving the Quality of Care through Litigation against Hospitals,” *New England Journal of Medicine*, May 11, 2006.

- Anesthesiologists were motivated by litigation to improve patient safety. As a result, this profession implemented 25-years-ago, “a program to make anesthesia safer for patients” and as a result, “the risk of death from anesthesia dropped from 1 in 5000 to about 1 in 250,000.”
- “[B]y working with patients (and their lawyers) to establish a patient’s right to safety, and by proposing and supporting patient-safety initiatives, physicians can help pressure hospitals to change their operating systems to provide a safer environment for the benefit of all patients.”

“As Hyman and Silver explain, the reason why tort liability promotes patient safety is obvious. As the title of their most recent article says, ‘it’s the incentives, stupid’: Providers are rational. When injuring patients becomes more expensive than not injuring them, providers will stop injuring patients. In short, the notion that errors would decline if tort liability diminished is ridiculous.”²⁶

No one said this better than Dr. Wayne Cohen, then-medical director of the Bronx Municipal Hospital, who said, “The city was spending so much money defending obstetrics suits, they just made a decision that it would be cheaper to hire people who knew what they were doing.”²⁷

FEAR OF LITIGATION IS NOT THE REASON DOCTORS DO NOT REPORT ERRORS OR COMMUNICATE WITH THEIR PATIENTS.

Professors Hyman and Silver write, “No statistical study shows an inverse correlation between malpractice exposure and the frequency of error reporting, or indicates that malpractice liability discourages providers from reporting mistakes.”²⁸ Further, “[e]xhaustive chronicles of malpractice litigation’s impact on physicians never once assert that physicians freely and candidly disclosed errors to patients once upon a time, but stopped doing so when fear of malpractice liability increased. Instead, the historical evidence indicates that there was never much *ex post* communication with patients, even when liability risk was low.”²⁹

In his recent book on medical malpractice, Tom Baker, Connecticut Mutual Professor of Law and Director of the Insurance Law Center at the University of Connecticut School of Law, confirms, “to prove that lawsuits drive medical mistakes underground, you first have to prove that mistakes would be out in the open if there were no medical malpractice lawsuits. That is clearly not the case.”³⁰

²⁶ Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007) at 47, citing David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It’s the Incentives, Stupid*, 59 Vand. L. Rev. 1085, 1131 (2006).

²⁷ Dean Baquet and Jane Fritsch, “New York’s Public Hospitals Fail, and Babies Are the Victims,” *New York Times*, March 5, 1995.

²⁸ David A. Hyman and Charles Silver, “The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?,” 90 Cornell L. Rev. 914 (2005).

²⁹ *Ibid* at 925-26, 947-48.

³⁰ Tom Baker, *The Medical Malpractice Myth* (2005) at 97.

As noted in our October 4 task force submission, a May 11, 2006 article in the *New England Journal of Medicine* noted that only one quarter of doctors disclosed errors to their patients, but “the result was not that much different in New Zealand, a country that has had no-fault malpractice insurance” [i.e., no litigation against doctors] for decades. In other words, “There are many reasons why physicians do not report errors, including a general reluctance to communicate with patients and a fear of disciplinary action or a loss of position or privileges.”³¹ Other studies have produced similar results.

For example, according to a recent study by Dr. Thomas Gallagher, a University of Washington internal-medicine physician and co-author of two studies published in the *Archives of Internal Medicine*, “Comparisons of how Canadian and U.S. doctors disclose mistakes point to a ‘culture of medicine,’ not lawyers, for their behavior.”³² In Canada, there are no juries, non-economic awards are severely capped and “if patients lose their lawsuits, they have to pay the doctors' legal bills... yet “doctors are just as reluctant to fess up to mistakes.” Moreover, “doctors' thoughts on how likely they were to be sued didn't affect their decisions to disclose errors.” The authors believe “the main culprit is a ‘culture of medicine,’ which starts in medical school and instills a ‘culture of perfectionism’ that doesn't train doctors to talk about mistakes.”³³

Another example is in Massachusetts, where nearly all hospitals fall under the state’s charitable immunity laws that cap their liability at \$20,000. Yet hospitals are still “vastly underreporting their mistakes to regulators and the public.” According to *Boston Magazine*, “The biggest challenge is finding a way to break the culture of silence in hospital corridors that has long crippled efforts to cut medical errors, just as the blue wall of silence has stifled police investigations.”³⁴

Hyman and Silver offer a number of explanations for physicians failure to report errors: a culture of perfectionism within the medical profession that shames, blames, and even humiliates doctors and nurses who make mistakes; fragmented delivery systems requiring the coordination of multiple independent providers; the prevalence of third-party payment systems and administered prices; overwork, stress, and burnout; information overload; doctors’ status as independent contractors and their desire for professional independence; the Health Insurance Portability and Accountability Act (HIPAA); a shortage of nurses; and underinvestment in technology that can reduce errors.³⁵

They write, “it is naive to think that error reporting and health care quality would improve automatically by removing the threat of liability.”³⁶

³¹ George J. Annas, J.D., M.P.H., “The Patient’s Right to Safety – Improving the Quality of Care through Litigation against Hospitals,” *New England Journal of Medicine*, May 11, 2006.

³² Carol M. Ostrom, “Lawsuit fears aren't reason for docs' silence, studies say,” *Seattle Times*, August 17, 2006 , citing from Thomas Gallagher, M.D., et al, “Choosing your Words Carefully: How Physicians Would Disclose Harmful Medical Errors to Patients,” *Archives of Internal Medicine*, Aug. 14, 2006.

³³ *Ibid.*

³⁴ Doug Most, “The Silent Treatment,” *Boston Magazine*, Feb. 2003.

³⁵ David A Hyman and Charles Silver, “The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?,” 90 *Cornell L. Rev.* 897-99 (2005); Maxwell J. Mehlman and Dale A. Nance, *Medical Injustice: The Case Against Health Courts* (2007).

³⁶ *Ibid.*

THE CRISIS CREATED BY VIRGINIA'S BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION FUND

Over the years, proposals have circulated that require wrongly injured persons to have their disputes resolved outside the court system. One thing is clear: these programs become immediately rife with problems. Once an area of law is removed from the civil justice system, it becomes vulnerable to money, politics and influence-peddling, and turns into a nightmare for they less powerful people they were supposed to help. This happens either through aggressive industry lobbying of legislators, industry influence on the agencies charged with implementing the system, or orchestrated media efforts. All have happened to Virginia's Birth-Related Neurological Injury Compensation Program, a program that has been in place for 19 years.

The Virginia program was established in the mid-1980s, during this country's last so-called "insurance crisis," as another misguided attempt to reduce insurance rates for doctors. This program was set up as an injury compensation system for catastrophically injured newborns. It is the exclusive remedy for children delivered by a participating OB/GYNs and hospital. All claims go before an administrative panel, established within the workers compensation system. The panel is "aided" by an "expert" panel of three doctors who determine if the injury is a covered birth-related neurological injury.

This program has been a tremendous failure on every level. It has hurt patients, has done nothing to help doctors with their insurance problems and may have allowed the state to become a safe harbor for negligent and reckless doctors who should not be practicing medicine at all. Virginia's Joint Legislative Audit and Review Commission suggested "abandoning or overhauling" the program³⁷ and "ridding the board of its heavy presence of medical professionals,"³⁸ and has found that the program could not be made fiscally sound.³⁹ In testimony before the Virginia Legislature, one parent called the program "a generous system of care gone awry, of state-sanctioned impunity for doctors and hospitals, and of the struggle families face caring for society's weakest children."⁴⁰

To begin, the program has been in fiscal crisis for years. The fund is close to \$130 million short of cash and it now looks like the legislature will decide to fix the problem on the backs of the victims and their families, in complete contradiction to the law's original intent, i.e., "by giving up their right to bring suit, families were promised lifelong medical care for eligible children."⁴¹ As recently reported in the *Richmond Post-Dispatch*, "documents obtained by *The Times-Dispatch* show that the [legislative] plan would erase as much as half the shortage, about \$70.3

³⁷ Bill McKelway, "Study Faults Program for Brain-Injured; Shortcomings Found in Care for Children," *Richmond Times Dispatch*, Nov. 13, 2002; Liz Szabo & Elizabeth Simpson, "Birth Injuries Get 'Minimal Review; State Report Says Board Must Hold Doctors Accountable,'" *Virginian-Pilot*, Nov. 15, 2002.

³⁸ Bill McKelway, "Brain-Injury Program's Outlook Dim; Cost Savings for Doctors Meant Less for Children," *Richmond Times Dispatch*, Nov. 16, 2002.

³⁹ *Ibid.*

⁴⁰ Bill McKelway, "Danville Has High Birth-Injury Rate; Critics Say Virginia Law Shields Doctors from Lawsuits," *News Virginian*, June 1, 2003.

⁴¹ Bill McKelway, "Plan could restore financial soundness," *Richmond Times Dispatch*, September 17, 2007.

million, by capping benefit payments to children and through accounting adjustments that lessen cash obligations by some \$44 million.”⁴²

But the fiscal problems and the potential for additional burdens on these devastated and struggling families are by no means the only problems. The following are some of its more notable shortcomings:

- **Prevents patients from receiving adequate compensation and understanding the medical errors and negligence responsible:** “Children born in Virginia with catastrophic neurological injuries are promised lifetime medical care by the birth-injury program. But these children and their families also have been forced to absorb stunning disparities in program benefits because of shifting priorities and cost reductions over which they had no control or voice. . . . ‘The program can end up providing very little,’ said Christina Rigney, referring to the minimal benefits her family received in the face of her son’s traumatic birth and brief life. ‘We believed there was negligence involved, but nothing ever came of it.’” Her son died three years after he was severely injured due to oxygen loss during birth. Because of the birth injury law, the family couldn’t file a malpractice suit, the obstetrician was never even asked to explain what happened, and the family could learn nothing from illegible notes that failed to account for long periods of time. Families of two other brain-injured infants he delivered faced the same limits on their ability to learn what happened, or seek to show he was negligent. He is facing a lawsuit, however, for a fourth case in which a woman giving birth bled to death after delivering a healthy baby.⁴³
- **Has allowed Virginia to become a safe harbor for bad doctors:** National birth-injury experts have reportedly expressed fear about Virginia becoming a safe harbor for bad doctors because of a lack of disciplinary actions under this law. “The birth-injury cases . . . are not reported to national databases that track actions against doctors and measure physicians’ insurability. With no court action, settlement or disciplinary actions, a doctor’s involvement in birth-injury cases can go undetected.”⁴⁴ In fact, as of four years ago, not a single case in the program’s history had produced a disciplinary action against a hospital or doctor, even though those cases “pose a high risk for findings of negligence against doctors, nurses and hospitals.”⁴⁵
- **Cannot adjust to new medical research:** The program has been unable to adjust to current medical understanding because definitions of which injuries are covered have not changed in 15 years, despite important advances in understanding the causes of brain damage in babies. The program has rejected claims because it used out-dated criteria for assessing birth injuries. “Decisions in the [Virginia program’s] cases can mean the

⁴² *Ibid.*

⁴³ Bill McKelway, “Danville Has High Birth-Injury Rate; Critics Say Virginia Law Shields Doctors from Lawsuits,” *News Virginian*, June 1, 2003.

⁴⁴ Bill McKelway, “Brain Injuries Spur No Action; Case Review, Required by Law, Is Not Being Done, Va. Study Found,” *Richmond Times Dispatch*, Jan. 14, 2003.

⁴⁵ Bill McKelway, “Brain-Injury Program’s Outlook Dim; Cost Savings for Doctors Meant Less for Children,” *Richmond Times Dispatch*, Nov. 16, 2002.

difference between lifetime care for some of society's most-disabled children and no guarantees that medical expenses will be covered. Many families have had to opt for institutionalizing their children."⁴⁶

- **Families of infants who died minutes after birth denied any compensation:** Until recently, the program provided for lifetime care but nothing for wrongful death (a new provision to provide up to \$100,000 to deceased children went into effect in July 2003). That led to perverse situations such as a recent case where the obstetrician and hospital successfully argued before the administrative body that an infant who lived only minutes qualified for the program, protecting them from any liability other than the care provided during the deceased infant's 30-minute lifetime.⁴⁷
- **Has not led to reduced malpractice insurance rates:** Doctors claim that the program has failed to protect them from unacceptable malpractice insurance rate increases.⁴⁸

In sum, adopting any program that resembles Virginia's would be simply trading one crisis for another, and would place the burden of solving an insurance problem, not to mention a patient safety problem, on the backs of sick and injured children and their families.

MEDICARE IS DEALING WITH THE PROBLEM OF ERRORS

According to a 2005 study of 39 million patient records, 241,280 deaths during Medicare hospitalizations were attributable to one or more common medical errors. In each year from 2001 through 2003, the study found that the number of medical errors or "patient safety incidents" at America's hospitals was approximately 1.18 million, with a cost to Medicare of nearly \$3 billion annually.⁴⁹

In August 2007, Medicare announced that it would no longer make payments to hospitals for a number of preventable errors, known as "never events" i.e., negligence. These conditions are: objects left in a patient during surgery; blood incompatibility; air embolism; falls; surgical-site infection after heart surgery; urinary tract infections from using catheters; pressure ulcers, or bed sores; and vascular infections from using catheters. There is a national consensus among experts that these can be entirely prevented through improved safety practices. The Centers for Medicare and Medicaid Services says it will add more conditions next year.⁵⁰

⁴⁶ Bill McKelway, "Old Rules Deny New Benefits; Children Rejected for Brain-Injury Program," *Richmond Times Dispatch*, June 5, 2003

⁴⁷ Bill McKelway, "Deceased Infant Put into Program; Ruling Blocks Suits Over Death of Baby," *Richmond Times Dispatch*, June 27, 2003

⁴⁸ See, e.g., Novelda Sommers, "Peace of Mind is Pricey; Some Malpractice Insurance Soars," *Daily Press* (Newport News, VA), June 5, 2003.

⁴⁹ Healthgrades, *Medical Errors Gap Widens Between Best and Worst Hospitals: Healthgrades Study*, (May 2005), <http://www.healthgrades.com/media/DMS/pdf/DHAPSNationalReleaseFINAL4May022005.pdf>.

⁵⁰ "Medicare to stop paying costs of preventable hospital infections, other errors," *Associated Press*, August 18, 2007.

SOME SOLUTIONS TO REDUCE MEDICAL ERRORS

REMOVE OR SANCTION THE SMALL NUMBER OF BAD DOCTORS COMMITTING MOST MALPRACTICE

The *New York Times* reported in 2005,

Experts retained by the Bush administration said on Tuesday that more effective disciplining of incompetent doctors could significantly alleviate the problem of medical malpractice litigation.

As President Bush prepared to head to Illinois on Wednesday to campaign for limits on malpractice lawsuits, the experts said that states should first identify those doctors most likely to make mistakes that injure patients and lead to lawsuits.

The administration recently commissioned a study by the University of Iowa and the Urban Institute to help state boards of medical examiners in disciplining doctors.

“There’s a need to protect the public from substandard performance by physicians,” said Josephine Gittler, a law professor at Iowa who supervised part of the study. “If you had more aggressive policing of incompetent physicians and more effective disciplining of doctors who engage in substandard practice, that could decrease the type of negligence that leads to malpractice suits.”

Randall R. Bovbjerg, a researcher at the Urban Institute, said, “If you take the worst performers out of practice, that will have an impact” on malpractice litigation.⁵¹

As noted above, the New York State Comptroller was critical of the state’s OPMC for failing to do to remove or sanction even the worst doctors in the state who continue to practice. I will not repeat here all the Comptroller’s recommendations for improvement, as the Health Department is no doubt aware of these. We support these recommendations.

What’s more, the validity of this approach was recognized by Physicians’ Reciprocal Insurers in its presentation at the September 19, 2007 Task Force meeting, where it advocated, “Remove ‘uninsurable’ healthcare providers - facilities as well as individuals from the pool by removing their licenses.”

As we noted in our letter for the September 19 task force meeting, New York law requires MMIP to decline no one, forcing it to insure the small number of objectively bad risks that cause most malpractice payouts in this state. In terms of both contributing to the deficit and reducing medical errors, this is terrible policy. MMIP, in whatever future form it takes, should be allowed to turn down bad risks based on an objective definition of good practice, i.e., doctors with clean records based on their specialty or location. If turned down, “surplus lines” carriers--carriers who are not licensed in the state but are licensed in other states – could be authorized to write

⁵¹ Robert Pear, “Panel Seeks Better Disciplining of Doctors,” *New York Times*, January 5, 2005.

medical malpractice coverage, in whatever way the state determines. Such a change would improve the results of the MMIP, would stop good doctors from paying for the small number of bad ones, and would make proper use of the insurance function to help weed out doctors with very poor experience.

Further, all medical malpractice insurers should be required to use claims history as a rating factor, and give that factor significant weight. Auto insurers use an individual's driving record as a rating factor; workers compensation insurers use the employer's loss experience as a rating factor. Malpractice insurers should do the same. In addition, medical malpractice insurers should be required to offer all "good" doctors— *i.e.*, all doctors meeting an objective definition of eligibility based on their claims history, their amount of experience and perhaps other factors — the lowest rate.

CONSUMER/PATIENT SAFETY GROUP RECOMMENDATIONS

The following are patient safety recommendations contained in the October 2004, study by NYPIRG, Center for Medical Consumers and Public Citizen entitled, *The Doctor Is In: New York's Increasing Number of Doctors*, which the Center for Justice & Democracy endorsed:

1. Better reporting of hospitals' and physicians' health care quality. Consumers should have easy access to hospital quality data already collected by the State Health Department. Such information should be contained in a "hospital profile" that includes reports of the experience level of a hospital and its physicians in performing particular surgeries and other treatments.
2. Create a system of periodic recertification of physicians. Both the Institute of Medicine and the State Health Department have recommended that physicians be recertified to assure that they continue to be able to practice as competent professionals. Over time, physicians may see some of their skills erode and it is difficult to keep current with the latest medical research and advances in technology. In an effort to identify these physicians *before* a patient gets harmed, a system of recertification based on testing competency is needed.
3. Require the State Health Department to review malpractice payments by physicians to identify potential problems. As mentioned earlier, a small percentage of physicians account for an extremely high percentage of malpractice payments in New York. The overwhelming majority of physicians make no malpractice payments, yet their high premiums help subsidize the losses caused by a few. The State Health Department collects insurer data on the malpractice payments of physicians and has pledged to use that data to identify problem doctors. However, there is no evidence that the DOH has begun to use this data. A law should be passed to make that pledge a Departmental requirement.
4. Require health care providers who harm patients as a result of a medical mistake to tell the patient or patient's family when such a mistake occurs. Physicians are required by

their own code of ethics to report medical mistakes even if such admission exposes them to liability. The force of law should back up this common sense ethical requirement.

5. The state should review its programs that help place physicians in underserved areas. New York currently provides financial assistance to encourage physicians to practice in underserved areas. A review of this program must examine what reforms, or expansions, are needed.

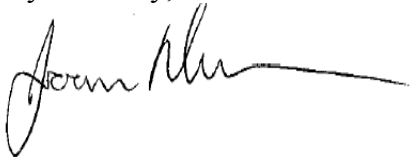
OTHER PATIENT SAFETY RECOMMENDATIONS

When New York hospitals adopt available technology, they provide better care with greater consistency, and their insurance rates can drop. In 2003, a newspaper story detailed how a handful of hospitals are using technology to make prenatal care and delivery safer. These hospitals began using computer software that improves monitoring and treatment by reminding staff of steps to take, stopping them from doing something wrong, and avoiding problems with illegible handwriting. The software helps avoid medical errors and, according to the director of women and infant services at the first hospital to install the software, “the program has already saved lives.” Maimonides Medical Center in Brooklyn negotiated a \$300,000 discount on its annual malpractice premium within two years after purchasing the program.⁵²

RN Staffing Ratios. Establishing safe RN staffing ratios would reduce the occurrence of medical errors and patient deaths. A 2002 study in the *Journal of the American Medical Association* found that patients on surgical units with patient-to-nurse ratios of 8:1 were 30 percent more likely to die than those on surgical units with 4:1 ratios.⁵³

We hope this is helpful. Please let us know if you have any questions.

Very sincerely,



Joanne Doroshow
Executive Director

⁵² Margaret Ramirez, “System Checks Steps in Care,” *Newsday*, Oct. 7, 2003.

⁵³ L.H. Aiken et al., “Hospital Nurse Staffing and Patient Mortality, Nurse Burnout, and Job Dissatisfaction,” 288 *JAMA* 1987 (Oct. 23/30, 2002).

APPENDIX I**MEDICAL MALPRACTICE IN NEW YORK -
A SMALL ILLUSTRATION OF ITS HUMAN TOLL****Susan Trinchitella**

Susan Trinchitella's mother Rose, of Port Washington, New York, was a 76 year old woman with a history of nose bleeds treated with packing of the nose. The constant packing caused a blood clot that resulted in a benign lesion on the side of her nose called a Masson's Lesion. The growth was biopsied and wrongly diagnosed as a cancerous tumor known as angiosarcoma. As a result, the doctors amputated her entire nose leaving a gaping hole in her face. They did not tell her the truth for weeks – the truth being that she did not have cancer. She was long discharged from the hospital before they admitted their mistake. The hospital settled. The amount was almost entirely for non-economic loss.

Charles Frye

Charles Frye of White Plains, New York, sustained severe neurological injuries as a result of a continuous failure to diagnose and treat his mother's high blood pressure over a period of several days before he was born in January 1983. The resulting damage done to Charles' brain has rendered him a quadriplegic, permanently confined to a wheelchair, and totally dependent on others for all of his tasks of daily living. The jury's award was reduced by more than 50 percent by the trial court.

Deanna Martorelli

Deanna Martorelli of Woodbury, New York, was a college graduate and on her way to a Masters Degree when she contracted an illness. A local doctor decided to treat her with toxic dosages of an anti-parasitic medication and did not monitor her with proper blood testing. The end result was blindness, a loss that is almost entirely non-economic.

Narine Ramnarine

Narine Ramnarine of the Bronx, New York, went in for simple hernia operation at the age of 35. Mr. Ramnarine went to a renowned medical center and the doctor's negligence left Mr. Ramnarine unable to walk. He sustained severe nerve damage. Today, he has severe difficulty walking, is in chronic pain in his groin and thigh and has been unable to work for six years. In order to cope with the excruciating pain, he takes strong pain medication, which has eliminated his enjoyment of life, his wife and his 10 year old daughter. Mr. Ramnarine had a limited income. His case settled and the settlement was mostly for non-economic loss.

Ernest Lim

The failure to diagnose appendicitis resulted in five subsequent operations for Ernest Lim of New York City. He had to be fed through a tube for a year and almost died twice during surgeries. He was left with a huge abdominal scar and possibility of future small bowel transplant. Mr. Lim did not have lost earnings so his settlement was for his lifetime pain and suffering..

Beth Myers

When Beth Meyers of Brooklyn, New York, was an infant, her brain was irrevocably damaged by an E. coli infection that went untreated for days despite multiple visits to her doctor. Antibiotics that were readily available could have prevented the damage. Now fourteen years old, Beth has become prisoner in her own body. She is aware of all that happens around her, but stricken with severe cerebral palsy, wheelchair bound, legally blind, and totally dependent on others for daily, routine tasks.

Camille Teichman

Camille Teichman of Long Island, New York, was pregnant with her third child when she was involved in an automobile accident in March 1986. She was brought to the Community Hospital of Western Suffolk having sustained a head injury. She was in her last month of pregnancy. After a series of errors that occurred at the hospital, Mrs. Teichman's daughter, Michelle was born but severely depressed in the nursery and ultimately a neonatologist arrived and administered to the child. There was ultimately evidence of a bleed in the child's brain and a shunt had to be inserted. Michelle required intensive care. Today, Michelle has severe permanent neurological deficits.

Theresa Geoghegan

Theresa Geoghegan of Staten Island, New York, had just recently completed her Masters Degree in Public Administration and secured a position as Director of Nursing at a facility in Brooklyn when she learned that she had been improperly diagnosed as having several small cysts in her breast that were, in fact, cancerous. Because of the delay in receiving the proper diagnosis, by the time she learned she had breast cancer, it had spread and she began a rigorous course of treatments. Sadly, after suffering through frequent pain and fatigue that forced her to give up the position she worked so hard to attain, Theresa died of cancer in May 2003.

Teresa Garcia

Teresa Garcia suffered complete blindness when a dialysis machine malfunctioned causing her blood pressure to become dangerously hypotensive. As a result of these hypotensive blood pressure levels being sustained for a substantial length of time and New York Hospital's failure to recognize that the machine was malfunctioning, her blood pressure became so dangerously low that Teresa suffered ischemic optic neurosis.

Rosemarie Lorentz

Rosemarie Lorentz of Staten Island, New York, was a 50-year-old woman who was undergoing chemotherapy for Hodgkin's disease. A resident extravasted the injection causing a severe chemical burn resulting in the loss of her breast and surrounding muscle. She received a settlement, the terms of which are confidential.

Marilyn Collangelo

Marilyn Collangelo's husband was the Chief of Detectives for the New York City Police Department. He had chest pain and underwent a stress thallium test. He was never advised that the results were positive and he suffered a heart attack and died after a period of time. She received a settlement but is bound by a confidentiality agreement.