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Perspective

Avoidable Brain Damage And Medical Liability

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New York state lawmakers are confronted with critical decisions in the legislative session that relate to patient safety, stability of liability insurance rates, and a proposal urging a radical change for brain injured newborns because they have the most serious injuries. The American College of Obstetricians and Gynecologists (ACOG) is the national professional organization for obstetricians. ACOG's proposed bill submitted to our Legislature seeks legal immunity (no fault).[1]

Noting since the 1980s that the greatest medical liability risk to their members involve claims of avoidable brain damage occurring during the labor and delivery birth process, ACOG has maintained that large payments in cases claiming oxygen deprivation at birth as a cause of neurologic impairment are meritless. ACOG's premise is that oxygen deprivation (a potentially avoidable event) rarely causes disabling brain damage and thus payment on meritless cases proves that the civil justice system does not work for their members who, therefore, should have liability immunity through a no-fault system.[2]

ACOG is pressing for a no-fault system, while medical liability insurers are seeking liability insurance stabilization. The New York State Trial Lawyers Association (NYSTLA) is urging a patient safety center. We believe that ACOG's position has been harmful to patients and the medical profession, and this article addresses its positions over the years.

Immunity, which ACOG pursues, runs counter to the principles that underlie the civil liability tort system. The legal obligation imposed by "fault" on the part of the tortfeasor to fully pay a patient is premised on the moral concept that the tortfeasor should bear the full financial responsibility for an avoidable bad outcome and importantly, the obligation to pay acts as a warning that the law demands the exercise of due care (accountability).[3] That accountability has created financial and other incentives that have promoted patient safety.

Can the method used by the American Society of Anesthesiologists to dramatically improve patient safety and lower insurance premiums work for obstetricians?

The American Society of Anesthesiologists (ASA), the national professional society for anesthesiologists, is an example of one organization that recognized this concept. In the 1980s, the ASA used information learned from liability cases to adopt mandatory safety standards. As a result, they made the administration of anesthesia safer. For example, they dramatically cut their anesthetic related mortality rates from about one for every 5,000 to 10,000 procedures to one per every 200,000 procedures[4] and also, their liability insurance premiums dropped dramatically.[5] Anesthesia is an intrinsically hazardous undertaking yet the specialty has been cited as a model for reducing patient errors.[6]

A comparison between what the ASA has done over the past 30 years (e.g., with anesthetic related avoidable deaths) with what ACOG has done in the same time frame is useful.

In 1987, ACOG published in its peer review journal an article that gives insight into a mind set preoccupied with defending liability claims related to labor and child birth. According to the author since "… most litigation is based upon events during the delivery process…" they recommended obtaining a sample of fetal blood only when the baby was depressed so they could use that information to help defend a liability case. On the other hand, if the baby was not depressed they recommend against obtaining a sample of blood because such might be "uncomfortably incriminating."[7]

With this insight, we can understand the motive behind ACOG's creation and adoption of certain criteria intended to define an event during the delivery process that might have caused disabling brain damage (and thus might potentially create liability). A list of criteria was initially created in 1992 by an ACOG committee chaired by Gary D.V. Hankins,

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M.D. and in 2003, an ACOG committee again chaired by Dr. Hankins issued new criteria modifying the former list.[8] One of the doctors who helped to create both the old and new criteria acknowledged that the creation of these criteria is "intended for litigation."[9]

No scientific studies or data support the criteria, yet the wording of these documents require that they all must stringently exist for causation to be established. The popularity and thus the appeal to obstetricians is when these criteria are stringently applied, few cases of disabling brain damage would be due to potentially avoidable causes.[10] Thus when a case would be brought, defense experts would swear that it would be impossible for causation to exist unless all of the criteria rigidly existed.

In Florida, it can be to the legal advantage of an obstetrician that a child's brain damage did occur during the labor birth process. In this regard Dr. Hankins when recently testifying in a Florida proceeding as an expert witness to support an obstetrician's legal position that a brain injury did occur during the labor and delivery process swore that the criteria were not essential. Even though Dr. Hankins has acknowledged that the criteria are usually used to support a defendant's position that causation can not exist, when the use of the criteria was not to the doctor's legal advantage, he swore that the criteria were not essential and each case must be evaluated on its own merits.[11] Evaluating each case on its own merits means using the differential diagnosis methodology (what fits and what does not fit with the specific facts of the case) which is the scientific methodology recognized by our courts as reliable.[12]

Can the method used by the ASA to dramatically improve patient safety and lower insurance premiums work for obstetricians?

A recent study demonstrated how a redesigned obstetrical patient safety process did produce a dramatic decline in litigation. Though advocating a liberal use of cesarean deliveries to avoid difficult deliveries they actually achieved fewer cesarean deliveries, fewer bad outcomes, and fewer liability claims. How? By focusing on the clinical and fetal monitoring information with a staff including a 24-hour in-hospital attending obstetrician focused on unambiguous guidelines and a mandatory obligation to halt any process deemed dangerous.[13]

The authors of the study noted that one "traditional approach" has been guidelines which are "purposefully ambiguous" intended to assist the liability defense. The study concluded that specificity, not ambiguity, is the answer to help achieve both patient safety and litigation benefit.

We have discussed these issues in far greater detail elsewhere, and we have proposed mandatory standards and a Patient Safety Center. We invite the interested reader to seek out these details and proposals.[14]

We have had the res-ponsibility to advocate the legal rights of children who have been the victims of substandard obstetrical care. It is ACOG's taking of information that can be used to protect children and instead using that information to create a false illusion intended to enhance legal defenses that has undermined the safe practice of obstetrics. The ASA found strong leaders willing to admit its own patient safety efforts were not working. When strong, similarly motivated obstetrical leaders emerge, the pseudoscientific criteria will be scrapped, mandatory proactive standards will be adopted, and obstetrical care will become safer.

1. See Berkowitz, R.L., Hankins, G., etc.; A Proposed Model for Managing Cases of Neurologically Impaired Infants; OB-GYN March 2009; 113:683-6. Describing ACOG's "no fault" proposal submitted to the N.Y. State Legislature (S 7748).

2. See for example the submissions made on behalf of ACOG to Superintendent of Insurance, Eric Dinallo and Commissioner of Health, Richard F. Daines, M.D. who co-chaired a task force in September to December, 2007, looking into causes for medical liability insurance costs.

3. *Bing v. Thunig,* 2N.Y.S.2d 656, 666 (1957).

4. ACOG Clinical Review, Patient Safety a New Imperative, Vol. 6, Issue 4, July/August 2001.

5. David M. Gaba, Anesthesiology as a Model for Patient Safety in Health Care, 320 Brit. Med. J. 785 (2000). See also John H. Eichhorn, et. al., Standards for Patient Monitoring During Anesthesia at Harvard Medical School, 256 JAMA 1017, 1017-20 (1986).

6. Cooper, J.B., Gaba, D. "No Myth: Anesthesia Is a Model for Addressing Patient Safety." Anesthesiology, 97(6), 2002, pp. 1335-7. Institute of Medicine, to Err Is Human (Linda Kohn, et al.) 2000; at 32, 144-45.

7. Perkins, "Perspective on Perinatal Brain Damage," OB-GYN 69:807 (1987).

8. ACOG, Technical Bulletin 163-January 1992, Fetal and Neonatal Neurologic Injury. ACOG Neonatal Encephalopathy and Cerebral Palsy, Defining the Pathogenesis and Pathophysiology, January 2003.

9. Philadelphia Inquirer, Feb. 10, 2003, "A Dispute on Doctor Cerebral Palsy Role."

10. Goodlin, R.C., "Do Concepts of Causes and Prevention of Cerebral Palsy Require Revision?" AM. J. OB-GYN 1995: 172:1830-6. The paper refers to why the criteria are popular and thus have an appeal to obstetricians.

11. See: *Robert and Tammy Bennett, individually and as parents and natural guardians of Tristan Bennett, a minor, Petitioners v. Florida Birth-Related Neurological Compensation Association, Respondent*. Case No: 06-2422N. In that case Dr. Hankins testified on behalf of an obstetrician and hospital (intervenors) on June 11, 2007, and again on July 9, 2007. It was to the legal advantage of the obstetrician that the infant's brain damage be related to the labor and delivery events and thus Dr. Hankins opined that the 2003 criteria though not met didn't refute his opinion supporting causation.

12. See for example, *Westberry v. Gislaved Gummi A.B.*, 178 F.3d 257 (U.S. Court of Appeals for the Fourth Circuit, 1999), and *Hardyman v. North Fork and Western Railroad Company*, 243 F.3d 255 (U.S. Court of Appeals, Sixth Circuit, 2001).

13. See discussion in Clark, S.L., etc.: AM. J. OB-GYN 2008; 199:105.e1-e7.

14. See New York Law School Legal Studies Research Paper Series 07/08, "Brain Injured Children and the Civil Justice System." (The paper can be downloaded from the Social Science Research Network at: http://www.ssrn.com).