Medical Liability

An Ongoing Nemesis

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Medical liability and its effect on the practice of obstetrics and gynecology is one of the most important issues that face the specialty and each practitioner today. As a result, the American College of Obstetricians and Gynecologists (the College) has worked hard to achieve reform, especially at the national level. On five separate occasions during the 110th Congress (2007–2008), the College facilitated the passing of a bill by the House of Representatives that, if passed by the Senate, would have reduced the level of noneconomic liability significantly. In essence, these bills reduced the noneconomic awards that plaintiffs could receive. The bills were patterned after the Medical Injury Compensation Reform Act in California, which mandates a $250,000 cap on "pain and suffering." Before the Medical Injury Compensation Reform Act, the increasing costs of insurance in California resulted in increased patient costs and physicians moving out of state, culminating in reduced access to ob–gyns for patients. In all five attempts, the bills died in the Senate without even coming up for a vote because there was insufficient support to prevent a filibuster.

In the current Congress, which is immersed in health care reform, one of the College's major efforts is the inclusion of liability reform. At this writing, the only possible prospect appears to be modestly funded demonstration projects at the state level. President Obama, in his presentation to the American Medical Association House of Delegates in June 2009, clearly stated that he would support alternative approaches to liability reform as part of health care reform because he recognized the need.[1] However, he stated that this would not include "a cap on noneconomic damages."

Several states have developed and implemented legislation to enact liability reform. The most recent are Texas, where the legislature enacted a $250,000 cap on noneconomic damages, and Oklahoma, where a cap of $400,000 went into effect. On appeal by trial lawyers, the Supreme Court of Texas ruled the legislation unconstitutional. Texas physicians and patients initiated a campaign to pass a constitutional amendment to make the law constitutional. The passage of this legislation has resulted in an increase in liability insurance carriers, reductions in premiums, a decrease in liability lawsuits, and increased access to care, providing evidence that reform can work.

As a top priority of the College, the reform of the current liability system in the United States includes both national and state-by-state action plans. The current situation is causing physicians to change their practices, for example, by retiring early, ceasing to provide obstetric care or to treat high-risk obstetric patients, and engaging in defensive medicine.

2009 College Survey

To understand the scope of the effect of the current professional liability environment on the individual ob–gyn as well as the effects on practice at the state, district, and national levels, the College has conducted surveys of Fellows at approximately 2- to 4-year intervals since 1983. In every survey, the percentage of physicians reporting changes in their practice has increased in states without liability reform. This trend reversed slightly in 2009,[2] possibly owing to changes in survey methodology or to the fact that, on average, liability premiums have decreased since 2006.[3] Still, 62.9% of survey respondents made changes to their practice because of the high risk or fear of claims. It is clear that professional liability is a vital and enduring concern for the practicing ob–gyn.

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Data from these surveys enables the College to demonstrate to lawmakers and the public how increased litigation and lack of affordable liability insurance has adversely affected ob–gyn practices and diminished women's access to health care.

The initial surveys were mailed to College Fellows and Junior Fellows in Practice based on a random sampling ratio of 1 to 5. In 2006, we surveyed all Fellows and Junior Fellows in Practice and also provided the option of completing the survey online. The 2009 survey was sent to all College Fellows and Junior Fellows exclusively online.

Over the years, each survey has contained approximately 20 to 30 questions, or up to 50 if a claim was reported. The majority of the questions were designed to understand the effect that professional liability had on the various aspects of the practice of the specialty as well as the related plans of the individual physician. Additional questions were designed to determine the number and frequency of liability claims and their outcome.

The results were compared to determine trends or significant changes. Each survey identified the state or district in which the physician practiced to compare differences among regions of the country with and without liability reform, and to identify where the liability crisis is most acute.

The response rate for the 2009 Survey on Professional Liability[2] was 17.8% of the 31,665 online surveys, which was less than half of the response rate in 2006 (36.8%). This may be a result of the survey being available exclusively online for the first time. This is congruent with existing research findings that report a lower response rate for online compared with mailed survey instruments. Table 1 displays respondent demographics for the two surveys where available. Table 2 indicates practice type of the 2009 survey respondents only; practice type was not addressed in the 2006 survey.

Table 1. Demographics

	2006	2009
Average age (y)	48.5	49.2
Men	56.9	52.6
Women	43.1	47.4
Practice site		
Urban		39.4
Suburban		46.0
Rural		14.6

Data are % unless otherwise specified.
A total of 31,665 ACOG Fellows and Junior Fellows in Practice were surveyed in 2009. The final data represent only those 5,644 ob–gyns who responded to the survey.

Table 2. Practice Type

2009 Survey Respondents (n=5,632)	
Solo	21.7
Group	51.6
Salaried hospital	12.0
Faculty	9.9
Government	1.6
Outpatient only	0.9
Other	3.3

Data are %.

Areas of Practice

A total of 74.3% of respondents to the 2009 survey indicated they are providing both obstetric and gynecologic care, which is slightly lower than the 2006 survey result of 77.7%. The average age of stopping obstetrics was 48 years in both the 2006 and 2009 surveys. Of the reasons for stopping obstetrics, liability or litigation issues were most often cited in both 2006 (39%) and in 2009 (32%). When questioned about the number of inpatient and outpatient surgical procedures performed in an average month, respondents reported means of 34.8 in 2006 and 37.0 in 2009.

Liability Insurance

A majority of respondents (96.3% in 2006, 95.7% in 2009) reported that they were covered by a professional liability insurance policy. Two-thirds carried claims-made policies, with a per claim limit of $1,000,000 and an aggregate of $3,000,000. The cost of premiums averaged 17.80% of gross income. This is approximately one dollar for every six that the physician receives. To compensate for this expense, costs to patients and insurers must increase.

Table 3. Practice Changes

	2006	2009
Practice changes as a result of the risk or fear of professional liability claims or litigation		
Decreased high-risk obstetrics	33.1	30.2
Increased cesarean deliveries	37.1	29.1
Stopping VBACs	32.7	25.9
Decreased gynecologic surgery	16.4	14.7
Stopped obstetrics	8.3	8.0
Stopped major gynecologic surgery	4.9	5.2
Stopped all surgery	2.1	2.0
Practice changes as a result of the affordability or availability of professional liability insurance		
Increased cesarean deliveries	28.5	19.5
Decreased total deliveries	11.7	10.4

VBAC, vaginal birth after cesarean.
Data are %.

Table 4. Claims Filed as a Result of Care Rendered During Residency

	2006	2009
None	62.7	57.2
One	26.2	28.6
Two	7.6	9.3
Three	2.2	2.9
Four or more	1.3	2.1

Data are %.

Practice Changes

Not surprisingly, physicians reported changes in their clinical practice as a result of the liability climate over the years. Nearly 60% of ob–gyn respondents to the 2009 survey made one or more changes to their practice as a result of the affordability or availability or both of professional liability insurance, and 62.9% made one or more changes to their practice as a result of the risk or fear of professional liability claims or litigation (Table 3).

Claims

The number of actual claims physicians had ever incurred indicated a very high percentage. A total of 89.2% of the respondents in 2006 and 90.5% of the respondents in 2009 reported that a claim had been filed against them at least once during their career. Of those groups that experienced claims, 37.3% in 2006 and 42.8% in 2009 reported that at least one of the claims arose out of care rendered during residency (Table 4). The mean number of claims resulting from care rendered during residency was 1.42 in 2006 and 1.64 in 2009. The total number of claims during the physician's career to date is reported in Table 5.

Approximately 62% of claims reported in 2009 were related to obstetrics. The breakdown of primary allegations is seen in Table 6. "Neurologically impaired infant" was most likely to be the primary allegation of an obstetric claim (30.8% in 2006, 30.5% in 2009). "Stillbirth or neonatal death" was the second most frequent primary obstetric allegation (15.8% in 2006, 15.6% in 2009). For claims related to gynecology only (Table 7), the top primary allegations were patient injury–major (22.8% in 2006, 26.9% in 2009) and delay/failure to diagnose (28.8% in 2006, 24% in 2009). Of the claims involving delay/failure to diagnose that were related to cancer, breast cancer was the most frequently cited, comprising 45.5% of such claims in 2006 and 46.4% in 2009 (Table 8).

Table 5. Number of Claims Experienced During Career

	2006	2009
None	10.8	9.5
One	22.0	21.1
Two	19.5	18.9
Three	18.2	18.0
Four or more	29.5	32.5
Mean	2.62	2.69

Data are % unless otherwise specified.

Table 6. Obstetric Claims: Primary Allegations

	2006	2009
Neurologically impaired infant	30.8	30.5
Stillbirth/neonatal death	15.8	15.6
Other major neonatal injury	10.0	11.2
Delay/failure to diagnose	14.1	10.7
Maternal injury—major	5.1	4.5
Foreign object	2.1	1.7
Other	20.2	19.3

Data are %.

Table 9 shows the outcome of those claims resolved at the time of the 2006 and 2009 surveys. For the 2009 survey period, 53.0% of claims were reported dropped or settled without any payment. This included those dropped by the plaintiff (37.4%), dismissed by the court (12.1%), and settled without payment on behalf of the ob–gyn (3.5%). A total of 47.0% of respondents reported an outcome that involved payment. Outcomes include those settled in advance of trial or before verdict (31.0%), those closed through arbitration or other alternative dispute resolution mechanism (3.2%), and those closed through jury or court verdict (12.8%). The average for all paid claims was $512,049, with a median of $250,000.

In analysis of the 2009 survey results, the greatest risk of a claim, as well as reported changes in practice in response to this risk, occurred in District II (New York State), District III (Pennsylvania, New Jersey, and Delaware) and District IV (Southeast, including Florida).

Table 7. Gynecologic-Only Claims: Primary Allegations

	2006	2009
Patient injury—major	22.8	26.9
Delay/failure to diagnose	28.8	24.0
Patient injury—minor	19.4	17.0
Foreign object	4.9	5.4
Patient death	6.2	4.9
Informed consent	5.1	4.5
Failure of sterilization	1.3	1.3
Failure to refer		0.7
Other	14.9	15.4

Data are %.

Table 8. Gynecologic Claims: Cancer Site for Delay In Diagnosis or Failure to Diagnose

	2006	2009
Breast	45.5	46.4
Cervix	15.8	15.2
Uterus		13.0
Ovary	10.1	10.9
Other	29.1	14.5

Data are %.

For the rest of the districts, there were variable findings. District IX (California) and District XI (Texas) consistently were in the lowest percentile in all areas.

DISCUSSION

Our nation provides exceptional medical education, training some of the world's finest obstetricians and gynecologists. Nonetheless, the 2009 College survey data reinforces the negative findings of previous studies, showing a sustained pattern of physicians modifying practice and decreased care. A total of 90.5% of College Fellows report they have been sued at least once. On average, ob–gyns are sued 2.7 times during their careers, and nearly 63% have made changes to their practice during the last three years because of the high risk of liability claims. In total, 38% have either decreased the number of high-risk obstetric patients treated or have ceased providing obstetric care altogether; 15% have decreased gynecologic surgical procedures. Over 37% of respondents to the 2006 survey indicated they had been sued as a result of care rendered during residency. In 2009 this number increased to 42.8%. This can and does have an effect on students choosing to enter an ob–gyn residency and career.

The average age at which physicians cease practicing obstetrics is now 48 years, an age once considered near the midpoint of an ob–gyn's professional career. Current concerns about the economy, coupled with anecdotal reports of resumption of practice of obstetrics, had led the College to believe that the age at which physicians ceased to practice obstetrics would increase. Unfortunately, the 2009 survey results did not sustain this impression. Because the typical resident is approximately 30–32 years of age on completion of training, a conclusion from this finding is that 16 to 18 years is the average span of practicing obstetrics. As the population continues to grow, so does the danger that there will be an insufficient supply of practicing obstetricians to handle the needs of the obstetric population in the future.

Table 9. Results of Liability Claims

	2006	2009
Dropped by plaintiff	37.3	37.4
Dismissed by court	13.0	12.1
Settled without payment	17.1	3.5
Arbitration or other ADR	3.4	3.2
Settled with payment	20.1	31.0
Jury/court verdict	10.2	12.8

ADR, alternative dispute resolution.
Data are %.

There are other aspects of the survey results that need to be more closely evaluated. Only one in five obstetrician-gynecologists is now in solo practice. More than half are in group practice, which probably reflects the goals of recent graduates to have an improved lifestyle. Almost 30% of respondents who stopped obstetrics did so to have more personal time. Other reports to the College indicate an increase in the number of graduates who elect to engage only in office-based practice. This will be studied in future College surveys as it will also have a major effect on available work force if the trend continues.

Although the response rate for the 2009 survey decreased in comparison to past surveys, two factors suggest the results are reliable and accurate. First, results from the 2009 survey are similar to results from prior surveys. Additionally, at meetings of the College districts where the results were discussed, there was a consensus that the results accurately reflect the existing liability environment. Unfortunately, there are no other detailed reports of this scope specific to obstetrics and gynecology that can confirm our findings. Data from the PIAA (Physician Insurers Association of America) published in August 2009 and based on 2008 data for closed claims revealed similar findings regarding overall ob–gyn claims.[4]

Looking Ahead

For many years, the College has advocated for reform of our broken medical liability system, including caps on noneconomic damages and other reforms like those found in Texas and California. We are pushing hard in the states and Congress for a variety of alternatives to our current civil justice system that can help reduce the need for defensive medicine and other practice changes. Several such alternatives are now ripe to be tested in the states. For more than 20 years, the College has supported measures that address the failings of the current system including long delays, excessive costs, and unpredictability and inequality of compensation. Successful alternatives could help guarantee that injured patients are com-

pensated fairly and quickly while promoting quality of care and patient safety, reducing the incidence of frivolous lawsuits, and reducing liability premiums. With the intricacies involved in these various approaches, it is important that they are done correctly.

The following alternatives will meet the core principles and goals of putting patient safety first, reducing preventable injuries, fostering better communication between doctors and their patients, ensuring that patients are fairly and quickly compensated for medical injuries, reducing the incidence of frivolous lawsuits, and reducing liability premiums.

Early Offer

Early offer programs would allow a physician or hospital to offer economic damages–past, present, and future–to an injured party without involving the courts. This offer would not constitute an admission of liability and would be inadmissible if a lawsuit were filed in the case. Physicians would have incentives to make good faith offers as early as possible after the injury is discovered and patients would have incentives to accept legitimate offers of compensation. Early offer programs would require the injured party to meet a higher burden of proof and negligence standard if she chose to reject the offer and file a lawsuit. The College supports this alternative and believes it has great potential. However, it is important to include a stipulation that compels the injured party to meet both a higher burden of proof and a more stringent standard of negligence if she rejects the offer.

Health Care Courts

Health care courts would allow for a bench or jury trial presided over by a specially trained judge to exclusively hear medical liability cases. These courts have the potential to correct severe deficiencies of the current medical justice system, as well as reduce health system errors and improve patient safety. Presently, the average case against ob–gyns takes 4 years to resolve, with 13% of cases taking 7 or more years. Such cases involve scientific and ethical questions about disease, biology, and appropriate medical treatments that can be highly complex. A judge with specialized training would resolve disputes with greater reliability, consistency, and efficiency than untrained judges or juries, and could issue opinions that define standards of care or set legal precedent. Health care courts would provide patients with a faster and less expensive adjudication process, more reliable and consistent decisions, and more equitable and predictable compensation. Additionally, de-identified claims information would be provided to patient safety authorities and providers to examine patterns of errors. The College supports health care courts as long as they are designed to allow for bench or jury trials.

Expert Witness Qualifications

This alternative would limit expert witness standing only to individuals who are licensed and trained in the same specialty as the defendant, have particular expertise in the disease process or procedure performed in the case, were in active medical practice in the same specialty as the defendant within 5 years of the claim, or taught at an accredited medical school on the medical care and type of treatment at issue. The College supports strict versions of this alternative, especially if a uniform national standard is adopted for expert witness qualifications. For that reason, the College encourages the adoption by states of the Federal Rules of Civil Procedure and Federal Rules of Evidence.

I'm Sorry

These programs encourage physicians to directly discuss errors and injuries with a patient, apologize, and discuss corrective action. The apology is not permitted to be constructed as, or offered as evidence of, an admission against the physician's interest. Discussions are inadmissible if the patient brings a lawsuit. The College fully supports these provisions and believes there is value in furthering this concept.

Voluntary Alternative Dispute Resolution

States would encourage other innovative systems for compensating individuals who are injured in the course of receiving health care services. The College believes this alternative holds great promise and is very interested in it being tested in the states. Such a program has been successfully implemented in Colorado, but is currently limited to claims under $30,000.

Defined Catastrophic Injury Systems

These systems would establish a fund for individuals with bad outcomes regardless of whether the health care provider was negligent; birth injury funds are an example of this model. The College strongly supports incentives for Defined Catastrophic Injury Systems and urges the federal government to test this concept in the states. However, this alternative might not be easily replicated under a demonstration project, given financial constraints.

Certificate of Merit

A certificate of merit program would require plaintiffs to file an affidavit with the court showing that the case has merit before the case can move forward. Certifi-

cates would require the written opinion of a qualified health care provider affirming that the defendant failed to meet the standard of care exercised by a reasonably prudent health care provider, which caused or directly contributed to the damages claimed. The College is supportive of this alternative. However, many states have already adopted this requirement, and we believe that other alternatives should receive priority in this initiative.

CONCLUSION

Obstetric and gynecologic practice is changing. Both professional liability concerns and the cost of practicing defensive medicine are key factors in these changes. As seen in Texas, where reform has been enacted, premium costs stabilize and even decrease as the number of companies providing liability insurance increases. Defensive medicine also increases the cost of care. For example, survey respondents noted that they are performing more cesarean deliveries.

Unfortunately, there is a lot of pressure from trial lawyers to prevent reform. In 2006, members of the Association of Trial Lawyers changed the organization's name to the American Association of Justice, because they felt that the original name left negative impressions and could affect tort reform.[5] Their Web site, www.98000reasons.org, explains their positions.

Professional liability risk and fear is adversely affecting our specialty and the way it is practiced. Change is needed, whether as insurance reform, alternative resolution methods, or other approaches. The College is dedicated to finding a solution to the current liability environment. The success of the Texas Tort Reform actions has shown that judicial nullification of reform can be overcome and that reform legislation can and will result in a more favorable practice environment.

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