

Medical Malpractice Reform: Neurologically Impaired Newborns

The current medical malpractice system—in many states and certainly New York—compensates individuals unevenly and inaccurately. The system is full of delays and diverts tremendous resources from the health care system in many ways, including through high premiums and other coverage costs. In a new *Health Care News In-Depth* series, GNYHA will explore a number of reform options in detail, starting with the process by which neurologically impaired newborns are compensated.

Cases involving neurologically impaired newborns are one of the principal drivers of high medical malpractice coverage costs for hospitals and physicians. While devastating, these cases often are not the result of provider negligence. And yet, the full cost of defending and paying for such cases is borne entirely by providers. Why? Research shows that the key predictor of compensation in malpractice cases is not the presence of provider negligence, but the degree of patient disability.¹

Revising the system for compensating these individuals could greatly expedite payments for needed care, eliminate the unnecessary costs of litigation, and spread the cost of care more broadly in recognition of the fact that providers are not responsible for many of the impairments that occur.

Neurological Impairments and Their Causes

“Neurological impairment” describes an

array of conditions or disabilities, but in the context of the high cost of medical malpractice coverage, it often refers to cerebral palsy (CP), neonatal encephalopathy, or other forms of substantial motor deficits occurring in newborns. The disabilities can be significant and require a lifetime of care. However, well-regarded studies and reports have concluded that the majority of such disabilities do not occur due to lack of oxygen during labor and delivery—as typically alleged in malpractice claims—but are most often attributable to events that occur during gestation (before labor begins).

The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics in 2003 released one of the most significant reports on the subject, entitled, “Neonatal Encephalopathy and Cerebral Palsy: Defining the Pathogenesis and Pathophysiology.” Endorsed by the Centers for Disease Control and Prevention, March of Dimes Foundation, and

National Institutes of Health, among others, the report stated advances in science and technology indicate that most cases of neurological impairment do not originate during labor and delivery, and are thus rarely caused by perinatal asphyxia. Rather, “It is now accepted that most neonatal encephalopathy and cerebral palsy have their origins in developmental abnormalities, metabolic abnormalities, autoimmune and coagulation defects, infection, trauma, or combinations of these factors.”² Cerebral palsy is also linked to children with low birth weight or gestational age, other conditions unaffected by the process of labor and delivery, with nearly one-quarter of all cerebral palsy cases occurring in infants weighing less than 1,500 grams (3.3 pounds) at birth.³

More recent articles by Dr. Karin B. Nelson of the National Institute of Neurological Disorders and Stroke and others underscore that lack of oxygen during delivery causes only a small proportion of cerebral palsy cases. Dr. Nelson has written that a study of eight types of complications that can cause an acute interruption in oxygen to a fetus found that only one complication—the umbilical cord wrapped

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1. Studdert, David M. LL.B., Sc.D., M.P.H., Michelle M. Mello J.D., Ph.D., and Troyen A. Brennan, M.D., J.D., M.P.H. “Medical Malpractice” *The New England Journal of Medicine* 350, no. 3 (Jan. 15, 2004): 283–292.

2. “Neonatal Encephalopathy and Cerebral Palsy: Defining the Pathogenesis and Pathophysiology” *The American College of Obstetricians and Gynecologists and American Academy of Pediatrics* (2003).

3. *Ibid.*

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around the fetus's neck—was linked to cerebral palsy in children with normal birth weight.⁴ Perhaps even more significant is the conclusion that, “despite serious efforts, CP due to birth asphyxia has not been shown to be preventable.” Even when cerebral palsy risk factors are known, “in none of these problems has obstetric intervention been demonstrated to reduce the risk of CP, largely because useful and specific indicators of intrauterine events do not yet exist.”⁵

In spite of the foregoing, in neurological impairment medical malpractice claims, plaintiffs' attorneys typically allege that delivery should have been more immediate. In response, Dr. Nelson has written that “there is no evidence of good quality that [cesarean] delivery can prevent cerebral palsy.”⁶ In this regard, a study conducted in ten countries, including the United States, concluded that “despite a 5-fold increase in cesarean deliveries over recent decades driven in part by the use of fetal monitoring, the incidence of CP has remained steady at about 1 in 500 births...”⁷ At the same time, major complications occur in about 2% of cesarean deliveries. According to the authors of the ten-country study, “Operative intervention based on [electronic fetal] monitoring has probably done more harm than good.”⁸

High Coverage Costs

In spite of the fact that most cases of neurologically impaired newborns are not the result of provider negligence, GNYHA estimates that obstetrical (OB) services account for about 35% to 50% of hospital members' medical malpractice coverage costs, due in great part to the costs associated with claims involving such disabili-

ties. GNYHA projects that its members' total coverage costs exceed \$1.6 billion per year, meaning hospitals in New York spend between \$560 million and \$800 million each year for malpractice coverage for their OB services alone.

Recent GNYHA research suggests many hospitals suffer significant losses from their OB services, in most cases entirely attributable to the cost of their related malpractice coverage. One hospital in New York City has reported that its malpractice expense for each delivery is \$9,400.

MALPRACTICE COSTS FOR OB ARE A MEDICAID ISSUE

MEDICAID COVERS:

- 50% of all deliveries in the State
- 60% of all deliveries in NYC
- Over 70% of all deliveries in Brooklyn and the Bronx

Not including malpractice expenses, the hospital's net income for each delivery of a Medicaid-covered newborn would be \$1,500; however, including the malpractice expenses, the hospital actually loses almost \$8,000 each time it delivers a Medicaid-covered newborn. Because Medicaid covers 60% of this particular hospital's newborn discharges, it, like most others, is experiencing significant losses from providing OB services.

In this environment of spiraling costs and devastating payment cuts—particularly in Medicaid—hospitals are necessarily looking to reduce operating costs. In trying to preserve the whole hospital for the community's benefit, OB services are often targeted for reduction, as they are among the

biggest sources of operating losses. Given that Medicaid covers so many deliveries in New York, the State has a particular interest and investment in this problem: Medicaid covers nearly 50% of the deliveries statewide. In New York City, the Medicaid program covers nearly 60% of deliveries, and in Brooklyn and the Bronx, more than 70% of all births are covered by Medicaid.

The Need for Alternative Compensation Approaches

Due to high coverage costs associated with neurologically impaired newborns and the fact that science and medicine have concluded that most such cases are

not due to provider negligence, it is important that states, particularly New York, create alternative systems for handling and funding claims related to them. The systems should be designed to cover the reasonable costs of care for eligible children and funded through a wider array of sources in recognition that the cost of caring for such individuals is society's obligation, rather than the sole responsibility of providers. The systems should also be designed to minimize, if not eliminate, the unnecessary costs and time required to litigate such cases. A no-fault system that would provide payments to children based solely on the disability or injury involved would best accomplish those goals. Funding could come from several sources, including:

- assessments on all types of insurers, many of which abandoned the malpractice market;
- Medicaid third-party recoveries; and
- government appropriations.

Such a system would reduce hospital mal-

4. Nelson, Karin B. “Can We Prevent Cerebral Palsy?” *The New England Journal of Medicine* 349, no. 18 (Oct. 30, 2003): 1765–1769.

5. MacLennan, Alastair, M.D., Karin B. Nelson, M.D., Gary Hankins, M.D., Michael Speer M.D. “Who Will Deliver Our Grandchildren? Implications of Cerebral Palsy Litigation” *Journal of the American Medical Association* 294, no. 13 (October 5, 2005) 1688–1690.

6. Nelson.

7. MacLennan, et al.

8. MacLennan, et al.

practice costs in New York by an estimated 40%, or \$640 million, annually.

In 2008, State Senators Kemp Hannon (R-Garden City) and Dale Volker (R-Depew) introduced S. 7748, which would establish a no-fault approach. Though the bill did not advance during the last legislative session, it is expected to be re-introduced in 2010.

One alternative to a no-fault system is to process cases through the existing litigation system, but create a medical indemnity fund to cover future medical care costs, as incurred, in the event of a settlement or award. Funding sources could be similar to those in the no-fault fund approach. The medical indemnity fund would not eliminate litigation costs and would still require providers to bear all non-medical costs, as well as pre-settlement/award medical costs. It would, however, reduce the cost of settlements and awards by requiring payment of future medical care from the indemnity fund only as required, and it would share medical care costs more broadly in recognition of the fact that most such adverse outcomes

are not due to provider negligence. It is estimated that the medical indemnity fund approach would reduce hospital malpractice costs by 20%–25%, or \$320 million to \$400 million, per year. The establishment of a medical indemnity fund has been recommended in prior

years and in particular during New York State’s 2007 Medical Malpractice Liability Task Force proceedings.

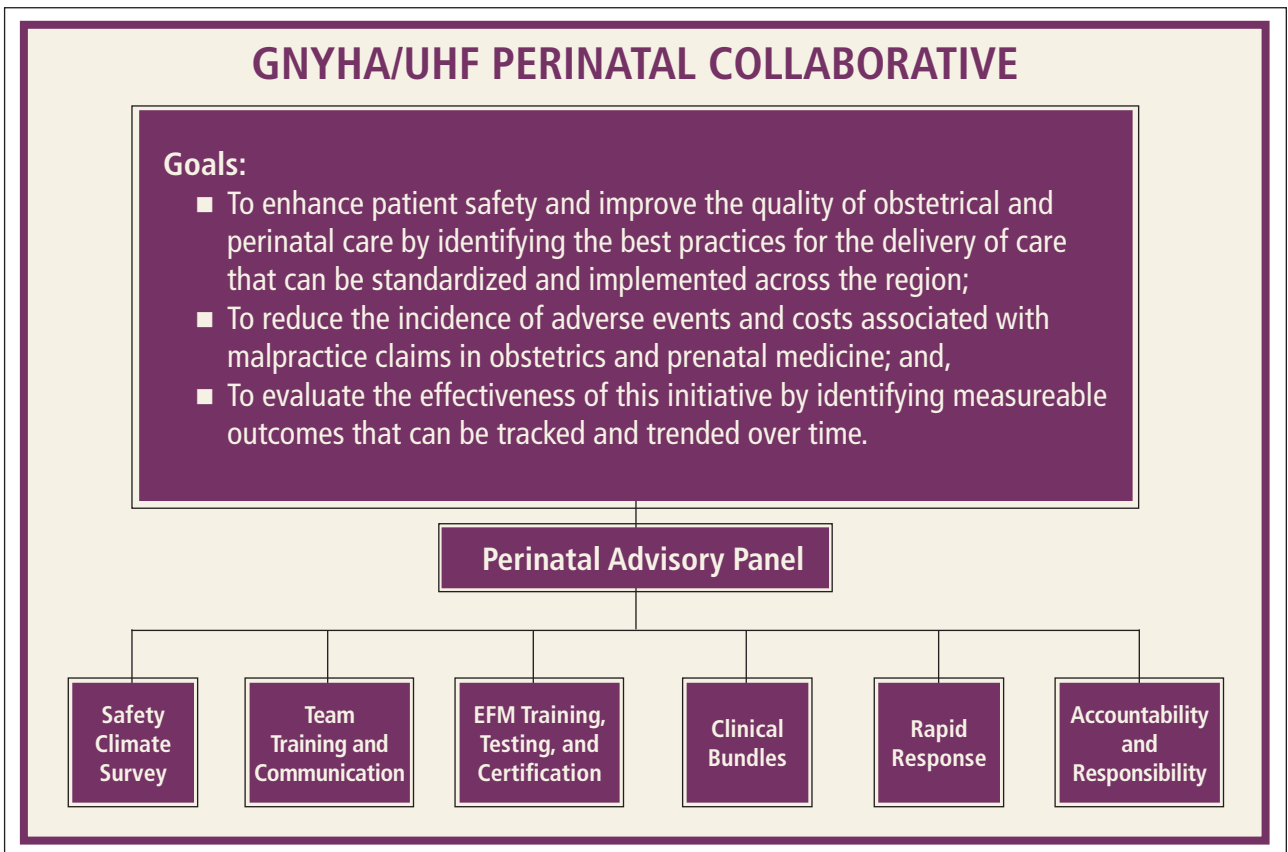
Reducing Adverse Outcomes

Though evidence demonstrates that providers cannot currently prevent most cases of neurological impairment in newborns, GNYHA has devoted significant efforts toward reducing avoidable adverse events in the perinatal setting to the extent possible. Its most significant effort is its Perinatal Safety Collaborative, launched in 2007 in partnership with the United Hospital Fund (UHF). More than 40 hospitals are working to improve the quality of obstetrical and perinatal care by implementing a standard set of patient care practices, called the “perinatal safety bundle.” GNYHA and UHF developed the bundle with input from an advisory panel that includes member hospitals, the American College of Obstetricians and Gynecologists (District II/New York), the New York State Department of Health, and the Healthcare Association of New York State. For more information, see GNYHA’s May 18, 2009, *Health Care News In-Depth*, “Perinatal

‘Bundles’ Deliver Safety.”

While the birth of a neurologically impaired newborn is devastating for patients, their families, and providers, New York State has an ethical—and financial—obligation to ensure that these cases are resolved in a way that provides appropriate care and support for patients while distributing costs across society at large, rather than holding providers solely financially responsible such that their ability to deliver care to entire communities is compromised. GNYHA and its members will continue to work on this issue on behalf of patients and providers. Watch for upcoming issues of *Health Care News In-Depth* that will explore more issues related to medical malpractice reform. ■

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PROPOSALS TO COMPENSATE NEUROLOGICALLY IMPAIRED NEWBORNS

PROPOSAL	MAIN FEATURES AND BENEFITS	% REDUCTION IN HOSPITAL COSTS PER YEAR	HOSPITAL COST DECREASE PER YEAR
NO-FAULT FUND	Claims are made to administrative body and payments are made from no-fault fund based solely on impairment	40%	\$640M
	Eliminates cost of, and delays related to litigating causation		
	Eligible persons would receive compensation/coverage swiftly and without acrimony		
	Shares the cost of care broadly, in light of low probability of provider negligence		
	Mechanism for reviewing care for quality improvement and oversight purposes		
MEDICAL INDEMNITY FUND	Claims would proceed through judicial system	20%–25%	\$320M– \$400M
	Future medical costs identified through settlement or award would be paid from medical indemnity fund, as incurred		
	Providers would, if found negligent, be responsible for the cost of past medical care, the cost of all non-medical care expenses related to injuries, and plaintiff attorney fees related to future medical care settlement/award		
	Would not eliminate cost of, and delays related to litigating causation		
	Would reduce overall cost of medical care since future costs would be paid only as incurred, rather than being estimated in advance, which can result in greater compensation than may be required		
	Would spread the cost of medical care more broadly, in light of low probability of provider negligence		