

# eNeonatal Review

Jointly presented by the Johns Hopkins University School of Medicine and the Institute for Johns Hopkins Nursing

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## JANUARY 2006 VOLUME 3, NUMBER 5

### In this issue...

"Medical malpractice" — two words that affect every aspect of every physician's practice. In our specialty, independent of clinical skills, most NICU physicians can expect to be sued for malpractice if they just practice long enough. These malpractice suits affect clinical practice patterns (e.g. "defensive medicine"), selection of a practice location (e.g. a "crisis" state vs. a "non-crisis" state), and ultimately practice income.

In this issue we examine aspects of this current medical malpractice "crisis", and review many of the reform options that have been proposed to improve the system.

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### This Issue

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Joseph Vitterito, MD  
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**Learning Objectives**

The Johns Hopkins University School of Medicine and The Institute for Johns Hopkins Nursing take responsibility for the content, quality, and scientific integrity of this CE activity.

**At the conclusion of this activity, participants should be able to:**

- Describe the frequency of malpractice claims among neonatologists and obstetricians and the "risk factors" of malpractice filings based on patient, unit and provider characteristics.
- Discuss the impact that the malpractice crisis is having upon clinical practice.
- Critically evaluate the "fairness" of some of the reform options being proposed.

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**Length of Activity**

1.0 hour

**Expiration Date**

January 15, 2007

**Next Issue**

February 15, 2006

**Commentary**

Neonatologists in the United States are in the midst of a nationwide medical malpractice "crisis" that has broad economic and non-economic ramifications on both the medical profession and on patients and families. Some physicians are having difficulty obtaining affordable malpractice insurance coverage, some have limited their exposure to high-risk patients, some have relocated to states with "fairer" laws, others have abandoned the practice of neonatal medicine altogether. The impact of this crisis on practice style is reflected in the widespread use of the "defensive medicine" techniques documented by Studdert, while the effects upon specialist supply and access to care are analyzed by Mello et al.

The Chauhan article reports that a typical obstetrician in the US can expect at least two malpractice claims during his/her career, with a higher risk for male obstetricians than for females. Traditionally, neonatologists have not been sued as often as obstetricians; still, according to Meadow, at least 60% of neonatologists in practice for greater than 15 years have been sued at least once (interestingly, Meadow did not find an increased risk of lawsuits among male neonatologists). The work of Mangurten and colleagues identifies the common factors for suits arising from the NICU care as:

1. increased unit growth,
2. parental perceptions of negligence, and
3. full-term infants with a diagnosis associated with neurological injury.

Preferred approaches to preventing of malpractice suits include fostering strong doctor-patient relationships with honest communication and acknowledgement of medical mistakes. Other clinical error reduction strategies (e.g. computerized drug ordering) for NICUs are being developed. However, despite our best efforts, some adverse events and adverse clinical outcomes will always occur.

In theory, various institutional mechanisms should provide ample opportunities to review the quality of the clinical care provided in cases associated with an adverse outcome. State Boards of Medicine, health care insurers, hospital credentialing systems, and hospital Quality Assurance reviews all monitor a neonatologist's pattern of care and evaluate cases with adverse outcomes. Yet it is rare for these systems to impose any punitive action against a practitioner - even those practitioners with a disproportionate number of adverse

outcomes or with a history of repeated acts of proven negligence. Additionally, even if these systems were to reprimand an individual health care provider for an act of negligence, they are not empowered to compensate the injured patient.

Therefore, the medical malpractice legal system remains the primary means to assess the quality of care an injured individual has received, to leverage sanctions against a negligent provider, and to compensate injured patients if the injury was indeed caused by an act of negligence. While the current medical malpractice system will most likely remain a part of our profession, there are problems inherent in it that present many opportunities for reform and improvement. Mehlman discusses the importance of "fairness" in formulating such reforms, and summarizes the various reform options that have been proposed.

Neonatal care providers are encouraged to understand the scope of this medical malpractice problem, the impact it has upon the clinical practice of medicine and the care they provide to their patients, and the implications of the proposed malpractice system reforms.

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## RISK FACTORS ASSOCIATED WITH MALPRACTICE IN THE NICU

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**Mangurten HH, Angst DB, See C, Boyle D, Beckman S.**

Professional Liability in a Neonatal Intensive Care Unit: A Review of 20 Years' Experience. *J Perinat* 2000;4:244-248

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In order to characterize and quantify the risk factors associated with malpractice in a neonatal unit, Mangurten et al undertook a retrospective review of malpractice claims in neonatology. The study reviewed all malpractice claims in one Level III NICU from 1972 to 1992, stratifying the data into three epochs coincident with the increase of available beds in the unit: 1972-1974 (7 beds); 1975-1979 (16 beds); and 1980-1992 (36 beds). The cases associated with 31 claims out of 9367 total NICU admissions were analyzed along with parent depositions using a standardized data retrieval form. The analysis categorized family demographics, labor and delivery information, the diagnoses, general data, and outcomes of the infants, and legal information, including reasons for legal action.

The authors found the overall incidence of legal action to be 3.3/1000 admissions (0.33%). Although there was a greater incidence in malpractice claims with an increase in the size and complexity of the unit, the difference was not considered statistically significant. The study further describes the primary characteristics associated with legal claims to be (1) an infant who was full-term, (2) an infant with one or more diagnoses associated with a possibility of impaired mental capacity and permanent disability, and (3) family demographics consistent with being white, English-speaking, and privately insured. Additionally, the family's perception of negligent care - specifically the notions of misdiagnosis, treatment done erroneously or with delay, or equipment problems - was found to have a role in initiation of legal action.

With an increasing incidence of malpractice suits worldwide (apart from cases of true negligence, as the authors note), the physician-to-patient/family relationship is an essential component in modifying the parents' intent to instigate a malpractice claim. This study emphasizes the continuing need to further enhance genuine care and facilitate communication and open discussions with parents, especially in cases where the outlook may be associated with long-term morbidity and/or poor neurological outcomes.

## MALPRACTICE EXPERIENCE IN THE NICU

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**Meadow W, Bell A, Lantos J.**

Physicians' Experience with Allegations of Medical Malpractice in the Neonatal Intensive Care Unit. *Pediatrics* 1997;99(5):E10.

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Meadow et al sought to provide a reference from which trends in litigation may be studied by characterizing allegations of malpractice by NICU physicians using subjective recollection. This 1997 study takes a novel approach compared to prior chart-review focused studies<sup>1</sup> by surveying physicians directly about their experiences.

The authors define three models or hypotheses of malpractice:

1. the **"evil-doer"** model, i.e. those physicians who consciously practice medicine in unethical or unprofessional manner. An example is a physician that makes numerous medical mistakes because of a chemical dependency.
2. the **"evil-deed"** model, comprising the rare and random case of true malpractice. As an illustrative example: a physician orders 8.5 mg of a medication, the nurse doesn't see the decimal point and gives 85 mg, and the patient then suffers an overdose. While most people would consider this to be an "honest mistake", it is a mistake nonetheless, and the patient deserves compensation for this act of malpractice.
3. the **"evil-outcome"** model describes those malpractice cases resulting from improper expectations of outcomes; e.g. the bad outcomes that may or may not be related to the actual care obtained. For example, despite all appropriate care, a 600 gram preterm infant does not survive. Although there was no act of negligence causing the death, the outcome did not meet the expectation of the family, and the family sues for malpractice.

Meadow's group contacted 2498 neonatologists; 1813 completed a questionnaire focused on demographics, malpractice experience, and views on perceived motives of the malpractice system. Among the results of the survey:

- 43% of physicians reported experience with at least one malpractice claim.
- The probability of experiencing a claim increased with the number of years in practice - 60% of neonatologists in practice for greater than 15 years had experienced at least one malpractice lawsuit.
- Male and female practitioners were equally likely to be sued.
- Neonatologists in community settings had a higher probability of a malpractice claim than their university-based counterparts.

Evaluation of the physicians' feelings about malpractice revealed NICU physicians believe most cases of malpractice action do not represent true malpractice, most allegations are not reasonable, the current system is not effective in identifying true malpractice cases, and that malpractice cases have an injurious effect on health care. It should be noted that none of these parameters was significantly associated with whether or not a respondent had been sued. The physicians surveyed were also able to identify and rank six causes of true malpractice and ranked the two most common causes of filed malpractice lawsuits as poor outcomes and conflict of information. The study further reported that physicians believed approximately 80% of malpractice claims were inappropriate, and that 80% of true malpractice events escaped detection of the legal system.

The compiled data describing the connection between malpractice allegations and true physician malpractice refutes the assumption that malpractice allegations will serve to identify "evil-doers". These data, when adjusted for years in practice, also demonstrate the absence of a connection between the probability of a malpractice allegation and provider gender.

Based on their data, the authors speculate that a positive change in the malpractice system (as defined by fewer inappropriate law suits) will not be achieved by better training physicians in their specialties or by producing a more empathetic role as care provider. Instead, they conclude that malpractice allegations tend to be somewhat random events with the potential for large financial payouts. In that sense they function like a lottery, albeit a lottery with extensive social, personal, and economic consequences.

#### References:

1. Brennan TA, Leape LL, Laird NM, [Incidence of adverse events and negligence in hospitalized patients. Results of the Harvard Medical Practice Study I.](#) *N Engl J Med* 1991; 324:370-376

## ANALYSIS OF OB-GYN PROFESSIONAL LIABILITY CLAIMS

Chauhan SP, Chauhan VB, Cowan BD, Hendrix NW, Magann EF, Morrison JC.

Professional Liability Claims and Central Association of Obstetrician and Gynecologists Members: Myth versus Reality. *Am J Obstet Gynecol* 205;192:1826-1828.

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To investigate the belief among members of the American College of Obstetricians and Gynecologists (ACOG) that litigation is prevalent and awards plentiful, Chauhan et al designed a survey to correlate the prevalence of claims and the characteristics of those against whom claims have been filed.

Working with the 897 member Central Association of Obstetricians and Gynecologists (CAOG) - the authors explain their overall findings are likely applicable to the physicians of the ACOG because of demographic similarities of the memberships - Chauhan et al gathered demographic data, types of clinical cases and respective outcomes, insurance information including cost, and the professional change that any physician may have made as a result of a lawsuit. (Additionally, although the findings were not reported in this article, the respondents ranked on a five point scale the degree of stress reaction to litigation.) Seventy-six percent (682) of the membership responded to the computer-coded survey; 658 of those responses were complete and summarized for this study. Most of the respondents were white and male, with a median age of 58 years and a median practice experience of 26 years. Twenty-two percent of the participants were claim-free. The median number of claims was two per clinician.

The study identified the five most common causes of claims as:

1. neonatal brain damage;
2. gastrointestinal or genitourinary injury;
3. fetal death;
4. missed diagnosis of cancer; and,
5. patient death.

Further analysis of the data revealed the lack of a strong relationship between physician demographics and the number of claims; severity of injury vs settlement reward; and cost of insurance and trial verdict/settlement amount. However, malpractice cases that lasted longer in litigation generally had higher settlement costs. Significant in the case-control sub-analysis were the observations that female physicians were more likely to be claim-free, have cases dismissed or dropped, and as a whole had a lower mean number of claims. Interestingly, the verdicts at trial for the male and female groups were similar.

In summary, this study found a smaller number of litigation claims against the respondents than the authors had anticipated, and that, apart from true negligence, neither practice patterns nor physician demographics were good predictors of malpractice claims or settlement outcomes. The case-control analysis findings warrant further research to better understand the lower litigation risk of female obstetrician-gynecologists.

## PRACTICING DEFENSIVE MEDICINE AS A RESULT OF MALPRACTICE CONCERNS

Studdert DM, Mello MM, Sage WM, DesRoches CM, Peugh J, Zapert K, Brennan TA.

Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment. JAMA 2005;293:2609-2617

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Changing clinical behavior due to the reasonable concern of malpractice liability is deemed "defensive medicine", and may include adding superfluous tests, treatments, and referrals, and/or refusing to care for certain patients. For the purposes of this study, Studdert et al defined "assurance behavior" or "positive defensive medicine" as adding medical services to reduce adverse outcomes, and "avoidance behavior" or "negative defensive medicine" as a physician's attempt to steer clear of cases fraught with malpractice risk. The authors present a qualitative study reviewing physicians' practice of defensive medicine in the high-risk fields of emergency medicine, general surgery, orthopedic surgery, neurosurgery, obstetrics and gynecology, and radiology in a climate of high liability premiums.

The researchers queried physicians in the aforementioned fields in Pennsylvania, a state greatly affected by malpractice claims and rising premiums. The survey, completed by 65% (824) of the 1333 physicians contacted, questioned practitioners about decision making, liability insurance, malpractice experience, and demographics. The physicians rated the frequency (never, rarely, sometimes or often) of how malpractice concerns altered both assurance and avoidance behaviors, specifically defined as:

### Assurance behaviors:

- ordering more tests than necessary
- prescribing medicines not indicated
- suggesting unnecessary referrals to specialists
- suggesting unnecessary procedures

### Avoidance behaviors:

- avoiding procedures or intervention
- avoiding high-risk patients

For those participants who recorded avoidance behaviors, an additional open-ended question provided an opportunity to be more descriptive.

Of those surveyed, 88% had previously been sued and 51% had been dropped from an insurance carrier. 93% of the physicians stated they sometimes or often practice at least 1 out of the 6 forms of defensive medicine (assurance and/or avoidance behaviors as above). 42% of the physicians had restricted their clinical practice secondary to malpractice risk concerns. While assurance behavior practices were prevalent in all specialties, the most common clinical scenario cited as a reason for defensive medicine was cancer detection (to assure the avoidance of a missed cancer diagnosis). Avoidance behaviors, though present, were less prominent among the overall group surveyed. Furthermore, additional descriptive analyses demonstrated those physicians lacking confidence in their liability coverage and those with perceptions of premium burdens were more apt to practice defensive medicine.

In summary, this study characterizes the acts of defensive medicine in high-risk specialties in a region of the country especially burdened with malpractice pressures. The study confirms that physicians' practices are oftentimes influenced by the trends in litigation, perceptions of the inadequacies of their own insurance liability coverage, and insurance premium loads. The authors assert that these acts of defensive medicine in response to the threat of litigation have an impact on the quality of delivered care — including cost to the patient in form of pain and the expenses and additional risks associated with otherwise unnecessary tests, as well as direct social, economic, and psychological consequences on the physician — and urge continuing educational efforts aimed at physicians and patients to decrease these defensive practices.

## PHYSICIAN SUPPLY AND PRACTICE CHANGES DUE TO MALPRACTICE CONCERNS

Mello MM, Studdert DM, DesRoches CM, Peugh J, Zapert K, Brennan TA, Sage WM.

Effects of a Malpractice Crisis on Specialist Supply and Patient Access to Care. *Ann Surg* 2005;242:621-628.

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Anecdotal experience has shaped the concept of a "physician exodus" from areas in the country saturated with high malpractice burdens. This idea promotes the belief that a "malpractice crisis" has driven physicians, mainly specialists, to move, change, or even close their practices. Theoretically, this effect can limit the local availability of physicians and negatively impact patient access to diverse medical care. Mello et al investigated these theories in both the region surrounding Philadelphia — an area identified as heavily affected by rising malpractice costs and high physician turnover secondary to medical malpractice claims — as well as in all Pennsylvania counties.

A survey of physicians was conducted in six fields particularly affected by malpractice charges: general surgery, neurosurgery, orthopedic surgery, obstetrics/gynecology, radiology, and emergency medicine. Using a questionnaire directed at a random sample of Pennsylvania physicians from these specialties who were active in patient care, the authors sought data describing malpractice experience, demographics, changes in the physicians' practices (including relocating or closing the practice), and the respondents' own thoughts about specialist supply and access to care.

The findings demonstrated 12% of specialists "very likely", 17% "somewhat likely", and 4% "definitely sure" to relocate their practice within the two years after the study because of malpractice insurance costs (in addition to effects of managed care reimbursement). Up to a third of the respondents indicated that they were likely to retire early, stop direct patient care, or restrict their scope of practice (especially the perceived high-risk aspects of practice). Physicians in practice by themselves were more inclined to change practice or relocate; early retirement was also a prevalent option for solo practitioners (although, the authors note, this may be due to the fact that solo practitioners tended to be older).

The respondents also described changes they believed that either their practices or hospitals could make to counteract liability cost increases. As many as 50% of the respondents mentioned avoiding high risk patients (e.g. obese patients and high risk pregnancies), restricting new patients (especially those with unfavorable insurance reimbursement), and selecting for patients from insurance plans with greater reimbursement. Insurance costs were considered the main factor by 80% of the respondents for the reduced supply of specialists and restricted patient access to care in the "high risk" geographic areas. Only 20% of the respondents attributed reimbursement rates as the primary factor for this problem.

Though this study demonstrated that practice changes and relocation will likely decrease the supply of specialists, the magnitude of possible change is less than had been reported previously<sup>1,2</sup>. As perceived by the physicians in this study, a redistribution in the supply or overall concentration of services to central, larger centers (for example, academic centers) and away from malpractice "crisis" areas may affect access to care. The risks and costs of liability and subsequent constraints placed on physicians continue to affect patient care, requiring further studies to more specifically quantify this problem.

### References:

1. Hammond CB. [Who Will Deliver America's Babies?](#) Remarks on HR5, the HEALTH Act of 2003. February 6, 2003.
2. Pennsylvania Orthopedic Society. [Physician Exodus and Malpractice Insurance Availability Survey](#), 2002

## ASSESSING THE "FAIRNESS" OF MALPRACTICE REFORM OPTIONS

Mehlman MJ.

Malpractice Reforms: Are They Fair? Clinics Perinatol 2005;32:235-249.

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Mehlman et al present an academic evaluation of some of the various malpractice reform options that have been proposed. These evaluations are based on the concept of "fairness" — "fairness" in achieving adequate compensation to harmed patients, in deterring poor quality medical care, in punishing providers who commit malpractice — while maintaining affordable malpractice insurance and access to care. "Fairness", as defined by the authors, also requires legal procedures that assure protection of the legal rights of both the injured patient and the defendant provider; the system must produce fair outcomes, employ rules acceptable to both parties, offer meaningful representation to all parties, provide scientifically sound decisions, and employ neutral and impartial decision-makers.

Among the actual and suggested malpractice reforms subjected to the authors' "fairness" analysis and found to be fair were: changing from a lump sum payment to periodic payments, tightening the regulation of insurers, deterring frivolous claims, and limiting attorney contingency fees (assuming patients can still receive adequate representation). Further, the establishment of practice guidelines to determine when a provider has acted negligently were considered fair only if they were developed without the bias of creating the least stringent guidelines to purposely avoid liability. Scheduling damages (to consistently provide the same payment for a given diagnosis) was also evaluated as fair as long as patients received, on average, compensation amounts equal to what the current system awards.

The use of expert screen panels was found to be unfair because decision-makers are commonly neither neutral nor impartial. The authors found that many patients feel there is a bias for physician panel members to unfairly favor other physicians. Reducing the statute of limitations was also evaluated as unfair because it would prevent filing of some meritorious claims.

Caps on non-economic damage, such as those for pain and suffering, also did not pass the authors' "fairness" test. These caps disproportionately impact several patient groups such as the young (who have much longer to live and to experience pain and suffering, yet receive the same amount as an elderly individual with a terminal illness) and women (who tend to establish lesser amounts of economic harm than men). In addition, most proposed caps are "flat" (i.e. providing the same maximum payment regardless of the degree of injury); here the authors propose a sliding scale with larger amounts allowed for more severe injury as more likely to achieve fairness. Finally, some caps (such as those used in California since 1975) have not been adjusted for inflation and may be inappropriate in today's economy.

Certain systematic reform options were considered fair only if properly implemented. One example the authors note is the establishment of alternate dispute resolution services such as mediation and arbitration - these

systems achieve fairness only when they are voluntary and non-binding. Establishment of workers compensation-type or no-fault systems can also be achieved in a fair manner as long as they do not reduce the amount of compensation victims would on average receive from the current system. Other examples of no-fault systems established in a fair manner are those in Virginia and Florida for birth-related injuries.

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### **Learning Objectives · [back to top](#)**

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- Describe the frequency of malpractice claims among neonatologists and obstetricians and the "risk factors" of malpractice filings based on patient, unit and provider characteristics.
- Discuss the impact that the malpractice crisis is having upon clinical practice.
- Critically evaluate the "fairness" of some of the reform options being proposed.

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- Dr. Noguee has indicated a financial relationship of grant/research support with Forest Laboratories and has received an honorarium from Forest Laboratories.
- Dr. Lawson has indicated a financial relationship of grant/research support from the NIH. He also receives financial/material support from Nature Publishing Group as the Editor of the Journal of Perinatology.
- Dr. Lehmann has indicated a financial relationship with Eclipsys Corporation.

All other faculty have indicated that they have not received financial support for consultation, research, or evaluation, nor have financial interests relevant to this e-Newsletter.

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