Medical Misdiagnosis in Arkansas:
Challenging the Medical Malpractice Claims of the Doctors' Lobby

`

Congress Watch
January 2003

Acknowledgments

The principal authors of "Medical Misdiagnosis in Arkansas: Challenging the Medical Malpractice Claims of the Doctors' Lobby" were Public Citizen's Congress Watch Director Frank Clemente, Legislative Counsel Jackson Williams, and Research Director Neal Pattison. Significant research contributions were made by Civil Justice Fellow Gretchen Denk, Legislative Assistant Rebecca Romo, Senior Researcher Andrew Benore, and Research Consultant Luke Warren.

About Public Citizen

Public Citizen is a 150,000 member non-profit organization based in Washington, D.C., with more than 400 members in Arkansas. We represent consumer interests through lobbying, litigation, research and public education. Founded by Ralph Nader in 1971, Public Citizen fights for consumer rights in the marketplace, safe and affordable health care, campaign finance reform, fair trade, clean and safe energy sources, and corporate and government accountability. Public Citizen has five divisions and is active in every public forum: Congress, the courts, governmental agencies and the media. Congress Watch is one of the five divisions.

Public Citizen's Congress Watch
215 Pennsylvania Ave. S.E.
Washington, D.C. 20003
P: 202-546-4996
F: 202-547-7392
www.citizen.org

Medical Misdiagnosis in Arkansas:
Challenging the Medical Malpractice Claims of the Doctors' Lobby

Table of Contents

Executive Summary

The Arkansas Medical Society and its allies have made a number of sensational allegations about what they call a malpractice "crisis." We agree that there is a *temporary* "crisis" and malpractice insurance costs have spiked over the last two years. But claims that it has been caused by "many frivolous lawsuits," an "out-of-control legal system," "an irrational lottery," or "astronomic jury verdicts" have no basis in fact.

This Public Citizen study, which examined statistics from numerous government agencies and other reputable sources, has two principal findings:

1) The medical malpractice "crisis" in Arkansas, as in the rest of the country, is not a long-term problem nor has it been caused by the legal system. It is a short-term problem triggered by a brief spike in medical malpractice insurance rates for some physicians. This spike in rates is a result of the cyclical economics of the insurance industry and investment losses caused by the country's economic slowdown.

2) A more significant, longer-term malpractice "crisis" faced by Arkansas is the unreliable quality of medical care being delivered – a problem that health care providers have not adequately addressed. Taking away people's legal rights, as is proposed under a cap on non-economic damages, would only decrease deterrence and reduce the quality of care.

Highlights of this report include:

- **The cost of medical negligence to Arkansas' patients and consumers is considerable, especially when measured against the cost of malpractice insurance to Arkansas' doctors.** Extrapolating from Institute of Medicine findings, we estimate that medical errors cause 418 to 931 preventable deaths in Arkansas each year. The cost resulting from preventable medical errors to Arkansas' residents, families, and communities is estimated at $161 million to $275 million each year. But the cost of medical malpractice insurance to Arkansas' doctors is less than $40 million a year.

- **Arkansas doctor's liability premiums are among the lowest in the nation.** Malpractice insurance premiums in Arkansas are some of the lowest in all 50 states and the District of Columbia, according to data collected by *Medical Liability Monitor*. The median premium for a general surgeon practicing in Arkansas in 2002 was $16,400 – about the same amount paid by general surgeons in North Dakota or South Dakota, and higher than those in only four other states.

- **Government data shows that large malpractice award payments have been the rare exception in Arkansas.** According to the federal government's National Practitioner Data Bank (NPDB), Arkansas physicians made only two multi-million dollar award payments between 1998 and 2001. The largest was only $2,550,000. The number of large (more than $100,000) malpractice payments in Arkansas remained constant over the past four years, and so has the total amount of malpractice payments – declining from $15.8 million in 1998 to $15.1 million in 2001. Adjusting for inflation, this steady level of awards represents a significant decline in dollar value.

- **Government data show that malpractice payments in Arkansas have increased at a slower pace than national medical costs.** According to the National Practitioner Data Bank, the median medical malpractice payment by an Arkansas physician to a patient rose 48.6 percent between 1992 and 2002, or less than 5 percent a year. However, during those same years, medical costs increased by 53.7 percent nationally, or 5.4 percent a year. (Medical costs typically represent the lion's share of most malpractice awards.) Moreover, between 1999 and 2002, the median malpractice payment by an Arkansas physician actually dropped by more than 10 percent.

- **Arkansas' cumulative median malpractice payment has remained less than the national average.** Among the 50 states and the District of Columbia, Arkansas historically has ranked below the national average for the median malpractice payment by a physician to a patient. According to the NPDB, the cumulative median malpractice payment from 1991 to 2001 was $90,000 in Arkansas – compared with $100,000 nationally for the same period.

- **The number of Arkansas malpractice lawsuits filed in 2002 was less than in the preceding years.** In each of the past two years, which was the height of the insurance "crisis," the number of malpractice lawsuits filed in the state decreased. In 2002, 371 malpractice cases were filed in Arkansas, compared with 383 in 2001, and 413 in 2000. Overall, this represented a 10 percent decrease in lawsuits filed.

- **Doctors diagnose a crisis where the Chamber of Commerce sees none.** The American Medical Association added to a false sense of crisis when it included Arkansas on a list of states showing "problem signs" with their medical liability systems. On the same list, however, the AMA included Delaware and Virginia – states that the U.S. Chamber of Commerce ranks first and second among states with the *best* liability systems.

- **The number of doctors in Arkansas has been increasing.** Despite gloomy forecasts issued by those declaring a malpractice "crisis" in the state, the Arkansas State Medical Board reports that from 1998 to 2002 the state experienced an increase of 209 doctors, an average of 52 additional doctors each year. In 1995, Arkansas had 192 doctors for each 100,000 citizens. By 2001, the ratio was 212 per 100,000, an improvement of 10.4 percent.

- **"Repeat offender" physicians are responsible for the bulk of malpractice costs.** According to the federal government's National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, 2.6 percent of Arkansas' doctors have made two or more malpractice payments to patients. These repeat offender doctors are responsible for 43.7 percent of all payments. Overall, they have paid out $48.9 million in damages. Even more surprising, less than 1 percent of Arkansas' doctors, each of whom has paid three or more malpractice claims, are responsible for 20.3 percent of all payments.

- **Repeat offender doctors suffer few consequences in Arkansas.** The Arkansas state government and the state's health-care providers have done little to rein in those doctors who repeatedly commit negligence. According to the National Practitioner Data Bank and Public Citizen's analysis of NPDB data, disciplinary actions have been few and far between

for Arkansas physicians. Of the 153 physicians in Arkansas who have made two or more payments to patients for malpractice since 1990, only 15 have been disciplined by the Arkansas State Board of Medicine – that is fewer than one out of 10. Moreover, only 14 percent of those doctors who made three or more malpractice payments were disciplined by the Board. A brief description of eight repeat offender doctors is contained in the body of this report.

- **Where's the doctor watchdog?** The Arkansas State Board of Medicine is dangerously lenient with doctors, repeatedly letting serious and sometimes repeat offenders off the hook. In 2001, only 24 doctors in Arkansas had serious sanctions levied against them. Arkansas took 4.18 serious actions per 1,000 doctors – slightly better than the national average, but only half as good as the best performing states and not nearly high enough to prevent bad doctors from practicing. Further, Arkansas is one of 10 states that provides no public information about doctors disciplined by their licensing boards.

- **The spike in medical liability premiums was caused by the insurance cycle, not by "skyrocketing" malpractice awards.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that amounts charged for premiums do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums.

- **Insurer mismanagement compounded the problems.** Underpriced premiums, reckless cash-flow policies, and ill-fated involvement with Enron and asbestos subsidiaries forced one major carrier, the St. Paul Companies, to stop offering malpractice insurance. The company had covered more than 40 percent of Arkansas' doctors. According to a *Wall Street Journal* analysis, St. Paul generated large cash reserves by raising rates during the 1980s, and then released $1.1 billion from reserves between 1992 and 1997 – dramatically boosting its bottom line. This artificial profitability attracted numerous, smaller competitors into the malpractice insurance market and led to widespread price-cutting. By the end of the 1990s, revenue from premiums no longer could cover malpractice claims, causing some companies to collapse and others, like St. Paul, to drop coverage.

Introduction:
Misleading the Public to Escape Responsibility for Negligence

There is no dispute that medical malpractice rates are rising in Arkansas and across the country, in some cases to a considerable degree. No one wants to see doctors forced to pay more to insure themselves against liability, even if they are surgeons earning $500,000 a year.

For the past year, Arkansas business and medical leaders have worked in tandem to make it harder for nearly all consumers to collect compensation when they have been harmed physically or financially. The blending of goals and messages by the Arkansas Medical Society, the Committee to Save Arkansas Jobs, and the U.S. Camber of Commerce shows that this broad campaign has more to do with the bottom-line for businesses than with medical care for patients.[1]

To argue their case, the medical lobby and its allies have resorted to irresponsible rhetoric, castigating "runaway jury awards"[2] and a "litigation lottery mentality."[3] In their campaign to limit patients' legal rights, they have received support from the state Insurance Commissioner, whose newspaper column assailed "the inequities and excesses of our civil justice system,"[4] and a candidate for the U.S. Senate, who appeared before the state Chamber of Commerce to advocate a "cap" on the amounts injured patients can receive.[5]

Lost amid this anti-consumer onslaught was a wealth of data showing that the state's record of lawsuits and verdicts is not extreme, malpractice premiums have been relatively low – and that there is no real crisis in Arkansas.

The American Medical Association added to the false sense of crisis when it included Arkansas on a list of states showing "problem signs" with their medical liability systems. On the same list, however, the AMA included Delaware and Virginia – states that the U.S. Chamber of Commerce ranks first and second among states with the *best* liability systems.[6]

This Public Citizen report shows that the spike in some medical malpractice premiums is an insurance industry pricing and profitability problem – not a litigation problem. This report also exposes the real long-term threats to quality health care in Arkansas: the frequency of medical mistakes, and the lack of practitioner oversight and discipline. And it provides suggestions for averting these problems in the future.

Rather than reducing the real threats that medical care poses to their patients, the doctor's lobby would prefer to shift the costs of injuries onto individuals, their families, voluntary organizations, and taxpayers. This is unfortunate because doctors, patients and consumers should be allies on this issue – not be pitted against each other. Doctors should join with patients and consumers in working to reform the business practices of the insurance industry, rather than blaming the victims and their lawyers; and to better police the very small number of their profession who commit most of the state's malpractice.

Medical Liability Premium Spike Is Caused by the Insurance Cycle and Mismanagement, Not the Legal System

For much of the 1990s, doctors benefited from artificially lower insurance premiums. According to the International Risk Management Institute (IRMI), one of the leading analysts of commercial insurance issues, "What is happening to the market for medical malpractice insurance in 2001 is a direct result of trends and events present since the mid to late 1990s. Throughout the 1990s, and reaching a peak around 1997 and 1998, insurers were on a quest for market share, that is, they were driven more by the amount of premium they could book rather than the adequacy of premiums to pay losses. In large part this emphasis on market share was driven by a desire to accumulate large amounts of capital with which to turn into investment income." IRMI also noted: "Clearly a business cannot continue operating in that fashion indefinitely."[7]

IRMI's findings were buttressed in a recent report by the West Virginia Insurance Commissioner. According to the Insurance Commission, "[T]he insurance industry is cyclical and necessarily competitive. We have witnessed these cycles in the Medical Malpractice line in the mid-'70s, the mid-80s and the present situation. This particular cycle is, perhaps, worse than previous cycles as it was delayed by a booming economy in the '90s and is now experiencing not just a shortfall in rates due to competition, but a subdued economy, lower interest rates and investment yields, the withdrawal of a major medical malpractice writer and a strong hardening of the reinsurance market. Rates will, at some point, reach an acceptable level to insurers and capital will once again flow into the Medical Malpractice market."[8]

Other authoritative insurance analysts and studies indicate that this is a temporary "crisis" unrelated to the legal system:

- **Medical liability premiums track investment results.** J. Robert Hunter, one of the country's most knowledgeable insurance actuaries and director of insurance for the Consumer Federation of America, recently analyzed the growth in medical liability premiums. He found that premiums charged do not track losses paid, but instead rise and fall in concert with the state of the economy. When the economy booms and investment returns are high, companies maintain premiums at modest levels; however, when the economy falters and interest rates fall, companies increase premiums in response.[9]

- **Corporate mismanagement fueled malpractice problems.** Pressure on Arkansas' physician premiums intensified after December 2001, when a major carrier, the St. Paul Arkansas' Insurance Companies, quit the medical liability business. The company had covered 41 percent of all doctors in Arkansas.[10] St. Paul's departure had much less to do with jury awards than with the company's cash flow policies, its disastrous involvement with Enron, and its ill-fated acquisition of two companies that manufactured asbestos products.

Only days before St. Paul discontinued its malpractice business, it reported to the Securities and Exchange Commission (SEC) that it had $84 million of exposure from the Enron collapse and held another $23 million in unsecured Enron debt. In that disclosure to the SEC, St. Paul also listed "a series of actions intended to improve profitability" – foremost of which was the insurance company's plan to "exit its medical malpractice business."[11] In August 2001, St. Paul's quarterly earnings report also warned that it faced liability for incalculable asbestos claims resulting from its ownership of two subsidiaries, Western MacArthur and USF&G.[12] Within the year, St. Paul had agreed to pay $988 million to settle those claims.[13]

Even without these large setbacks, St. Paul had contributed to a catastrophic cycle of low prices and artificially high profits in the malpractice insurance industry. Only a few months before St. Paul withdrew from the market, one industry expert warned that these business practices would inflict "chaos" on the market. "The end result is that premiums must increase, losses must decrease, or the insurer will eventually cease operating," predicted Charles Kolodkin of Gallagher Healthcare Insurance Services.[14] In fact, as St. Paul announced its withdrawal from the Arkansas market, a corporate spokesman told journalists the company had allowed its premiums to remain too low for too long.[15]

And a *Wall Street Journal* investigation into the decline in the medical liability insurance market made these points:

> "[A] price war that began in the early 1990s led insurers to sell malpractice coverage to obstetrician-gynecologists at rates that proved inadequate to cover claims. Some of these carriers had rushed into malpractice coverage because an accounting practice widely used in the industry made the area seem more profitable in the early 1990s than it really was. A decade of short-sighted price slashing led to industry losses of nearly $3 billion last year."[16]

- **The same trends are present in other lines of insurance.** Property/casualty refers to a large group of liability lines of insurance (a total of 30) including medical malpractice, homeowners, commercial, and automobile. The property/casualty insurance industry has exhibited cyclical behavior for many years, as far back as the 1920s. These cycles are characterized by periods of rising rates leading to increased profitability. Following a period of solid but not spectacular rates of return, the industry enters a down phase where prices soften, supply of the insurance product becomes plentiful, and, eventually, profitability diminishes or vanishes completely. In the down phase of the cycle, as results deteriorate, the basic ability of insurance companies to underwrite new business or, for some companies, even to renew some existing policies can be impaired. This is because the capital needed to support the underwriting of risk has been depleted through losses. The current market began to harden in 2001, following an unusually prolonged period of soft market conditions in the property-casualty section in the 1990s. The current hard market is unusual in that many lines of insurance are affected at the same time, including medical malpractice. As a result, premiums are rising for most types of insurance. The increases have taken policyholders by surprise given that they came after several years of relatively flat to decreasing prices.[17]

The Costs of Medical Malpractice to Arkansas' Patients & Consumers vs. Arkansas' Doctors

In 1999, the Institute of Medicine (IOM) estimated that from 44,000 to 98,000 Americans die in hospitals every year from *preventable* medical errors.[18] The IOM also estimated the costs to individuals, their families and society at large for these medical errors at $17 billion to $29 billion a year. These costs include disability and health-care costs, lost income, lost household production and the personal costs of care.

The true impact of medical malpractice in Arkansas should be measured by the cost to patients and consumers, not the premiums paid by doctors to their insurance companies. Extrapolating from the IOM findings, we estimate that there are 418 to 931 preventable deaths in Arkansas each year that are due to medical errors. The costs resulting from preventable medical errors to Arkansas' residents, families and communities is estimated at $161 million to $275 million each year. But the cost of medical malpractice insurance to Arkansas' doctors is $39.7 million a year.[19] [See Figure 1]

Figure 1

418 - 931

Preventable Deaths Due to Medical Errors Each Year

$161 million - $275 million

Costs Resulting from Preventable Medical Errors Each Year

$39.7 million

Cost of Arkansas Doctors' Annual Medical Malpractice Premiums

Sources: Preventable deaths and costs are prorated based on population and based on estimates in To Err is Human, Institute of Medicine, November 1999. Malpractice premiums are based on "Medical Malpractice Net Premium and Incurred Loss Summary," National Association of Insurance Commissioners, July 18, 2001.

Trends in Arkansas Medical Malpractice Premiums, Awards & Claims: Reliable Sources Contradict Doctors

The Arkansas Medical Society likes to claim that malpractice premiums are "skyrocketing" because of "runaway jury awards" and a "litigation lottery mentality." It is easy to be confused by the doctors' claims because the data cited can be misleading. Setting aside the rhetoric, consider the following:

- **Independent statistics indicate Arkansas doctors' liability premiums are among the lowest in the nation.** Malpractice insurance premiums in Arkansas are some of the lowest in all 50 states and the District of Columbia, according to data collected by *Medical Liability Monitor*, an independent industry newsletter. The median premium for a general surgeon practicing in Arkansas in 2002 was $16,400 – about the same amount paid by general surgeons in North Dakota or South Dakota, and higher than those in only four other states (Idaho, Oklahoma, Vermont and Minnesota).[20]

- **Government data show that malpractice payments in Arkansas have increased at a slower pace than national medical costs.** According to the federal government's National Practitioner Data Bank (NPDP), the median medical malpractice payment by an Arkansas physician to a patient rose 48.6 percent between 1992 and 2002, from $87,500 to $130,000 – or less than 5 percent a year. During those same years, medical costs increased by 53.7 percent nationally, or 5.4 percent a year.[21] (Medical costs typically represent the lion's share of most malpractice awards.) Moreover, between 1999 and 2002, the median malpractice payment by an Arkansas physician actually dropped by more than 10 percent.

- **Arkansas' cumulative median malpractice payment has remained less than the national average.** Among the 50 states and the District of Columbia, Arkansas historically has ranked 38th – below the national average – for the median malpractice payment by a physician to a patient. According to the NPDB, the cumulative median malpractice payment from 1991 to 2001 was $90,000 in Arkansas – compared with $100,000 nationally for the same period.[22]

- **The number of Arkansas malpractice lawsuits filed in 2002 was less than in the preceding years.** In each of the past two years – during the purported malpractice "crisis" in Arkansas – the number of malpractice lawsuits filed decreased. In 2002, 371 malpractice cases were filed in Arkansas, compared with 383 in 2001, and 413 in 2000. Overall, this represented a 10 percent decrease in lawsuits filed.[23]

Larger Malpractice Award Payments in Arkansas Have Been the Rare Exception

Physicians have used anecdotal evidence to convince lawmakers and the media that gigantic jury verdicts are commonplace. In Arkansas, the coalition of doctors and business says little about government statistics or long-term trends, but instead relies on sensational headlines generated by an isolated multi-million-dollar award made in June 2001. That verdict, which is still under appeal, was against a nursing home corporation, *not* doctors. But the Arkansas Medical Society's desire to use this case from the town of Mena for political gain was trumpeted by its lobbyist:

> "Tort reform has not been a big issue on the legislative agenda because we've had low malpractice premiums," said Lynn Zeno. "Had Mena happened during the last legislative session, we probably would have a cap on damages in place."[24]

According to the National Practitioner Data Bank, large malpractice award payments have been the rare exception in Arkansas. Arkansas physicians made only two multi-million dollar award payments between 1998 and 2001.[25] The largest was only $2,550,000. The number of large (more than $100,000) malpractice payments in Arkansas remained constant over the past four years, and so has the total amount of malpractice payments – declining from $15.8 million in 1998 to $15.1 million in 2001. [See Figure 2] Adjusting for inflation, this steady level of awards represents a significant decline in dollar value.

Figure 2

Medical Malpractice Payments Over $100,000 in Arkansas, 1998 to 2001

Year	Number of Payments Between $100,000 – $500,000	Number of Payments Between $500,001 – $1,000,000	Number of Payments More Than $1,000,000	Total Dollar Value of Payments
1998	35	6	0	$15,818,750
1999	32	4	0	$12,253,250
2000	34	5	2	$15,897,300
2001	32	7	0	$15,146,750

Source: National Practitioners Data Bank

"Decline" in Physician Numbers Is Fiction

The medical community has warned that the quality of Arkansas' health care is being jeopardized by the threat of lawsuits and high malpractice premiums, which it claims discourage many doctors from practicing in the state. A closer examination of the numbers reveals that there has been no decline in the total number of Arkansas doctors.

- According to the Arkansas State Medical Board, from 1998 to 2002, Arkansas witnessed an increase of 209 doctors who are practicing in state, an average of 52 additional doctors each year.[26] [See Figure 3]

- In 1995, Arkansas had 192 doctors for each 100,000 citizens. By 2001, the ratio was 212 per 100,000, an improvement of 10.4 percent. Nationwide, the doctor-to-population ratio improved by only 7.1 percent during the same period.[27]

Figure 3

Licensed Physicians & Osteopaths with Arkansas Addresses

Year	Licensed Physicians
1998	4987
1999	4950
2000	5034
2001	5128
2002	5196

Source: Arkansas State Medical Board

Repeat Offender Doctors Are Responsible for Almost Half of Medical Malpractice

The insurance and medical community has argued that medical liability litigation constitutes a giant "lottery," in which lawsuits are purely random events bearing no relationship to the care given by a physician. If the tort system is a lottery, it is clearly a rigged one, because some numbers come up more often than others. A small percentage of doctors have attracted multiple claims, and it is these doctors who are responsible for much of the malpractice in Arkansas.

- According to the federal government's National Practitioner Data Bank, which covers malpractice judgments and settlements since September 1990, 2.6 percent of Arkansas' doctors have made two or more malpractice payments to patients.[28] These repeat offender doctors are responsible for 43.7 percent of all payments. Overall, they have paid out $48.9 million in damages. Even more surprising, less than 1 percent of Arkansas' doctors (45), each of whom has paid three or more malpractice claims, are responsible for 20.3 percent of all payments. [See figure 4]

Figure 4

Number of Medical Malpractice Payments and Amounts Paid by Arkansas Doctors 1990 – 2002

Number of Payment Reports	Number of Doctors that Made Payments	Percent/Total Doctors (5,738)	Total Number of Payments	Total Amount of Payments	Percent of Total Number of Payments
All	667	11.6%	915	$131,929,800	100.0%
1	515	8.9%	515	$83,013,750	56.3%
2 or More	152	2.6%	400	$48,916,050	43.7%
3 or More	45	0.8%	186	$17,153,550	20.3%
4 or More	18	0.3%	105	$10,171,250	11.5%
5 or More	10	0.2%	73	$5,208,750	8.0%

Source: National Practitioner Data Bank

Repeat Offenders Suffer Few Consequences

The Arkansas state government and the state's health-care providers have done little to rein in those doctors who repeatedly commit negligence. According to the National Practitioner Data Bank and Public Citizen's analysis of NPDB data, disciplinary actions have been few and far between for Arkansas physicians.

- Of the 153 physicians in Arkansas who have made two or more payments to patients for malpractice since 1990, only 15 have been disciplined by the Arkansas State Board of Medicine – that is fewer than one out of 10. Moreover, only 14 percent of those doctors who made three or more malpractice payments were disciplined by the Board.[29]

The extent to which doctors can commit negligence in Arkansas and not be disciplined is illustrated by the following eight NPDB descriptions of offenders who practice in Arkansas, *none* of whom have been disciplined by the state:

- **Physician Number 986** settled four malpractice lawsuits between 1991 and 1993 involving two incidents of surgery, one medication administration related incident, and failure to obtain consent/lack of informed consent. The damages add up to $287,500.

- **Physician Number 1074** settled four malpractice lawsuits between 1991 and 2001 involving a retained foreign body, three incidents of improper performance of surgery, and improper management of a surgical patient. The damages add up to $912,500.

- **Physician Number 59909** had eight malpractice actions filed against him or her, at least five of which were settled (three were in Arkansas, and five were in Puerto Rico). The actions took place between 1994 and 1998 and involved improper management of a surgical patient, treatment, failure to obtain consent/lack of informed consent, unnecessary surgery, surgery, two incidents of failure to diagnose, improper performance of surgery, and delay in treatment. The damages add up to $977,500.

- **Physician Number 107780** settled four malpractice lawsuits between 1997 and 2000 including diagnosis, failure to diagnose, and two incidents of failure to treat. The damages add up to $1,002,500.

- **Physician Number 122749** settled four malpractice lawsuits and lost two malpractice judgments between 1998 and 2002 involving failure to medicate, two incidents of failure to obtain consent/lack of informed consent, surgery, retained foreign body, and improper performance of surgery. The damages add up to $675,000.

- **Physician Number 907** had four malpractice actions filed against him or her, at least two of which were settled (three took place in Colorado, and one took place in Arkansas). The actions took place between 1992 and 1999 and involved improper performance of surgery, improper management of surgical patient, three incidents of surgery, and delay in treatment. The damages add up to $1,002,500.

- **Physician Number 59454** had four malpractice actions filed against him or her, at least three of which were settled (all four incidents took place in Texas, although the physician was licensed in Arkansas). The actions took place between 1994 and 1999 and involved improper management of a surgical patient, anesthesia – failure to complete patient assessment, two incidents of anesthesia, and surgery. The damages add up to $322,500.

- **Physician Number 14147** settled five malpractice lawsuits between 1993 and 1999 (all incidents took place in Kansas, although the physician was licensed in Arkansas). The cases involved three incidents of improper performance of surgery, treatment, improper management of surgical patient, and surgery. The damages add up to $1,265,000.

Where's the Doctor Watchdog?

In 2001, only 24 doctors in Arkansas had serious sanctions levied against them by the State Medical Board for incompetence, misprescribing drugs, sexual misconduct, criminal convictions, ethical lapses and other offenses, according to an ongoing Public Citizen project that tracks "Questionable Doctors" in Arkansas and other states.[30] Most of these doctors were not required to stop practicing, even temporarily.

The Arkansas State Board of Medicine is dangerously lenient with doctors, repeatedly letting serious and sometimes repeat offenders off the hook.

Nationally in 2001, there were 3.36 serious actions taken for every 1,000 physicians. Although Arkansas ranks among the top third of states when its diligence in taking disciplinary actions is measured – 4.18 serious actions per 1,000 doctors – it is important to emphasize that Arkansas has a great deal of room for improvement.[31] The top states listed in the report discipline doctors twice as often as Arkansas does. Further, Arkansas is one of 10 states that provides no public information about doctors disciplined by their licensing boards, perpetuating a climate of secrecy and mistrust around its disciplinary practices.[32]

Solutions to Reduce Medical Errors and Long-term Insurance Rates

Reducing compensation to victims of medical malpractice does not, as doctors contend, "reduce costs;" it merely shifts the costs of injuries away from dangerous doctors and unsafe hospitals and onto the injured patients, their families, and taxpayers. This, in turn, reduces the incentive to practice medicine with due regard to patient safety. The only way to reduce the cost of medical injuries is to reduce negligence; the best way to accomplish this is by reforming the regulatory oversight of the medical profession. Public Citizen's recommendations for addressing the real medical malpractice problems are:

Implement Patient Safety Measures Proposed by the Institute of Medicine

Public Citizen believes in personal responsibility and accountability for negligence as one of the principal methods for deterring medical errors. Nevertheless, we acknowledge that the "systems approach" to patient safety advocated by the Institute of Medicine shows considerable promise. We are disappointed that some three years after the release of its report, almost nothing has been done to establish mandatory nationwide error reporting systems, identify unsafe practices, or raise performance standards.

- **Medication errors are among the most common preventable mistakes, but safety systems have been put in place in ver few hospitals.** Although experts using the systems approach have identified a number of promising strategies to reduce malpractice, few have been implemented. Experts have estimated that more than 950,000 serious drug errors occur annually in hospitals alone.[33] Recent studies show that computer physician order entry (CPOE) systems can reduce error rates by 55 percent,[34] CPOE is an electronic prescribing system that intercepts errors where they most commonly occur – at the time medications are ordered. Physicians enter orders into a computer, rather than on paper. Orders are automatically checked for potential problems, such as drug interactions or allergies. CPOE also resolves problems associated with deciphering doctors' notoriously bad handwriting. But in spite of these benefits, fewer than three percent of hospitals have fully implemented CPOE.[35]

- **Evidence-based hospital referral could save 4,000 lives every year, but has not been implemented.** Evidence-based hospital referral means directing patients with high-risk conditions to hospitals with characteristics shown to be associated with better outcomes. Dr. Adams Dudley, a researcher at the University of San Francisco at California, identified 10 surgical procedures for which outcomes were strongly related to hospital volume. Using data from California hospitals, he estimated that using evidence-based hospital referral for those 10 procedures would prevent over 4,000 deaths across the U.S. each year.[36]

- **Surgery performed on the wrong part of the body, to the wrong patient, and performing the wrong procedure on a patient are all completely preventable, yet continue to occur.** Such mistakes should *never* happen, according to a special alert reissued December 5, 2001 by the Joint Commission on Accreditation of Healthcare Organizations.[37] To prevent these accidents, the JCAHO recommends the surgical site be marked with a permanent marker. Sometimes referred to as "signing your site," doctors place their initials on the surgical site with a permanent marking pen in a way that cannot be overlooked and then actually operate through or next to the initials. JCAHO also recommends orally verifying the surgery in the operating room just before starting the operation.[38]

Open the National Practitioner Data Bank to Empower Consumers with Information About Their Doctors

Information about doctor discipline, including state sanctions, hospital disciplinary actions and medical malpractice awards is now contained in the National Practitioner Data Bank. HMOs, hospitals and medical boards can look at the National Practitioner Data Bank. Unfortunately, consumers cannot because the names of physicians in the database are kept secret from the public. Congress should lift the veil of secrecy and allow the people who have the most to lose from questionable doctors to get the information they need to protect themselves and their families.

Limit Physicians' Workweek to Reduce Hazards Created by Fatigue

American medical residents work among the highest—if not the highest—number of hours in the professional world. They work up to 120 hours a week, including 36-hour shifts for several weeks at a time.[39] After 24 hours of wakefulness, cognitive function deteriorates to a level equivalent to having a 0.10 percent blood alcohol level.[40] In other words, doctors who would be considered too unsafe to drive may still treat patients for 12 more hours. 41 percent of resident-physicians attribute their most serious mistake in the previous year to fatigue.[41] 45 percent of residents who sleep less than four hours per night report committing medical errors.[42] Working these extreme hours for years at a time also has ill-effects on doctors' own personal health and safety. Multiple studies in the medical literature demonstrate that sleep-deprived and overworked residents are at increased risk of being involved in motor vehicle collisions, suffering from depressed mood and depression, and giving birth to growth-retarded and/or premature infants.[43] If the maximum workweek for residents was limited to 80 hours, it could considerably reduce mistakes due to fatigue and lack of supervision.

Refine the Malpractice Insurance System

The number of classifications of doctor specialties for insurance rating purposes should be reduced to more broadly spread the risk. Risk pools for some are too small and thus overly influenced by a few losses and the concentration in a few specialties of doctors handling the highest risk patients. Often the high-risk patients are "referred up" from general practitioners who do not bear any of the risk.

Improve Oversight of Physicians

Public Citizen has long sought greater consumer access to information about doctors, and there have been recent improvements in making that information available. Most state medical boards now provide some physician information on the Internet, but the information about disciplinary actions varies greatly, is often inadequate and can be difficult for people to access.[44]

For more than a decade, Public Citizen's Health Research Group has been carefully scrutinizing the performance of state medical boards. As reported in our *Questionable Doctors* publication,[45] too little discipline is being done. Too many state medical boards, despite their duty to protect the public, still believe their first responsibility is to rehabilitate "impaired physicians" and shield them from the public's prying eyes. Fewer than one-half of one percent of the nation's doctors face any serious state sanctions each year. 2,708 total serious disciplinary actions a year, the number state medical boards took in 2001, are a pittance given estimates that between 44,000 and 98,000 deaths of hospitalized patients are caused by medical errors annually.

State discipline rates ranged from 10.52 serious actions per 1,000 doctors (Arizona) to 0.73 actions per 1,000 physicians (District of Columbia), a 14.4-fold difference between the best and worst states. If all the boards did as good a job as the lowest of the top five boards, Kentucky's rate of 6.32 serious disciplinary actions per 1,000 physicians, it would amount to a total of 5,089 serious actions a year. That would be 2,381 more serious actions than the 2,708 that actually occurred in 2001. It is likely that patients are being injured or killed more often in states with poor doctor disciplinary records than in states with consistent top performances.

Negligent doctors are rarely disciplined with loss or suspension of their license for inferior care. Instead, state medical boards focus on more easily documentable offenses such as prescription drug violations and fraud convictions or disciplinary action in another state as potential indicators of substandard care. Congress could encourage better oversight through grants to state medical boards, tied to the boards' agreements to meet performance standards. The following state reforms would help protect patients:

- **Reform medical board governance.** States should sever any remaining formal, debilitating links between state licensing boards and state medical societies. Members of medical boards (and separate disciplinary boards, where present) should be appointed by the governor, and the governor's choice of appointees should not be limited to a medical society's nominees. At least 50 percent of the members of each state medical board and disciplinary board should be well-informed and well-trained public members who have no ties to health care providers and who, preferably, have a history of advocacy on behalf of patients. The governor should appoint members to the Medical Board whose top priority is protecting the public's health, not providing assistance to physicians who are trying to evade disciplinary actions.

- **Beef up medical board funding and staffing.** State legislatures should permit medical boards to spend all the revenue from medical licensing fees, rather than being forced to give part to the state treasury. The medical boards should raise their fees to $500 a year. All boards could benefit from hiring new investigators and legal staff. Boards should employ adequate staff to process and investigate all complaints within 30 days, to review all malpractice claims filed with the board, to monitor and regularly visit doctors who have been disciplined to ensure their compliance with the sanctions imposed, and to ensure compliance with reporting requirements. They should hire investigators to seek out errant doctors, through review of pharmacy records, consultation with medical examiners, and targeted office audits of those doctors practicing alone and suspected of poor care.

- **Require risk prevention.** States should adopt a law, similar to one in Massachusetts, that requires all hospitals and other health care providers to have a meaningful, functioning risk prevention program designed to prevent injury to patients. Massachusetts also requires all adverse incidents occurring in hospitals or in doctors' offices to be reported to the medical board.

- **Require periodic recertification of doctors based on a written exam and audit of their patients' medical care records.**

[1] Press release, Arkansas Medical Society, "Business Coalition Joins Medical Society's Tort-Reform Efforts," Jan. 8, 2003; and Tim Pickens, "Tort Reform Allows Better Access to Courts," *Arkansas Democrat-Gazette*, Jan. 12, 2003.
[2] Jill Bayles, "Premiums, Verdicts Fuel Fight for Tort Reform," *Arkansas Business*, Jan. 13, 2003. Reprinted from the *Journal of the Arkansas Medical Society*.
[3] Michael Rowett, "Senate Hopefuls Address State Chamber," *Arkansas Democrat-Gazette*, Oct. 19, 2002.
[4] Tim Pickens, "Tort Reform Allows Better Access to Courts," *Arkansas Democrat-Gazette*, Jan. 12, 2003.
[5] Id.
[6] U.S. Chamber of Commerce State Liability Systems Ranking Study, Jan. 11, 2002.
[7] Charles Kolodkin, "Medical Malpractice Insurance Trends? Chaos!" International Risk Management Institute. http://www.irmi.com/expert/articles/kolodkin001.asp
[8] "State of West Virginia Medical Malpractice Report on Insurers with over 5 percent Market Share," Office of the West Virginia Insurance Commission, November 2002.
[9] Americans for Insurance Reform, "Medical Malpractice Insurance: Stable Losses/Unstable Rates," Oct. 10, 2002. See also: http://www.insurance-reform.org/StableLosses.pdf.
[10] Tanya Albert, "How much did it hurt," *American Medical News*, July 2002.
[11] St. Paul Companies Inc., SEC form 8-K, Item 5. Other Events and Regulation FD Disclosure, Edgar Online, Dec. 19, 2001.
[12] St. Paul Companies Inc., Quarterly Report, SEC form 10-Q, Aug. 14, 2001.
[13] Charles E. Boyle, "The St. Paul Agrees to Pay $988 Million in Asbestos Settlement," *Insurance Journal*, June 24, 2002.
[14] Charles Kolodkin, "Medical Malpractice Insurance Trends? Chaos!" International Risk Management Institute, September 2001.
[15] Mary Hargrove, "Tort reform: Collision of Values," *Arkansas Democrat-Gazette*, Oct. 6, 2002; and Jake Bleed, "Arkansas Doctors Feel the Pinch," *Arkansas Democrat-Gazette*, Feb. 5, 2002.
[16] Rachel Zimmerman and Christopher Oster, "Insurers' Missteps Helped Provoke Malpractice 'Crisis,'" *Wall Street Journal*, June 24, 2002.
[17] "Hot Topics & Insurance Issues," Insurance Information Institute, www.iii.org
[18] To Err is Human, Building a Safer Health System, Institute of Medicine, 1999, p. 26-27.
[19] "Medical Malpractice Net Premium and Incurred Loss Summary," National Association of Insurance Commissioners, July 18, 2001.
[20] "Trends in 2002 Rates for Physicians' Medical Professional Liability Insurance," *Medical Liability Monitor* special report, October 2002.
[21] Public Citizen calculation of median awards based on National Practitioner Data Bank, Annual Reports, Sept. 1, 1990 – Sept. 30, 2002. The National Practitioner Data Bank (NPDB) is the most comprehensive source of information about a physician. It is the only database that collects information on both physician disciplinary proceedings and malpractice claim payments. The names of individual physicians are not made available to the public.
[22] Public Citizen calculation of median awards based on National Practitioner Data Bank, Annual Reports, September 1990 – September 2001.
[23] Arkansas Office of Courts, 2002.
[24] Mary Hargrove, "Tort reform: Collision of Values," *Arkansas Democrat-Gazette*, Oct. 6, 2002.
[25] National Practitioner Data Bank, Annual Reports, Sept. 1, 1990 – Sept. 30, 2002.
[26] Arkansas State Medical Board, 2002. Medical Board records do not cover the years preceding 1998.
[27] Interview with Derek Smart, American Medical Association, Jan. 24, 2003.
[28] National Practitioner Data Bank, Annual Reports, Sept. 1, 1990 – Sept. 30, 2002.
[29] National Practitioner Data Bank, Annual Reports, Sept. 1, 1990 – Sept. 30, 2002.
[30] "Public Citizen's database is available at http://www.questionabledoctors.org/.
[31] "Questionable Doctors," Public Citizen's Health Research Group, 2002; see at: www.questionabledoctors.org.
[32] "Problem' Doctors Often Not Reported; HMOs fail to inform government of all disciplinary actions," Associated Press, May 29, 2002.
[33] Birkmeyer JD, Birkmeyer CM, Wennberg, DE Young MP, "Leapfrog Safety Standards: Potential benefits of universal adoption." The Leapfrog Group. Washington, DC: 2000. Available at: http://www.leapfroggroup.org/PressEvent/Birkmeyer_ExecSum.PDF.

[34] Bates DW, Leape LL, Cullen DJ, Laird N, et al. *Effect of computerized physician order entry and a team intervention on prevention of serious medical errors*. *JAMA*. 1998;280:1311-6.
[35] Sandra G. Boodman, "No End to Errors," *Washington Post*, Dec. 3, 2002.
[36] Birkmeyer JD. High-risk surgery – follow the crowd." *JAMA*. 2000; 283:1191-3; See also Dudley RA, Johansen, KL, Brand R, Rennie DJ, Milstein A. "Selective Referral to High Volume Hospitals: Estimating Potentially Avoidable Deaths." *JAMA*. 2000; 283: 1159-66.
[37] "A follow-up review of wrong site surgery," JCAHO, *Sentinel Event Alert*, Issue 24, Dec. 5, 2001.
[38] *"Joint Commission Issues Alert: Simple Steps By Patients, Health Care Practitioners Can Prevent Surgical Mistakes."* See JCAHO web site: http://www.jcaho.org/news+room/press+kits/joint+commission+issues+alert+simple+steps+by+patients,++health+care+practitioners+can+prevent+surg.htm
[39] American Medical Student Association, *Fact Sheet, Support H.R. 3236 limiting resident-physician work hours*; *See also:* http://www.amsa.org/hp/rwhfact.cfm.
[40] Id.
[41] Id.
[42] Id.
[43] Public Citizen, "Petition to the Occupational Safety and Health Administration requesting that limits be placed on hours worked by medical residents" (HRG Publication #1570), April 30, 2001; See also*:* http://www.citizen.org/publications/release.cfm?ID=6771.
[44] See http://www.citizen.org/publications/release.cfm?ID=7168
[45] www.questionabledoctors.org