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# Forum on Malpractice Issues in Childbirth

PROLIFERATING MALPRACTICE SUITS, spiraling jury awards, soaring premiums for liability insurance, and the refusal of a growing number of insurers to renew malpractice policies have led to a crisis in maternal health care, most experts at a July 1985 forum on malpractice issues in childbirth agreed. Speaker after speaker testified that these trends are driving many maternal health care providers out of the field, restricting access of pregnant women to appropriate medical care, changing obstetrical practice, and increasing health care costs.

The 2-day forum, held at the National Institutes of Health in Bethesda, MD, was first proposed by the International Childbirth Education Association (ICEA) and was cosponsored by the National Institute of Child Health and Human Development and the Health Resources and Services Administration's Division of Maternal and Child Health. It brought together some 80 representatives of all parties involved in the malpractice situation as it affects maternal health care—obstetricians and gynecologists, family practitioners, nurse midwives, hospitals, birth centers, the Federal Government, State legislators, third-party insurers, malpractice underwriters, attorneys, and childbirth and health consumer organizations—to examine the many facets of the problem and develop constructive recommendations for action.

## Crisis Effects Widely Felt

In opening statements, officials of the sponsoring agencies outlined the concerns that had led them to convene the forum.

Susan K. Baker, ICEA President, said the association's worries about the malpractice situation are threefold: actual malpractice, diminished access of women to appropriate prenatal and obstetrical care, and a reduction in choices for childbearing families.

"Action must be taken to reduce injuries caused through negligence by health providers," she said. "Litigation and compensation must continue to be options available to those injured through negligence. However, the role of litigation in health care should not be restrictive to the point of curtailing quality of care and the ability of providers and consumers to work together in a trusting environment. It should not be a major determining factor in health care decisions."

Citing the growing number of malpractice suits, rising liability premiums, and problems some care providers are having in obtaining any malpractice insurance at all, Baker said that in some communities "women may be left with few birth alternatives for professional maternity care, and thus their pregnancy outcomes could be jeopardized."

ICEA is also concerned that childbirth choices are being reduced, she continued. "As malpractice claims become more frequent and settlements become higher, health care providers and hospitals become less flexible, interventions such as prenatal diagnostic testing and electronic fetal monitoring become more routine, and parents have fewer options available. . . . ICEA is concerned that this trend has shifted the emphasis of birth from that of a most significant human event that is usually low-risk to a high-risk, high-tech experience."

Vince Hutchins, MD, Director of the Division of Maternal and Child Health, Health Resources and Services Administration, quoted nurse educator Reva Rubin's statement that "without investment in the pregnant woman, she cannot invest in her child."

"That investment begins with prepregnancy care and counseling and continues with early and comprehensive prenatal care," Hutchins said. "Our concern is that health providers—certified nurse midwives, obstetricians, family practitioners, public health nurses—will be available, especially to low-income women, to provide that care in a complete and timely fashion."

In addition to the concerns outlined by Baker and Hutchins, Duane Alexander, MD, Acting Director of the National Institute of Child Health and Human Development (NICHD), emphasized the "constraint placed on research that is imposed by a system that becomes driven primarily by lawsuits."

*'The public will lose substantially if significant numbers of family physicians are economically compelled to forgo obstetrics.'*

This is affecting the Institute's research program in two ways, he said. "First, our ability to test new drugs and devices related to pregnancy has been curtailed because of the inability of some of the investigators we support to obtain liability insurance at any price. If we cannot do the clinical testing, we cannot bring new products to the public.

"Second, our ability to conduct research on alternative obstetric practices to what is standard, accepted, and safe from a medicolegal standpoint faces constraints based on fear of a malpractice suit if an adverse outcome occurs in the experimental group. . . . When we are forced into a situation where we must follow established dogma rather than be allowed to try something new and possibly better, for fear of a malpractice suit, medical research and progress will come to a halt and the health care of our people will suffer. This must not be allowed to happen."

"The traditional professional liability insurance system seems to be breaking down," said Kenneth V. Heland, JD, Associate Director of the Department of Professional Liability, American College of Obstetricians and Gynecologists (ACOG), first of a series of participants who gave prepared statements at the forum's opening session.

Before 1976, malpractice suits were being filed each year against 1 out of every 20 obstetricians and gynecologists. Today the proportion of OB-GYNs being sued has risen to 1 in 6, according to Heland. This burgeoning of lawsuits has occurred despite continuing declines in infant and maternal mortality rates, he pointed out.

Heland said a national survey of ACOG fellows conducted in 1983 disclosed that the threat of malpractice suits had prompted 9.1 percent to give up the practice of obstetrics entirely and 17.7 percent to stop accepting high-risk obstetrical patients. Data due soon from a similar survey, conducted this year, are expected to show that these percentages have increased significantly.

Liability insurance premiums for OB-GYNs rank among the highest for any medical specialists, according to Heland. Premiums paid by OB-GYNs for $1 million worth of coverage now range from $6,200 in Arkansas to $82,700 on New York's Long Island, he said. For Maryland, Michigan, and West Virginia, there have been recent rate increases ranging from 93 to 147 percent.

But "more frightening in its implications for quality health care is unavailability of insurance," Heland continued. "Right now, every State has at least one malpractice carrier offering coverage for OB-GYNs. We are afraid that this will not be the case much longer." He stated that the ACOG-endorsed national policy covering malpractice was terminated by the insurer as of June 1, 1985, forcing some 820 OB-GYNs to secure alternative coverage. "We have not been successful in replacing [the national policy] and do not appear likely to do so."

Nor are OB-GYNs the only maternal health care providers threatened, Heland pointed out: "The crisis in obstetrics affects . . . all health care providers in the field. The American College of Nurse Midwives lost its national policy about the same time that the ACOG policy was terminated, and they have not been able to replace this policy. In Nevada and New Mexico, all of the professional liability carriers have rated family physicians and general practitioners who do obstetrics at the same premium level as OB-GYNs, thus threatening prenatal and obstetrical services in the rural areas of those States."

Sarah D. Cohn, CNM, Chairman of the Professional Liability Committee, American College of Nurse Midwives, reported that the organization's former group insurer "will not be writing insurance in what they have called the 'high-risk areas' . . . in part because the insurer cannot find adequate reinsurance.

"We've solicited proposals from more than a dozen insurers," she continued, "and all but one have declined even to submit a proposal for insurance for us. The companies, where they have agreed to tell us what the reasons are, have acknowledged that the liability claims rate for nurse midwives is very favorable, but still we provide what they call 'high-risk' services, and many companies are simply not insuring high-risk services any more."

In addition to cancellation of ACNM's group policy, many individual policies held by nurse midwives have been cancelled as well, Cohn reported. Although some nurse midwives in some parts of the country have been successful in finding alternative coverage, Cohn said insurers "are placing increasing restrictions on the type of practice that our membership may participate in. . . . Many com-

panies now are refusing to write independent policies for a nurse midwife, so in some parts of the country and in some kinds of practices, nurse midwives simply can't find an insurer and, without insurance, can't practice.

"We realize that we're not the only professional group having insurance problems," Cohn concluded, "but our group in particular may face eventual extinction if insurance doesn't become rather quickly available to our members, and at an affordable premium."

Richard G. Roberts, MD, of the Committee on Professional Liability, American Academy of Family Physicians, reported that malpractice insurance premiums for family physicians have risen to $36,000 in some States. "The inexorable rise in . . . premiums has resulted in higher charges for obstetrical services—charges that family doctors are reluctant or unable to pass on to their less affluent young families. Consequently, many family physicians have been forced to eliminate from their practices the obstetrical services they once offered to their patients. In certain States, particularly Florida, as many as one-half of family practitioners have discontinued obstetrics as a result of premium increases," he said.

"The public will lose substantially if significant numbers of family physicians are economically compelled to forgo obstetrics," Roberts warned. "Large segments of rural America will have no ready access to obstetrical services. . . . In addition, many Americans will lose access to the high-quality, family-centered maternal health care currently provided by family physicians."

Hospitals and birth centers are also feeling the effects of the malpractice crisis.

"The paradox that continues to trouble us all," said Claudette R. Krizek of the Office of Legal and Regulatory Affairs, American Hospital Association, "is that while the quality of care continues to rise and the number of poor results continues to fall, the number of claims and the size of awards continue to rise. All indicators seem to suggest that malpractice claims and awards are themselves 'a disease desperate grown.' "

Eunice Ernst, Director of the National Association of Childbearing Centers, warned that the current malpractice situation "presents the greatest threat to the survival of birth centers yet encountered."

She reported that in the 3 months preceding the forum, six birth centers announced closure or an intent to close. "Three additional centers have suspended physical care services, hoping for a resolution to the nonavailability of malpractice insurance. Thirty centers are now in jeopardy because the insurance they now hold will not be renewed due to nonavailability of reinsurance to cover the policy. This means that 30 percent of the birth centers operating in January 1985 would be closed by the end of the year. In addition, almost all preparations for new birth centers, and there are many, are on hold, awaiting resolution of the malpractice problem." Ernst pointed out that 80 percent of birth centers serve low-income women.

From the vantage point of the third-party insurer, Alan Richards, Senior Washington Representative and Legal Advisor for the Blue Cross and Blue Shield Association, said his association's concern is the "extra costs that the malpractice phenomenon creates for everybody who pays for health care in this country," as well as the threat it poses to availability of care.

"Our estimates about malpractice insurance costs range from $2 billion to $4 billion a year," Richards said. "Settling those malpractice suits, paying those awards to injured parties, is a very inefficient process.

"It is particularly disturbing," he continued, "that only a fraction of the money spent on professional liability protection reaches the injured patient. Legal costs, both plaintiff's and defendant's, insurance, and administrative costs eat up 60 to 70 cents of every malpractice insurance dollar . . . . It's simply not a very efficient way to take care of injured patients.

"Even more important, the specter of malpractice liability undoubtedly influences the professional judgments of providers of care," Richards added, noting that the American Medical Association's "conservative figure" for the cost of defensive medicine is $15 billion a year. "All of these costs, whether the high premiums for liability coverages or the extra expenses of defensive medicine, are passed on eventually to the patient and whoever is paying his bill."

Robert E. Scott, Jr., JD, of the Defense Research Institute, Defense Research and Trial Lawyers Association, summarized the impact of the malpractice situation this way: "It is no overstatement to suggest that the unlimited growth of malpractice awards, based on expanding concepts of liability and on overcompensation, poses a significant threat to health care delivery in this country. The ultimate cost of health services has dramatically increased, in part as a result, and it may well be that it will become impossible to provide some kind of service for all."

## Some Elements of the Crisis

"What we are talking about is an acute affair, and it should be viewed that way," said the forum's keynote speaker, Roger O. Egeberg, MD, a former Assistant Secretary for Health who is now Senior Scholar in Residence at the National Academy of Sciences.

"In 1984, the malpractice crisis had reached the point where, in spite of burgeoning premiums, for every $1 of premiums the insurers took in, they had costs—awards, lawyer's fees, and overhead—of $1.66," Egeberg said. "They made up some of that difference through interest earned, but they have reached the losing point, and the road ahead looks bleak. . . . There are those who say that this is an insurance company racket, but it is not."

Among other factors in the malpractice dilemma, Egeberg singled out the increasing number of lawsuits and "a contest to see who can get the most horrendous award." He noted that a serious consequence of the current litigious climate is damage to the provider-patient relationship: a "relationship of trust—deserved trust in far and away the greatest number of instances—[that] is in itself important to healing."

Unrealistic expectations of patients are playing an important role in the rising number of suits, said Egeberg. "In obstetrics, the patient always expects a good outcome—10 fingers, 10 toes, and a good brain. Unfortunately, that isn't always going to happen—regardless. Among other things, some defects come about by mothers' smoking greatly and drinking carelessly during pregnancy—and if the mother feels guilty, that's all the more reason to sue, and maybe bring about an expiation of her guilt."

In the view of Sal Fiscina, MD, JD, President-Elect of the American College of Legal Medicine, "As health care provision has become more complex, complicated, and unavoidably hazardous, a system capable of minimizing various adverse consequences of health care became necessary. This spawned consumer expectation, similar to the expectation of airline passengers that an airline will exercise checklists and train its personnel to fly in a safe and effective manner."

ACOG's Kenneth Heland feels that the crux of the malpractice problem is "the explosive verdict potential of the brain-damaged baby."

"These cases, when they are lost by the doctor, result in larger and larger verdicts," said Heland. "They are becoming more and more difficult to win, at the same time that a group of experts convened by the National Institutes of Health concluded that 'obstetric trauma now is a rare cause of neurologic damage to the baby.' "

(The report to which Heland referred—"Prenatal and Perinatal Factors Associated with Brain Disorders"—was mentioned by NICHD Director Duane Alexander in his opening statement. Alexander said the 460-page report—which was based on an extensive data search cosponsored by NICHD and the National Institute of Neurological and Communicative Disorders and Stroke—'may reorder thinking' and has been in heavy demand by both medical and legal experts. Single copies are available free from the Office of Research Reporting, NICHD, National Institutes of Health, Bldg. 31, Rm. 2A32, Bethesda, MD 20205.)

"We are not trying to protect the so-called bad doctor," Heland said. "Our review of cases indicates that the 'bad doctor' problem is a very small part of the current difficulties. We believe that more stringent peer review programs, the development of quality assurance programs, and stricter controls on hospital privileges can adequately deal with that portion of the problem.

"What concerns us," he emphasized, "is that the obstetricians most likely to be sued are often good doctors who are well trained and highly motivated. They significantly increase their malpractice risks by taking on difficult OB cases, knowing that there will be a higher percentage of bad outcomes, but knowing that their services are needed. We need to allow these physicians to continue to practice and assume these risks."

## The Search for Solutions

Following the forum's first plenary session, participants divided into seven work groups to develop recommendations on actions that maternal health care providers; the public; Federal, State, and local governments; medical malpractice underwriters; third-party insurers; and attorneys can take to prevent childbirth-related injury and reduce the adverse effects of malpractice claims. Space permits highlighting here only a few of the most important recommendations; however, they are covered in detail in the complete forum proceedings, which are being published by ICEA. (Those wishing to order the proceedings should write the Director of Publications, International Childbirth Education Association, P.O. Box 20648, Minneapolis, MN 55420-0048. Price per copy: $8.)

The crux of the task for the work groups was neatly summarized by the Defense Research Insti-

tute's Robert Scott: "How can [health care providers] be protected with affordable malpractice insurance, without diminishing the quality of medical care, while retaining the right of an injured patient to receive adequate compensation—but not a windfall—for an injury that was caused by [the provider's] negligence?"

A major factor contributing to high malpractice premiums and to the unavailability, in some areas, of insurance for so-called high-risk providers is the problem insurers face in obtaining reinsurance, as Roger Egeberg explained in his keynote address. "The deciding factor . . . is cost. The insurance companies can figure the odds [on suits] relatively well in the first 2 or 3 years after an alleged malpractice has occurred. After that, because of changes in technology, public sentiment, and judges' and juries' outrageous settlements, the figures fuzz up—they fuzz up badly—so the insurance companies look for reinsurers. The reinsurers see the same problems and become very skittish. To be safe, they may charge many times what they figure it might be, just in case." And in some instances, they may refuse to provide reinsurance at all.

Egeberg recommended, as did work group participants, that the Federal Government help solve the problem by itself providing reinsurance. Egeberg said rising health care costs attributable to the malpractice crisis are "probably right now costing the Government, through Medicare and Medicaid, $6 billion or $8 billion a year." Noting the estimated annual costs of malpractice premiums and of defensive medicine that have already been referred to, he said: "I figure that if one says the Government could save $8 billion by getting us out of this, I'm being conservative. . . . The States have much that you can ask for, such as stronger licensing boards, stronger insurance commissioners, and so forth. But the Federal Government needs to be in this in a noninterfering, and for them probably a profitable, way."

Among other important recommendations to come from the work groups were:

- Exploration of alternatives to litigation, such as formal grievance procedures; nonbinding arbitration; multidisciplinary tribunals to set rates and caps for birth-related injuries; and provision of Medicaid entitlement, with no means test, for birth-injured patients with catastrophic disability.
- Tort reforms, including elimination of the collateral source rule (which prevents juries from learning what plaintiffs have already received for their injuries from health insurance or other sources); shortening of the statute of limitations for injured-infant claims; limits on awards for noneconomic damages (for example, "mental suffering"); itemization of the jury award; and elimination of punitive damages from awards in malpractice suits against health care providers.
- Strengthening of methods for identifying and effectively disciplining incompetent health care providers.
- Better education of patients by health providers as to health risks related to pregnancy, realistic expectations about birth outcomes, and their own responsibilities for their and their infants' health.
- Health providers' careful attention to obtaining patients' documented, fully informed consent for care.
- Improvements in health providers' education to ensure state-of-the-art information about new developments in prenatal care and full knowledge and appreciation of the roles of all providers—physicians, midwives, and nurses.
- Education of the public about what constitutes good perinatal care and about its power and responsibility to effect needed changes.

## Looking to the Future

At the end of the forum, Diony Young, Public Policy Liaison for ICEA, and the forum chairperson, said the meeting had achieved its major goal, which was to bring together all groups who are part of the malpractice problem and make them part of the solution. "It has been an opportunity for opening new dialogues between people who haven't talked before on this particular issue," she said, "and I think it has itself formed a new foundation for discussion of the topic of malpractice."

Young suggested that the forum could serve as an important model for similar meetings, to be held at State and regional levels, that would address issues specific to the geographic area involved. (Such meetings were also a recommendation of the work groups.)

The importance of continuing dialogue was summed up by the American College of Medicine's Sal Fiscina. "There is no one-factor fix [for the malpractice crisis]," he said. "I would like to make a plea that this is an interdisciplinary problem—a multifaceted problem that is going to require an interdisciplinary approach." — ELLEN CASSELBERRY, Assistant Executive Editor, *Public Health Reports*