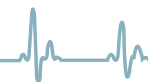


LABOR PAINS: LIABILITY TRENDS IN OBSTETRICS

BY PAUL GREVE, JD RPLU

No other specialty unit of an acute care hospital entails more risk for patient safety than the obstetrical unit. No other medical specialty is as difficult for medical professional liability underwriters as obstetrics/gynecology (OB/Gyn). In obstetrics, the potential for injury is at least double the risk faced in other cases for the simple fact that two lives are at stake: mother and infant. Further exacerbating the risk is the vulnerability of the child. Injuries to the infant are often catastrophic and can entail lifelong care. Plaintiffs in infant injury cases readily win sympathy from juries, and noneconomic damage caps are of little value since life care costs can be easily demonstrated.

While the national environment for healthcare professional liability has improved significantly over the last five years, certain types of claims still tend toward high severity, especially claims involving obstetrics and pediatrics. The plaintiffs' bar seeks out these cases through the media, especially television and internet ads. An informal search for large obstetrics verdicts rendered in 2008 and 2007 found eight verdicts/settlements from six different states totaling more than $158 million (see Figure 1). The size of these verdicts/settlements is both sobering and instructive.

OBSTETRICS: PRACTICE MACRO TRENDS

OB/Gyn is "a discipline dedicated to the broad, integrated medical and surgical care of women's health throughout their lifespan," according to the American College of Obstetrics & Gynecology (ACOG). OB/Gyns can "choose a…practice ranging from primary ambulatory health care to…a focused area of specialization." OB/Gyn practices can vary broadly but several trends have emerged that have direct or indirect impact on professional liability across the OB/Gyn spectrum.

• The move of OB/Gyn physicians from solo to group practice, or employment by hospitals and HMOs, affects communication of patient information. Taking after-hours calls and patient handoffs are more complicated in a group practice setting.

Figure 1

Recent Large Obstetric Verdicts/Settlements

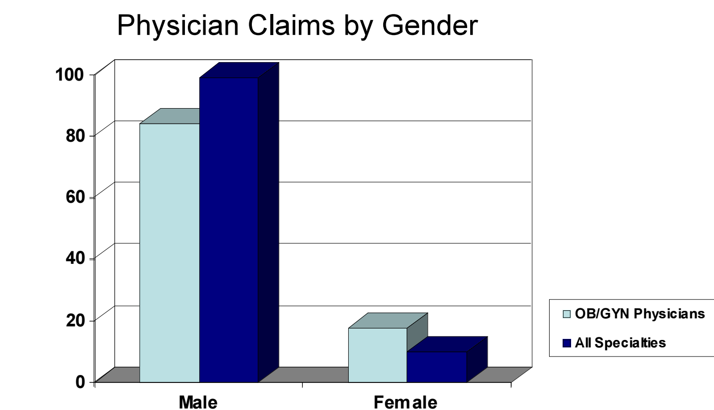
Date	Location	Facts	Amount
7/08	New York	Improper use of forceps	$19.6M (V)
7/08	Wisconsin	Improper monitoring, delay in C-section	$18.2M (S)
6/08	Florida	Nursing delay in calling the OB	$35M (V)
5/08	Ohio	Improper monitoring by nursing staff	$10M (S)
5/08	Ohio	Improper management of labor	$22.6M (V)
1/08	Illinois	Improper monitoring by the OB and nursing staff	$21.5M (V)
9/07	Iowa	Improper monitoring; delay in C-section	$13.5M (V)
4/07	Illinois	Improper monitoring by nursing staff and the OB	$18M (S)

• A gender shift among OB/Gyn practitioners has occurred in recent decades as more and more women have selected what was once a male-dominated specialty. While many patients may prefer a female OB/Gyn, this preference has not shielded them from litigation. The percentage of female obstetricians facing malpractice claims is almost double that of all physician specialties combined, according to the Physician Insurers Association of America (PIAA) (see Figure 2).

• Like other specialties, OB/Gyns must deal with several general trends in medicine: the explosion of new information in their field; advances in information technology; significant cuts in reimbursement, leading to increased patient volumes to make up revenue; difficulty balancing office practice and surgical practice; and increased use of hospitalists as well as physician assistants and midwives.

Figure 2

PIAA: Obstetrics and Gynecologic Surgery



• Notable clinical trends in obstetrics include increased genetic testing, the prevalence of obesity in teenage and adult women, the dramatic rise in the number of cesarean deliveries, the controversy of vaginal-birth-after-cesarean (VBAC) delivery, and findings on the causes of neonatal encephalopathy and cerebral palsy.

• Foremost among the challenges to this specialty may be the high cost of malpractice premiums. Obstetricians saw a four-fold increase in malpractice premiums from 1975 to 2000. Many obstetricians pay annual premiums of more than $80,000; premiums exceeding $100,000 are not uncommon.

CLOSED CLAIM TRENDS

Obstetrics ranked first among all specialties for the number of claims reported and for the total amount of indemnity paid, according to a PIAA study of closed malpractice claims. Of every medical specialty (excluding dentistry, where claims are comparatively small), obstetrics had the highest percentage of claims closed with payment at 35.31- to 5.5-percent higher than the norm for all specialty groups. OB/Gyn had the third highest average indemnity after neurology and neurosurgery (see Figure 3). The PIAA publishes annual Risk Management Reviews on many physician specialties. Their cumulative study, the Data Sharing System, has aggregated more than 230,000 closed malpractice claims since 1985, studying 28 medical specialties.

Closed claim statistics for 2007 show no improvement. In that year, the average indemnity payment on behalf of OB/Gyn physicians was $424, 560, 19.8-percent higher than the overall average indemnity payment for all physician specialties at $340,769. Closed claims on behalf of OB/Gyns constituted a large percentage of all claims reported to the PIAA in 2007 at 12.2 percent and constituted 18.9 percent of all indemnity dollars paid out. The PIAA noted that these percentages have remained virtually unchanged from a decade ago, although

Figure 3

PIAA: Comparative Claim Payment Analysis

Claims Closed Between 1985 and 2007: All Specialties

Specialty Group	Closed Claims	% Paid to Closed	Total Indemnity	Average Indemnity
Anesthesiology	8,866	32.43	$636,193,819	$221,285
Cardiovascular and Thoracic Surgery	6,960	23.59	356,739,943	217,259
Cardiovascular Diseases – nonsurgical	4,248	18.13	191,183,963	248,291
Dentists	838	43.56	14,869,780	40,739
Dermatology	2,620	28.89	101,440,748	134,004
Emergency Medicine	3,991	26.28	202,049,937	192,612
Gastroenterology	2,354	18.05	88,121,039	207,344
General and Family Practice	26,658	32.02	1,365,943,314	160,040
General Surgery	24,177	34.43	1,488,680,092	179,381
Gynecology	2,723	30.55	128,848,958	154,864
Internal Medicine	31,299	25.25	1,644,739,599	208,142
Neurology – nonsurgical	3,658	21.20	245,969.868	317,406
Neurosurgery	5,431	28.17	477,770,521	312,268
Obstetric and Gynecologic Surgery	**31,486**	**35.31**	**3,086,138,311**	**277,580**
Ophthalmology	6,703	28.72	347,735,112	180,642
Oral Surgery	62	32.26	538,583	26,929
Orthopedic Surgery	21,848	29.18	1,042,180,835	163,479
Other Nonsurgical Specialties	2,234	22.96	96,717,958	188,534
Otorthinolaryngology	3,819	31.42	241,644,424	201,370
Paraprofessional	376	23.14	18,194,867	209,136
Pathology	1,633	28.23	112,847,595	244,789
Pediatrics	6,794	27.92	505,084,556	266,254
Plastic Surgery	8,683	26.27	262,301,626	114,994
Psychiatry	2,276	20.12	74,568,108	162,812
Radiation Therapy	2,212	28.03	172,036,688	277,479
Radiology	12,970	29.20	736,138,969	194,386
Resident/Intern	130	32.31	2,515,932	59,903
Urologic Surgery	5,577	29.41	285,782,192	174,245
Totals:	**230,624**	**29.56**	**$13,926,975,337**	**$204,268**

indemnity payments for OB/Gyn have increased from 31.9 to 33.7 percent in that time frame.

In 2007, the percentage of claims closed with payment for all specialties was 27.1 percent, exceeded by OB/Gyn at 33.7 percent. OB/Gyn claims were the most expensive to defend of all specialties in 2007. This specialty also had the largest number of paid claims, 324, as well as the highest total indemnity amount paid at $137 million.

FURTHER PIAA OBSTETRICS FINDINGS

• The most prevalent OB/Gyn patient conditions leading to claims were pregnancy and the brain damaged infant. Almost half (49.4 percent) of all claims involving a brain-damaged infant closed with an indemnity payment. Closed claims involving the brain damaged infant had the highest average payment at $565,152 (see Figure 4). For claims closed in 2007, pregnancy and the brain damaged infant were the leading conditions; claims involving a brain damaged infant had the highest average payment at $688,600.

• The OB/Gyn procedure most likely to lead to a claim was cesarean delivery. Of 31,486 total closed OB/Gyn claims,14.1 percent involved a cesarean delivery.

• The most prevalent OB/Gyn misadventure was improper performance of a procedure—the primary issue in 33.3 percent of all claims (see Figure 5, page 8). This category led all others in 2007 as well, accounting for 30.1 percent of closed claims and 36.7 percent of all claims closed with indemnity.

Another closed claims analysis was undertaken by The Doctors Company to determine system errors and their impact on 363 malpractice claims from 2004 to 2006. One of the key findings was that of the 34 obstetrics claims, 26 percent involved non-timely performance of a cesarean section, while communications errors accounted for two-thirds of obstetrics claims system errors.

THE IMPACT OF MALPRACTICE

The frequency of high severity obstetrical malpractice verdicts and the concomitant increase in malpractice premiums has had a profound effect on this specialty. ACOG has stated that 75 percent of its membership has been sued at least once. In a survey conducted in 2006 with more than 10,000 responses, 64.6 percent of the practitioners said they had made one or more changes to their practice out of fear of professional liability claims. Malpractice costs have also caused obstetricians to take early retirement or limit their practice by ceasing to perform deliveries, reducing the number of high-risk patients or not offering VBACs. Some have relocated to states with more favorable malpractice climates. The impact goes beyond current practice and may affect the availability of obstetrical care in the future.

• Reduced Access to Prenatal Care. Reduced access to prenatal care has been especially problematic in rural areas. This may compromise the future ability of obstetricians to care for high-risk mothers and infants.

• Fewer Obstetric Residents. The decreasing numbers of medical students entering OB/Gyn residencies is alarming. The fear of being sued and high malpractice premiums often factor into medical students' decisions to bypass this specialty, particularly in states

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Figure 4

PIAA: Obstetric and Gynecologic Surgery

Claims by 10 Most Prevalent Patient Conditions

Cumulative Analysis: January 1, 1985 – December 31, 2007

Condition	Total Claims	% Paid to Closed	Total Indemnity	Average Indemnity
Pregnancy	3,485	29.31	$227,274,870	$250,027
Brain Damaged Infant	3,140	49.39	799,125,396	565,152
Sterilization, admission or office treatment for	1,064	31.84	26,983,455	82,267
Disorders of menstruation and other abnormal bleeding from female genital tract	940	33.53	47,664,839	165,502
Malignant neoplasms of the female breast	868	43,95	95,093,127	267,116
Ectopic pregnancy	814	33.51	21,067,504	81,657
Fetal distress	816	44.24	137,483,847	411,828
Benign neoplasms of uterus	772	35.89	47,263,218	186,811
Endometriosis	668	27.86	24,951,245	144,227
Delivery, normal, of single gestation	619	32.92	46,754,971	254,103
Totals:	**13,186**	**37.25**	**$1,473,662,274**	**$327,699**

PIMS, MEDPRO TEAM TO OFFER CUSTOMIZED RISK MANAGEMENT PLANS

Premier Insurance Management Services (PIMS) announced a new professional medical liability insurance program offering risk management and hospital medical malpractice protection to not-for-profit hospital members of the Premier healthcare alliance.

PIMS, a wholly owned subsidiary of Premier, selected Medical Protective as its partner for this sponsored liability program. The program offers customized risk management plans tailored to each hospital, targeting reductions in risk and improvements in patient safety through risk management tools, resources, education and other solutions designed to reduce exposures.

The program is geared towards community-based, acute-care hospitals, including critical access, general acute care and specialty (orthopedic, children's, cardiac, behavioral health, etc.) with 350 beds or less, which have a deductible or retention of not more than $500,000 in select targeted states. It features a premium discount for Premier members plus an additional discount for Premier Healthcare Informatics members using the Quality Manager or Clinical Advisor solutions. As the program grows and gains the spread of risk necessary, participants have potential for long-term savings through, where allowed by state law, a Safety Dividend Program. Under a Safety Dividend Program, if claims are lower than projected, participants may be refunded a portion of the excess premium.

"This offering from PIMS and Medical Protective expands beyond the traditional insurance plan," said Robert Dowdy, PIMS president. "It includes Medical Protective's review of self insured facilities that would now like to consider an alternative structure, such as loss portfolio transfer 'capital release' programs or risk transfer partnerships with self-funded entities.

"Our goal is to help our members further improve patient safety while reducing their insurance costs. In the worst-case scenario of a lawsuit, the coverage represents an organization, its assets and its reputation."

EXAMINING CURRENT LIABILITY TRENDS IN THE FIELD OF OBSTETRICS

CONTINUED FROM PAGE 5

with high costs.

HIGHER CESAREAN SECTION RATES

The classic claim scenario resulting in high damages involves litigation brought on behalf of a brain-damaged infant, alleging failure to detect fetal distress and/or to perform a cesarean section in a timely manner.

In 2004, the cesarean delivery rate in the U.S. reached 29.1 percent, a dramatic rise from 5.5 percent in 1970. This percentage translates to roughly 1.2 million cesarean deliveries annually—at a cost to the healthcare delivery system of approximately $16 billion. Changes in patient populations (e.g., more women 35 and older giving birth) alone do not account for this increase. The expectation of a perfect outcome at the time of delivery, and the difficulty of defending malpractice cases involving severely injured children, have had their impact. Cesarean delivery is often a form of defensive medicine.

VBACS: CONTROVERSY

Vaginal birth after a cesarean delivery (VBAC) came back into obstetric practice in the 1980s, mostly in an attempt to reduce the rising cesarean delivery rate. Both the National Institute of Health and ACOG supported VBAC trials of labor for appropriate patients.

The numbers of VBACs rose into the mid-1990s until reports of uterine rupture began to appear. VBACs have since become controversial, and many hospitals prohibit them. Many obstetricians refuse to let their patients attempt VBAC trials. Fear of litigation is one of the main reasons.

MANAGING OBSTETRICAL RISK: THE FUTURE

No other physician practice specialty or high-risk hospital unit has more claim volatility than obstetrics. Fortunately, many encouraging developments in the area of obstetric risk management and patient safety have emerged, such as simulation training.

Investments in obstetric patient safety maximize their return by preventing high-severity claims. Some patient safety approaches that hold promise include: OB rapid response teams; Medical emergency preparedness strategies, such as training, stocking appropriate supplies, early warning systems and specialized first responders ; Team training using crew resource management techniques borrowed from the military and the airline industry; and Commercially available clinical informatics systems that promote patient safety at the patient's bedside and in real time.

Paul Greve is senior vice president/senior consultant of healthcare practice at Willis. He would like to thankfully acknowledge the assistance of Sharon Regnier, Lutheran Hospital and Colleen Petrello, Esq., Sutter, O'Connell & Farchione.

Figure 5

PIAA: Obstetric and Gynecologic Surgery

Claims by 10 Most Prevalent Medical Misadventures

Medical Misadventure	Total Claims	% Paid to Closed	Total Indemnity	Average Indemnity
Improper performance	10,803	39.67	$933,193,647	$235,893
No medical misadventure	6,668	8.06	155,806,414	304,309
Errors at diagnosis	4,252	36.89	367,324,313	255,086
Failure to supervise or monitor case	2,775	45.87	399,678,356	345,743
Delay in performance	2,103	54.86	473,965,579	453,556
Not performed	1,747	54.65	311,966,791	351,314
Failure to recognize a complication of treatment	1,298	39.55	107,008,759	266,855
Performed when not indicated or contraindicated	1,001	47.32	85,531,185	175,990
Surgical foreign body left in patient after procedure	839	44.81	14,796,273	41,330
Failure to instruct or communicate with patient	650	34.26	28,607,215	145,214
Totals:	**32,426**	**35.16**	**$2,877,878,532**	**$276,685**