

RISKY MEDICINE, PART 2

ObGyn malpractice liability risk: 2020 developments and probabilities

Paid medical malpractice claims have trended downward in recent decades. Why?

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In this second in a series of 3 articles discussing medical malpractice and the ObGyn we look at the reasons for malpractice claims and liability, what happens to malpractice claims, and the direction and future of medical malpractice. The first article dealt with 2 sources of major malpractice damages: the “big verdict” and physicians with multiple malpractice paid claims. Next month we look at the place of apology in medicine, in cases in which error, including negligence, may have caused a patient injury.

CASE 1 Long-term brachial plexus injury

Right upper extremity injury occurs in the neonate at delivery with sequela of long-term brachial plexus injury (which is diagnosed around

6 months of age). Physical therapy and orthopedic assessment are rendered. Despite continued treatment, discrepancy in arm lengths (ie, affected side arm is noticeably shorter than opposite side) remains. The child cannot play basketball with his older brother and is the victim of ridicule, the plaintiff’s attorney emphasizes. He is unable to properly pronate or supinate the affected arm.

The defendant ObGyn maintains that there was “no shoulder dystocia [at delivery] and the shoulder did not get obstructed in the pelvis; shoulder was delivered 15 seconds after delivery of the head.” The nursing staff testifies that if shoulder dystocia had been the problem they would have launched upon a series of procedures to address such, in accord with the delivering obstetrician. The defense expert witness testifies that a brachial plexus injury can happen without shoulder dystocia.

A defense verdict is rendered by the Florida jury.¹

CASE 2 Shoulder dystocia

During delivery, the obstetrician notes a shoulder dystocia (“turtle sign”). After initial attempts to release the shoulder were unsuccessful, the physician applies traction several times to the head of the child, and the baby is delivered. There is permanent injury to the right brachial plexus. The defendant ObGyn says that traction was necessary to dislodge the shoulder, and that the injury was the result of the forces of labor (not the traction). The expert witness for



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The authors report no financial relationships relevant to this article.

the plaintiff testifies that the medical standard of care did not permit traction under these circumstances, and that the traction was the likely cause of the injury.

The Virginia jury awards \$2.32 million in damages.²

Note: The above vignettes are drawn from actual cases but are only outlines of those cases and are not complete descriptions of the claims in the cases. Because the information comes from informal sources, not formal court records, the facts may be inaccurate and incomplete. They should be viewed as illustrations only.

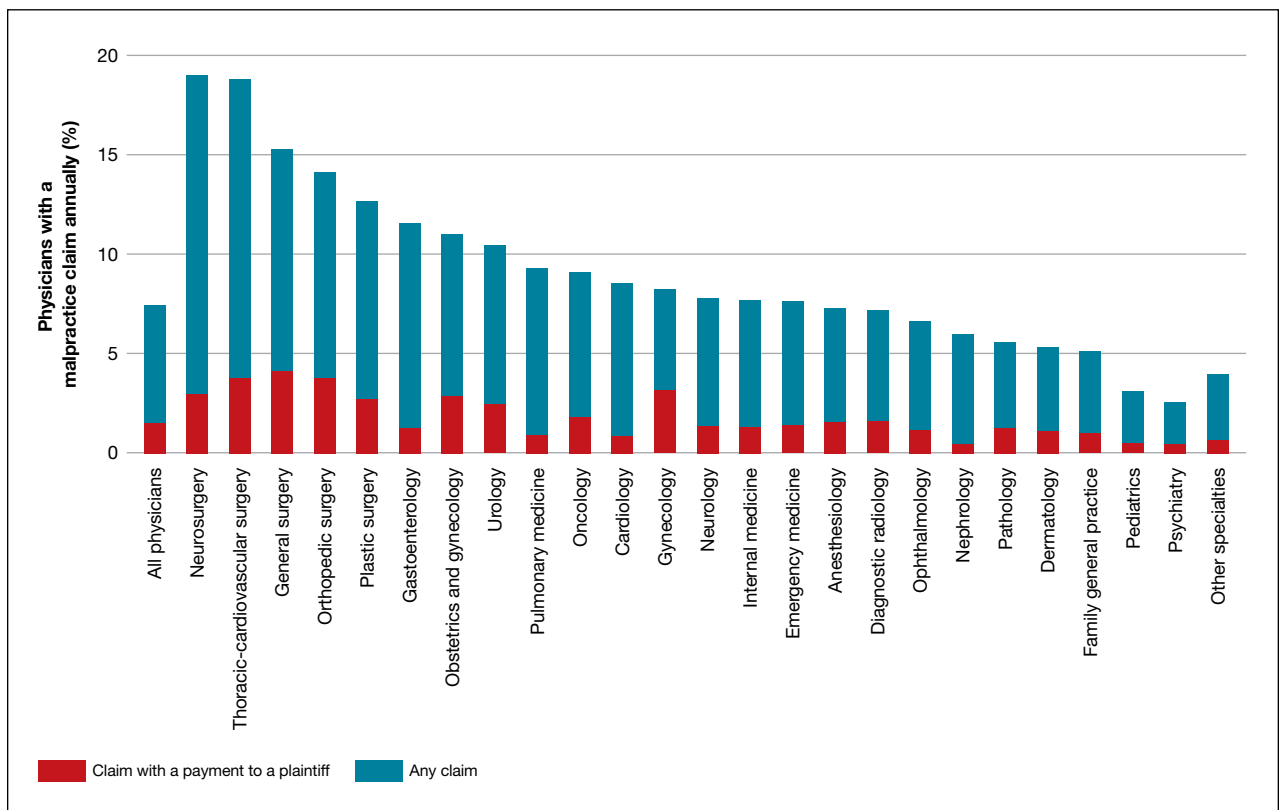
The trend in malpractice

It has been clear for many years that medical malpractice claims are not randomly or evenly distributed among physicians. Notably,



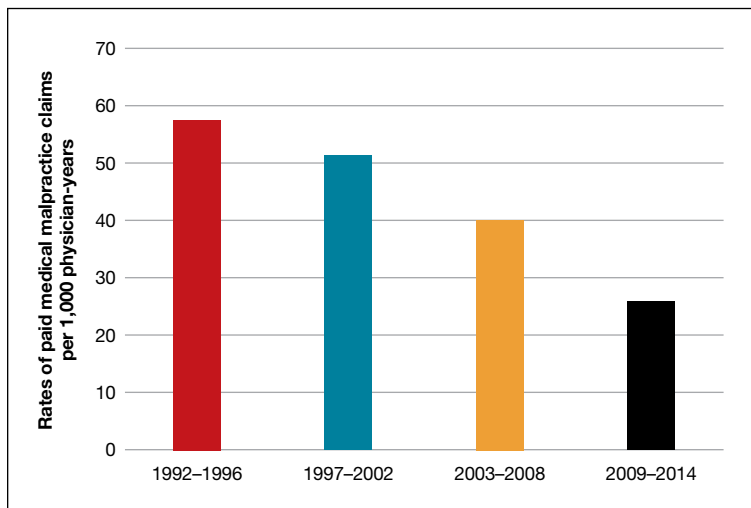
the variation among specialties has, and continues to be, substantial (FIGURE 1).³ Recent data suggest that, although paid claims per “1,000 physician-years” averages 14 paid claims per 1,000 physician years, it ranges from 4 or 5 in 1,000 (psychiatry and pediatrics) to 53 and 49 claims per 1,000 (neurology and plastic surgery, respectively). Obstetrics and gynecology has the fourth highest rate at 42.5 paid claims per 1,000 physician years.⁴ (These data are for the years 1992–2014.)

FIGURE 1 Medical malpractice by specialty³



Percentage of physicians facing a malpractice claim (with and without payment to a plaintiff) annually, according to specialty (1991–2005).

FIGURE 2 Annual rates of paid settlements⁶



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FIGURE 3 ObGyn medical professional liability insurance premiums for \$1M/\$3M policies, selected insurers, 2008 and 2017^{a,7}

Area of country	2008	2017
California (Los Angeles, Orange)	\$63,272	\$49,804
Connecticut	\$170,389	\$170,389
Florida (Miami, Dade)	\$238,728	\$190,829
Illinois (Cook, Madison, St. Clair)	\$178,921	\$177,441
New Jersey	\$117,340	\$90,749
New York (Nassau, Suffolk)	\$194,935	\$214,999
Pennsylvania (Philadelphia)	\$171,813	\$119,466

^aThe data are based on Annual Rate Survey (October) Issues of the Medical Liability Monitor, 2008-2017. The numbers are manual premiums reported by a liability insurer selected on the basis of data availability in every year. Premiums reported for Connecticut pertain to \$1 million/\$4 million limits, and Pennsylvania premiums include Patient Compensation Fund surcharges.

^bCounties to which the premiums refer are in parentheses. Counties in California (CA), Illinois (IL), and Pennsylvania (PA) changed slightly over time. However, CA counties always include Los Angeles, IL counties always include Cook, and PA counties always include Philadelphia.

The number of ObGyn paid malpractice claims has decreased over time. Although large verdicts and physicians with multiple paid malpractice claims receive a good deal of attention (as we noted in part 1 of our series), in fact, paid medical malpractice claims have trended downward in recent decades.⁵ When the data above are disaggregated by 5-year periods, for example, in obstetrics and gynecology, there has been a consistent reduction in paid malpractice claims from 1992 to 2014. Paid claims went from 58 per 1,000 physician-years in 1992-1996 to 25 per 1,000 in 2009-2014 (FIGURE 2).^{4,6} In short, the rate dropped by half over approximately 20 years.⁴

It is reasonable to expect that such a decline in the cost of malpractice insurance premiums would follow. Robert L. Barbieri, MD, who practices in Boston, Massachusetts, in his excellent recent editorial in OBG MANAGEMENT⁶ reported that his professional liability insurance premiums decreased 18% from 2014 to 2019, and his colleague reported a 22% reduction during the same time period.⁶ An American Medical Association report of 7 states or metropolitan areas for 2008 to 2017 found considerable variance. The study looked at the rates and the trend of rates for malpractice insurance in several areas of the United States (FIGURE 3).⁷ For ObGyns, one of these jurisdictions experienced increased rates; in one other, rates stayed the same, and in 5 jurisdictions, the rates went down. The premiums varied across the country, however. In 2017, Los Angeles/Orange had an average rate of \$49,804, and in Nassau and Suffolk counties, New York, the rate was \$214,999. The median rate was approximately \$170,000.⁷

Why have malpractice payouts declined overall?

Have medical errors declined?

It would be wonderful if the reduction in malpractice claims represented a significant decrease in medical errors. Attention to medical errors was driven by the first widely noticed study of medical error deaths. The Institute of Medicine (IOM) study in 2000, put the number of deaths annually at 44,000

TABLE 1. Health-system level medical error-reduction strategies for ObGyn practice⁶

- Elective induction bundle focused on safe use of oxytocin
- Augmentation bundle focused on early intervention for possible fetal metabolic acidosis
- Operative vaginal delivery bundle
- TeamSTEPPS teamwork training to improve communication quality
- Best practices education with focus on electronic fetal monitoring
- Regular performance feedback to hospitals and clinicians
- Implementation of quality improvement collaboration to support error-reduction interventions
- 24-hour in-house physician coverage of an obstetrics service
- Conservative approach to trial of labor after a prior cesarean delivery
- Utilization of a comprehensive, standardized event note in cases of a shoulder dystocia
- Judicious use of oxytocin, misoprostol, and magnesium sulfate
- Systematic improvement in quality of communication among physicians and nurses through the use of team training, preprocedure huddles, and time-out processes
- Rapid response systems to rescue hospital patients with worrisome vital signs
- Standardized responses to a worrisome category 2 or 3 fetal heart rate tracing
- Rapid recognition, evaluation, and treatment of women with hemorrhage, severe hypertension, sepsis, and venous thromboembolism
- Identification and referral of high-risk patients to tertiary centers
- Closed loop communication of critical imaging and laboratory results
- Universal insurance coverage for health care, including contraception, obstetrics, and pediatric care

to 98,000.⁸ There have been many efforts to reduce such errors, and it is possible that those efforts have indeed reduced errors somewhat.⁴ Barbieri provided a helpful digest of many of the error-reduction suggestions for ObGyn practice (TABLE 1).⁶ But the number of medical errors remains high. More recent studies have suggested that the IOM's reported number of injuries may have been low.⁹ In 2013, one study suggested that 210,000 deaths annually were "associated with preventable harm" in hospitals. Because of how the data were gathered the authors estimated that the actual number of preventable deaths was closer to 400,000 annually. Serious harm to patients was estimated at 10 to 20 times the IOM rate.⁹

Therefore, a dramatic reduction in preventable medical errors does not appear to explain the reduction in malpractice claims. Some portion of it may be explained by malpractice reforms—discussed on page 36.

The collective accountability factor

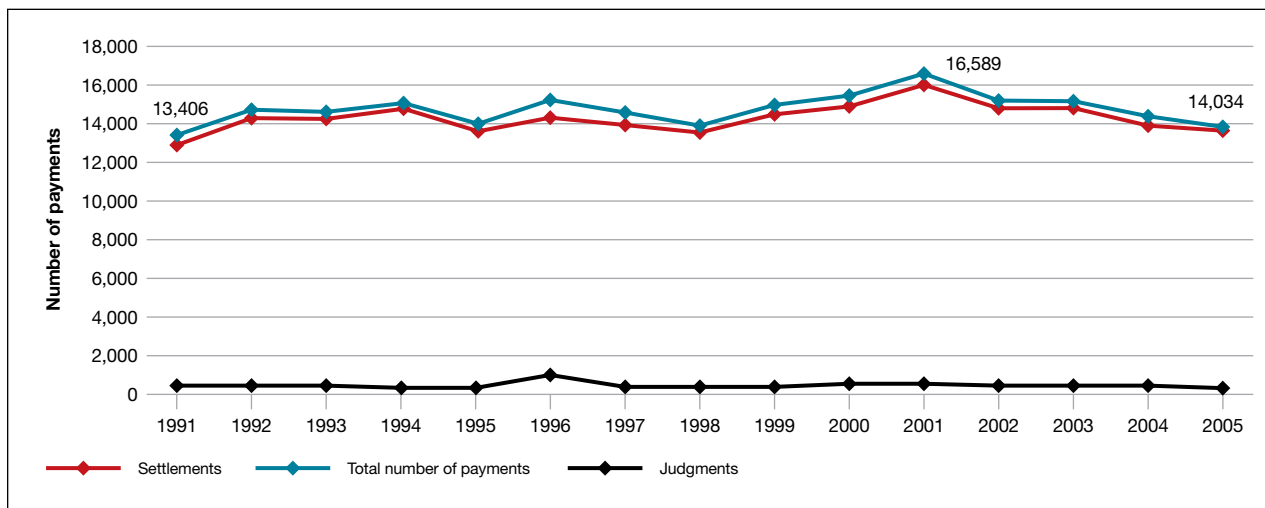
The way malpractice claims are paid (FIGURE 4, page 36),¹⁰ reported, and handled

may explain some of the apparent reduction in overall paid claims. Perhaps the advent of "collective accountability," in which patient care is rendered by teams and responsibility accepted at a team level, can alleviate a significant amount of individual physician medical malpractice claims.¹¹ This "enterprise liability" may shift the burden of medical error from physicians to health care organizations.¹² Collective accountability may, therefore, focus on institutional responsibility rather than individual physician negligence.^{11,13} Institutions frequently hire multiple specialists and cover their medical malpractice costs as well as stand to be named in suits.

The institutional involvement in malpractice cases also may affect apparent malpractice rates in another way. The National Practitioner Data Bank, which is the source of information for many malpractice studies, only requires reporting about individual physicians, not institutions.¹⁴ If, therefore, claims are settled on behalf of an institution, without implicating the physician, the number of physician malpractice cases may appear to

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FIGURE 4 Payments for medical malpractice¹⁰



Total number of malpractice payments with judgments and settlements.

decline without any real change in malpractice rates.¹⁴ In addition, institutions have taken the lead in informal resolution of injuries that occur in the institution, and these programs may reduce the direct malpractice claims against physicians. (These “disclosure, apology, and offer,” and similar programs, are discussed in the upcoming third part of this series.)

The medical reform factor

As noted, annual rates paid for medical malpractice in our specialty are trending downward. Many commentators look to malpractice reforms as the reason for the drop in malpractice rates.¹⁵⁻¹⁷ Because medical malpractice is essentially a matter of state law, the medical malpractice reform has occurred primarily at the state level.¹⁸ There have been many different reforms tried—limits on expert witnesses, review panels, and a variety of procedural limitations.¹⁹ Perhaps the most effective reform has been caps being placed on noneconomic damages (generally pain and suffering).²⁰ These caps vary by state (FIGURE 5)^{21,22} and, of course, affect the “big verdict” cases. (As we saw in the second case scenario above, Virginia is an example of a state with a cap on malpractice awards.) They also have the secondary effect of reducing the

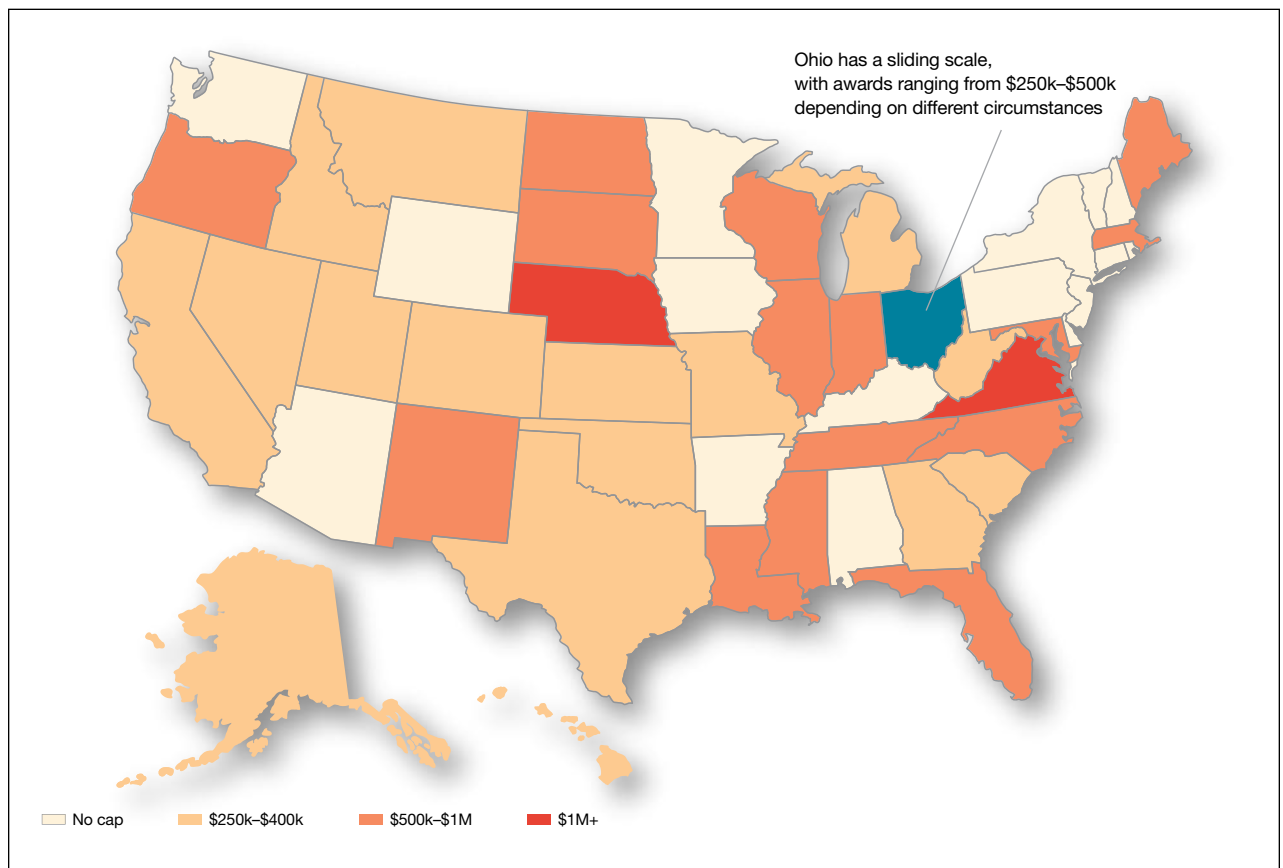
number of malpractice cases. They make malpractice cases less attractive to some attorneys because they reduce the opportunity of large contingency fees from large verdicts. (Virtually all medical malpractice cases in the United States are tried on a contingency-fee basis, meaning that the plaintiff does not pay the attorney handling the case but rather the attorney takes a percentage of any recovery—typically in the neighborhood of 35%.) The reform process continues, although, presently, there is less pressure to act on the malpractice crisis.

Medical malpractice cases are emotional and costly

Another reason for the relatively low rate of paid claims is that medical malpractice cases are difficult, emotionally challenging, time consuming, and expensive to pursue.²³ They typically drag on for years, require extensive and expensive expert consultants as well as witnesses, and face stiff defense (compared with many other torts). The settlement of medical malpractice cases, for example, is less likely than other kinds of personal injury cases.

The contingency-fee basis does mean that injured patients do not have to pay attorney fees up front; however, plaintiffs may have to pay substantial costs along the way. The other

FIGURE 5 An overview of noneconomic medical malpractice caps by state^{21,22}



side of this coin is that lawyers can be reluctant to take malpractice cases in which the damages are likely to be small, or where the legal uncertainty reduces the odds of achieving any damages. Thus, many potential malpractice cases are never filed.

A word of caution

The news of a reduction in malpractice paid claims may not be permanent. The numbers can conceivably be cyclical, and political reforms achieved can be changed. In addition, new technology will likely bring new kinds of malpractice claims. That appears to be the case, for example, with electronic health records (EHRs). One insurer reports that EHR malpractice claims have increased over the last 8 years.²⁴ The most common injury in these claims was death (25%), as well as a magnitude of less serious injuries. EHR-related claims result from system failures, copy-paste

inaccuracies, faulty drop-down menu use, and uncorrected “auto-populated” fields. Obstetrics is tied for fifth on the list of 14 specialties with claims related to EHRs, and gynecology is tied for eighth place.²⁴

A federal court ruled that a hospital that changed from paper records to EHRs for test results had a duty to “implement a reasonable procedure during the transition phase’ to ensure the timely delivery of test results” to health care providers.²⁵ We will address this in a future “What’s the Verdict?”

Rates of harm, malpractice cases, and the disposition of cases

There are many surprises when looking at medical malpractice claims data generally. The first surprise is how few claims are filed relative to the number of error-related injuries.

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TABLE 2 Goals of tort law

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1. Compensation: Provide money to cover the costs of those who were injured by the carelessness of others
 2. Deterrence: Reduce injuries (caused by carelessness) by requiring those harming others to pay for the damages they cause. It is appropriate to ask, "How effective and just is this system in the United States?"
-

Given the estimate of 210,000 to 400,000 deaths "associated with preventable harm" in hospitals, plus 10 to 20 times that number of serious injuries, it would be reasonable to expect claims of many hundreds of thousands per year. Compare the probability of a malpractice claim from an error-related injury, for example, with the probability of other personal injuries—eg, of traffic deaths associated with preventable harm.

The second key observation is how many of the claims filed are not successful—even when there was evidence in the record of errors associated with the injury. Studies slice the data in different ways but collectively suggest that only a small proportion of malpractice claims filed (a claim is generally regarded

as some written demand for compensation for injuries) result in payments, either through settlement or by trial. A 2006 study by Studdert and colleagues determined that 63% of formal malpractice claims filed did involve injuries resulting from errors.²⁶ The study found that in 16% of the claims (not injuries) there was no payment even though there was error. In 10% of the claims there was payment, even in the absence of error.

Overall, in this study, 56% of the claims received some compensation.²⁶ That is higher than a more recent study by Jena and others, which found only 22% of claims resulted in compensation.³

How malpractice claims are decided is also interesting. Jena and colleagues found that only 55% of claims resulted in litigation.²⁷ Presumably, the other 45% may have resulted in the plaintiff dropping the case, or in some form of settlement. Of the claims that were litigated, 54% were dismissed by the court, and another 35% were settled before a trial verdict. The cases that went to trial (about 10%), overwhelmingly (80%) resulted in verdicts for the defense.^{3,27} A different study found that

Why did the 2 opening case vignettes come out differently?

The two vignettes described at the beginning, with similar injuries (shoulder dystocia), had disparate outcomes. In one there was a defense verdict and in the other a verdict for the plaintiffs of more than \$2 million. The differences explain a number of important elements related to malpractice claims. (We have only very abbreviated and incomplete descriptions of the cases, so this discussion necessarily assumes facts and jumps to conclusions that may not be entirely consistent with the actual cases.)

These vignettes are unusual in that they went to trial. As we have noted, only a small percentage of malpractice cases are tried. And the verdict for the plaintiff-patient (in the second case) is unusual among those cases that go to trial, where plaintiffs seldom prevail.

From the facts we have, one significant difference in the 2 cases is that the plaintiff's expert witness specifically testified in the second case that the "medical standard of care did not permit traction under these circumstances." That is an essential element of a successful plaintiff's malpractice case. In this case, the expert could also draw a connection between that breach of standard of care and harm to the child. In the case without liability, the nursing staff was able to testify that there was no shoulder dystocia because if there had been such an injury, they would have immediately launched into special action, which did not happen. By contrast, in the liability case, there seemed to be critical gaps in the medical record.

It is also important to remember that these cases were tried in different states, with different laws. The juries and judges in the 2 cases were different. Finally, the quality of the attorneys representing the plaintiffs and defendants were different. We mention these factors to point out that medical malpractice is not an exact science. It depends on many human elements that make the outcome of cases somewhat unpredictable. This unpredictability is one reason why parties and attorneys like to settle cases.

only 9% of cases went to trial, and 87% were a defense verdict.²⁶ The high level of defense verdicts may suggest that malpractice defense lawyers, and their client physicians, do a good job of assessing cases they are likely to lose, and settling them before trial.

ObGyns generally have larger numbers of claims and among the largest payment amounts when there is payment. Fewer of their cases are dismissed by the courts, so more go to trial. At trial, however, ObGyns prevail at a remarkably high rate.²⁷ As for the probability of payment of a malpractice claim for ObGyns, one study suggested that there is approximately a 16% annual probability of a claim being filed, but only a 3% annual probability of a payment being made (suggesting about a 20% probability of payment per claim).³

The purposes and effects of the medical malpractice system

The essential goals of tort law (including medical malpractice) include compensation for those who are injured and deterrence of future injuries (TABLE 2). What are the overall effects to the medical malpractice system? Unfortunately, the answer is that the law delivers disappointing results at best. It has a fairly high error rate. Many people who deserve some compensation for their injuries never seek compensation, and many deserving injured patients fail in efforts to receive

compensation. At the same time, a few of the injured receive huge recoveries (even windfalls), and at least a small fraction receive compensation when there was no medical error. In addition to the high error rate, the system is inefficient and very expensive. Both defendants (through their insurance carriers) and plaintiffs spend a lot of money, years of time, and untold emotional pain dealing with these cases. The system also exacts high emotional and personal costs on plaintiffs and defendants.

Malpractice reform has not really addressed these issues—it has generally been focused on ways to reduce the cost of malpractice insurance. The most effective reform in reducing rates—caps—has had the effect of compensating the most seriously injured as though they were more modestly injured, and dissuading attorneys from taking the cases of those less seriously injured.

The medical and legal professions exist to help patients (the public). It does not seem that we have arrived at a system that does that very fairly or efficiently when a patient is injured because of preventable medical error. ●

Watch for the third and final article in this series next month, as we are going to look at “apology in medicine and a proactive response” to communication regarding a complication.

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