

RISKY MEDICINE, PART 1

Medical malpractice: Its evolution to today's risk of the “big verdict”

Those who practice unreasonably risky medicine are few and far between, but they drive up medical malpractice claims paid as well as insurance rates for all. A look at how we have evolved to today's medical malpractice climate.

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Medical malpractice (more formally, professional liability, but we will use the term malpractice) has been of concern to ObGyns for many years, and for good reasons. This specialty has some of the highest incidents of malpractice claims, some of the largest verdicts, and some of the highest malpractice insurance rates. We look more closely at ObGyn malpractice issues in a 3-part “What's the Verdict” series over the next few months.

In part 1, we discuss the background on malpractice and reasons why malpractice rates have been so high—including large verdicts and lawsuit-prone physicians. In

the second part we will look at recent experience and developments in malpractice exposure—who is sued and why. Finally, in the third part we will consider suggestions for reducing the likelihood of a malpractice lawsuit, with a special focus on recent research regarding apologies.

Two reports of recent trials involving ObGyn care illustrate the risk of “the big verdict.”^{1,2} (Note that the following vignettes are drawn from actual cases but are outlines of those cases and not complete descriptions of the claims. Because the information does not come from formal court records, the facts may be inaccurate and are incomplete; they should be viewed as illustrations only.)



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CASE 1 Delayed delivery, \$19M verdict

At 39 weeks' gestation, a woman was admitted to the hospital in spontaneous labor. Artificial rupture of membranes with clear amniotic fluid was noted. Active contractions occurred for 11 hours. Oxytocin was then initiated, and 17 minutes later, profound fetal bradycardia was detected. There was recurrent evidence of fetal distress with meconium. After a nursing staff change a second nurse restarted oxytocin for a prolonged period. The physician allowed labor to continue despite fetal distress, and performed a cesarean delivery (CD) 4.5 hours later. Five hours postdelivery the neonate was noted to



have a pneumothorax, lung damage, and respiratory failure. The infant died at 18 days of age.

The jury felt that there was negligence—failure to timely diagnose fetal distress and failure to timely perform CD, all of which resulted in a verdict for the plaintiff. The jury awarded in excess of \$19 million.¹

CASE 2 An undiagnosed tumor, \$20M verdict
A patient underwent bilateral mastectomy.

Following surgery, she reported pain and swelling at the surgical site for 2 years, and the defendant physician “dismissed” her complaint, refusing to evaluate it as the provider felt it was related to scar tissue. Three years after the mastectomies, the patient underwent surgical exploration and removal of 3 ribs and sternum secondary to a desmoid tumor. Surgical mesh and chest reconstruction was required, necessitating long-term opioids and

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sleeping medications that “will slow her wits, dull her senses and limit activities of daily living.” Of note, discrepancies were found in the medical records maintained by the defendant. (There was, for example, no report in the record of the plaintiff’s pain until late in the process.) The plaintiff based her claim on the fact that her pain and lump were neither evaluated nor discovered until it was too late.

The jury awarded \$20 million. The verdict was reduced to \$2 million by the court based on state statutory limits on malpractice damages.^{2,3}

Medical malpractice: Evolution of a standard of care

Medical malpractice is not a modern invention. Some historians trace malpractice to the Code of Hammurabi (2030 BC), through Roman law,⁴ into English common law.⁵ It was sufficiently established by 1765 that the classic legal treatise of the century referred to medical malpractice.^{6,7} Although medical malpractice existed for a long time, actual malpractice cases were relatively rare before the last half of the 20th century.⁸

Defensive medicine born out of necessity. The number of malpractice cases increased substantially—described as a “geometric increase”—after 1960, with a 300% rise between 1965 and 1970.^{7,9} This “malpractice maelstrom of the 70s”⁷ resulted in dramatic increases in malpractice insurance costs and invited the practice of defensive medicine—medically unnecessary or unjustified tests and services.¹⁰ Although there is controversy about what is defensive medicine and what is reasonably cautious medicine, the practice may account for 3% of total health care spending.¹¹ Mello and others have estimated that there may be a \$55 billion annual cost related to the medical malpractice system.¹²

Several malpractice crises and waves of malpractice or tort reform ensued,¹³ beginning in the 1970s and extending into the 2000s.¹¹ Malpractice law is primarily a matter of state law, so reform essentially has been at the state level—as we will see in the second part in this series.

Defining a standard of care

Medical malpractice is the application of standard legal principles to medical practice. Those principles generally are torts (intentional torts and negligence), and sometimes contracts.¹⁴ Eventually, medical malpractice came to focus primarily on negligence. The legal purposes of imposing negligence liability are compensation (to repay the plaintiff the costs of the harm caused by the defendant) and deterrence (to discourage careless conduct that can harm others.)

Negligence is essentially carelessness that falls below the acceptable standard of care. Negligence may arise, for example, from¹⁵:

- doing something (giving a drug to a patient with a known allergy to it)
- not doing something (failing to test for a possible tumor, as in the second case above)
- not giving appropriate informed consent
- failing to conduct an adequate examination
- abandoning a patient
- failing to refer a patient to a specialist (or conduct a consultation).

(In recent years, law reforms directed specifically at medical malpractice have somewhat separated medical malpractice from other tort law.)

In malpractice cases, the core question is whether the provider did (or did not) do something that a reasonably careful physician would have done. It is axiomatic that not all bad outcomes are negligent. Indeed, not all mistakes are negligent—only the mistakes that were unreasonable given all of the circumstances. In the first case above, for example, given all of the facts that preceded it, the delay of the physician for 4.5 hours after the fetal distress started was, as seen by the jury, not just a mistake but an unreasonable mistake. Hence, it was negligent. In the second case, the failure to investigate the pain and swelling in the surgical site for 2 years (or failure to refer the patient to another physician) was seen by the jury as an unreasonable mistake—one that would not have been made by a reasonably careful practitioner.

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The big verdict

Everyone—every professional providing service, every manufacturer, every driver—eventually will make an unreasonable mistake (ie, commit negligence). If that negligence results in harming someone else, our standard legal response is that the negligent person should be financially responsible for the harm to the other. So, a driver who fails to stop at a red light and hits another car is responsible for those damages. But the damages may vary—perhaps a banged-up fender, or, in another instance, with the same negligence, perhaps terrible personal injuries that will disable the other driver for life. Thus, the damages can vary for the same level of carelessness. The “big verdict” may therefore fall on someone who was not especially careless.

Big verdicts often involve long-term care.

The opening case vignettes illustrate a concern of medical malpractice generally—especially for ObGyn practice—the very high verdict. Very high verdicts generally reflect catastrophic damages that will continue for a long time. Bixenstine and colleagues found, for example, that catastrophic payouts often involved “patient age less than 1 year, quadriplegia, brain damage, or lifelong care.”¹⁶ In the case of serious injuries during delivery, for example, the harm to the child may last a lifetime and require years and years of intensive medical services.

Million-dollar-plus payouts are on the rise.

The percentage of paid claims (through settlement or trial) that are above \$1 million is increasing. These million-dollar cases represent 36% of the total *dollars* paid in ObGyn malpractice claims, even though they represent only 8% of the number of *claims* paid.¹⁶ The increase in the big verdict cases (above \$1 million) suggests that ObGyn practitioners should consider their malpractice policy limits—a million dollars may not be enough.

In big verdict cases, the great harm to the plaintiff is often combined with facts that produce extraordinary sympathy for the plaintiff. Sometimes there is decidedly unsympathetic conduct by the defendant as well. In the second case, for example, the problems with the medical record may have

suggested to the jury that the doctor was either trying to hide something or did not care enough about the patient even to note a serious complaint. In a case we reviewed in an earlier “What’s the Verdict” column, a physician left the room for several minutes during a critical time—to take a call from a stockbroker.¹⁶⁻¹⁸

The big verdict does not necessarily suggest that the defendant was especially or grossly negligent.¹⁶ It was a bad injury that occurred, for instance. On the other hand, the physician with several malpractice judgments may suggest that this is a problem physician.

Physicians facing multiple lawsuits are the exceptions

A number of studies have demonstrated that only a small proportion of physicians are responsible for a disproportionate number of paid medical malpractice claims. (“Paid claims” are those in which the plaintiff receives money from the doctor’s insurance. “Filed claims” are all malpractice lawsuits filed. Many claims are filed, but few are paid.) **ObGyn has high number of paid claims and high risk of claim payment recurrence.** Studdert and colleagues found that the probability of future paid malpractice climbed with each past paid claim.¹⁹ They also found that 1% of physicians accounted for 32% of all paid claims. The number of paid claims varied by specialty—obstetrics and gynecology accounted for the second largest number of paid claims (13%). The risk of recurrence (more than one paid claim) was highest among 4 surgical specialties and ObGyns (about double the recurrence rate in these specialties compared with internal medicine).¹⁹

A minority of physicians responsible for lion share of paid claims. Black and colleagues followed up the Studdert study. Although there were some differences in what they found, the results were very similar.²⁰ For example, they found that having even a single prior paid claim strongly predicted future claims over the next 5 years. They also found that some “outlier” physicians with multiple paid claims

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“Big verdicts”—paid claims, through settlement or trial, that are above \$1 million—are on the rise and represent 36% of the total dollars paid in ObGyn malpractice claims

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“are responsible for a significant share of paid claims.” They specifically found that, even for physicians in high-risk specialties in high-risk states, “bad luck is highly unlikely to explain” multiple claims within 5 years.

Both of the studies just mentioned relied on the National Practitioner Data Bank for information about paid claims. This source has some limitations in capturing claims or payments made by hospitals or other institutions for the actions of its agent-physicians. Some of these limitations were resolved in another recent study that looked at Indiana state insurance and licensing discipline records (over a 41-year period).²¹ Not surprisingly, this study found that claims paid increase with more severe licensure discipline. On the other hand, although, the “frequent fliers” in terms of malpractice claims made and paid could be identified as a “small number of repeat defendants,” these physicians were not routinely disciplined by the state medical board. This was only a single state study, of course, but it also found that a few physicians accounted for a significant

number of the claims. The state board was not taking licensing action against this small group, however.

Should the few bad apples be picked from the orchard?

Collectively, these studies are fairly overwhelming in demonstrating that there are some physicians who are “prone” to malpractice claims (for whom all physicians in the specialty are probably paying higher malpractice rates), but who do not attract the attention of licensing agencies for careful examination. In addition to its self-interest in eliminating physicians prone to malpractice claims and payments, the obligation of professions to protect the public interest suggests that state boards should be more aggressive in pursuing those physicians practicing risky medicine. ●

This medical malpractice series will continue next month with a look at how to reduce malpractice exposure.

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In a single state study, the medical board did not routinely discipline the few physicians who accounted for a significant number of the malpractice claims paid

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