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PRESIDENTIAL ADDRESS

Should medical malpractice prevention be considered separately or as an integral part of comprehensive health care safety improvement?

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Since the initiation of comprehensive collaborative care and health care safety protocols in the last 10 plus years, there is evidence that medical liability payments may be diminishing in obstetrics and gynecology when patient safety measures are instituted. The author reviewed Oregon's malpractice data from 1996 to 2010 and discusses the relationships between liability payments and utilization of safety protocols.

My clinical practice in obstetrics and gynecology began in 1973, but my secondary interest in peer review and administrative oversight evolved over many years, culminating with my selection as the medical director of the Oregon Medical Board in 1995. This interest in administrative oversight continued after my retirement when I was accepted as a public member of the Oregon State Bar Board of Governors in 2003 to a 4 year term.

During my career I observed, with interest and frustration, the evolution of what I saw as an increasing divide between efforts to improve patient safety and quality of care on the one hand and malpractice prevention, defensive medicine, and tort reform on the other. Although it is totally understandable for physicians to respond to the threat and costs of litigation, my concern has been that this somewhat divided approach to malpractice protection has at times been counterproductive, expensive, and detrimental to our relationship with our patients and may not be the most efficient or cost-effective way to reduce litigation. In the last 10 or more years, medicine has been involved in a movement emphasizing patient safety and professional collaboration that will hopefully have a significant impact on improved outcomes, reduction of adverse events, and a reduction in physician liability.

Oregon placed a cap on noneconomic liability damages in 1987. However, in 1999 the Oregon State Supreme Court found that the capping of noneconomic damages was unconstitutional, and in 2007 the Oregon Supreme Court also found that Oregon's liability cap for public bodies including their employees violated the Oregon Constitution, which substantially changed the Oregon Health Science University's liability exposure.[1,2] No other legislative actions involving medical tort reform or alternative dispute resolution have been enacted in Oregon since the 1999 and 2007 Supreme Court actions outlined in the previous text.

The Oregon Medical Board receives all complaints and malpractice claims involving Oregon's 12,000 active physician licensees. Insurance companies reported 4692 medical malpractice claim files were closed for the 15 year period 1996-2010. Oregon's closed malpractice claims are outlined in Table 1 and the indemnity paid for the years 1996-2010 closed claims are listed in Table 2. Table 3 lists the gynecological and obstetrical categories of claims paid more than $250,000. There was a rapid rise in both numbers of closed claims and indemnity paid from 1999-2001 through 2002-2004 followed by a steady decline, especially obstetrics-gynecology paid claims, over the following 6 years. Obstetric payments were the lowest in 2008-2010 since 1996-1998.

If Oregon's obstetrics-gynecology malpractice claims experience appears to be improving, is there a possible relationship to safety programs initiated in the last decade? The Oregon malpractice data do not answer that question, but it is

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TABLE 1
Oregon closed malpractice claims, 1996-2010

Years	1996-1998	1999-2001	2002-2004	2005-2007	2008-2010[a]	2008[a]	2009[a]	2010[a]
Total closed claims	1102	924	1085	926	658	236	252	170
Total paid claims	248	287	311	209	180	70	59	51
Obstetric closed claims	36	43	56	52	23	12	7	4
Gynecological closed claims	51	50	75	69	47	19	15	13
Paid obstetric claims	12	20	30	16	10	4	3	3
Paid gynecological claims	19	12	14	22	24	8	5	6
Obstetric-gynecologic paid/ total claims	13%	11%	14%	18%	19%	17%	10%	18%

[a] 2008-2010 displayed by year.

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my hope that they are related, as suggested in other recent studies. Noneconomic liability caps or liability limitation does not appear to be factors in the reduced Oregon obstetrics-gynecology liability payments.

Much of the current impetus to patient safety and improved patient outcomes began after the publication of *To Err Is Human* in 1999.[3] *Why Hospitals Should Fly* (2008), The *Checklist Manifesto* (2009), and *Smart Patients, Smart Hospitals* (2010) were also published, bringing issues of patient safety and solutions to both health care professionals and the public.[4-6] We have all learned a new vocabulary around collaborative care and patient safety.

The current emphasis on patient safety is a work in progress. The airline industry assumes that all airline accidents are preventable, but in medicine not all complications or deaths are preventable, even in the best of circumstances. Pronovost et al[7] recommended that medicine needs to create more accurate measures of harm and provide incentives for hospitals to create methods to reduce preventable harm after accurately estimating the extent to which harm is preventable. Meaningful measures of preventable harm require clear definitions of the event (numerator) and those at risk for the event (denominator) and a standardized surveillance system to identify both indicators. Clinicians have labeled virtually all harm as inevitable for decades and focused on individual skills and failures rather than team skills and system failures. Medicare and Medicaid have labeled all harm as preventable, such as all hospital mortality and most listed complications. Both approaches have risks and benefits and implications regarding patient safety, liability, practice standards, and disciplinary actions and need to be rectified.

TABLE 2
Oregon closed malpractice claims, 1996-2010 indemnity paid

Years	Total obstetrics	Total gynecology	Total claims, obstetrics gynecology	Total, $
1996-1998	$2,867,400	$4,711,899	$78,336,822	10%
1999-2001	$30,322,774	$3,764,578	$142,403,558	24%
2002-2004	$54,373,710	$3,861,912	$128,224,690	45%
2005-2007	$22,031,000	$6,745,943	$80,640,225	24%
2008-2010[a]	$8,629,000	$4,026,697	$94,488,101	13%
2008[a]	$2,275,000	$2,417,697	$34,592,654	14%
2009[a]	$5,054,000	$704,000	$34,562,683	17%
2010[a]	$1,345,000	$905,000	$23,332,764	9%

[a] 2008-2010 displayed by year.

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In the 2000s, large multiinstitutional safety initiatives using well-designed collaborative protocols targeting specific risk areas demonstrated significant improvement in mortality and morbidity. Standardized central line protocols adopted in intensive care units are an excellent early example.[8] The Institute of Medicine (IOM) of the National Academy's charter has the stated goal that by the year 2020, 90% of clinical decisions will be supported by accurate, timely, and up-to-date clinical information and will reflect the best available evidence.[9] The IOM model for health care envisions a health system that does the following: (1) generates and applies the best evidence for the collaborative health care choices for each patient and provider, (2) drives the process of discovery as a natural outgrowth of patient care, and (3) ensures innovation, quality, safety, and value in health care.

As we work toward improvement in patient safety, we need to simultaneously address the historical veil of secrecy around discussions of errors and adverse outcomes with providers as well as patients and families. Withholding the truth violates ethical principles and takes away an opportunity to show empathy as well as an opportunity to counsel pa-

TABLE 3
Oregon closed malpractice claims, 1996-2010 indemnity paid to all parties claims greater than $250,000

Gynecology

Closed claims	Total awards	Operative injury negligence	Other complication	Failure to diagnose	Postoperative infection	Other
24	$19,451,578	10	2	7	5	0

Obstetrics

		Delivery management				
Closed claims	Total awards	Delayed delivery negligence	Shoulder dystocia and birth trauma	Delayed diagnosis	Infection	Other
58	$99,303,254	16	21	13	3	6

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tients, families, and providers. A frank discussion of errors and adverse outcomes can also create opportunities to reduce the financial burden on patients and families through counseling and early mediation.[10] Although not all situations require an apology, disclosure is essential and ethical and can be enhanced by having institutional protocols in place and trained staff to assist.[11,12]

There is an increasing number of studies that suggest a relationship between improved patient safety and decreased liability risk. In 2010, the Rand Institute for Civil Justice published a California malpractice study organized on the hypothesis that occurrence of adverse safety events is predictive of subsequent malpractice activity and, by extension, improved safety performance is associated with reduced malpractice claims.[13] Using the 2001-2005 California Healthcare Cost and Utilization Project and State Inpatient Database, the authors applied Patient Safety Indicators (PSI), quality measures that capture in-hospital events and complications with safety implications. Rand utilized malpractice claims activity from 4 of the largest physician medical liability carriers in California representing statewide coverage of more than 50% of non–self-insured physicians in California.

The study included an evaluation of more than 27,000 claims and 366,000 PSIs. Fifty-two percent of the patient safety indicators were specific to obstetrics. By 2005, 19 counties noted a reduction of malpractice claims of more than 30%, 28 counties noted 0-30% reduction, and 7 of the counties were found to have an increase in malpractice claims.

The Rand study found a significant correlation between frequency of adverse events and malpractice claims and determined that a decrease of 10 adverse events in a given year would also see a decrease of 3.7 malpractice claims. The study also suggested that nearly two thirds of the malpractice claims against physicians can be attributed to issues of patient safety and contend that the traditional legal doctrine of malpractice that focuses on deterring negligence does not adequately address the underlying problem of patient safety and malpractice prevention.

The Rand group suggests that the current patient safety movement is based on a different logic model in which injuries sometimes occur as a result of complex systems failure rather than through an individual's failure or negligence and that root-cause analysis and quality improvement activities undertaken by providers are widely believed to have prophylactic effects. The Rand group also suggested polices that facilitate the latter have the potential to make patients safer and to reduce malpractice litigation but expressed concern that any restriction on peer review, risk management, or root cause analysis could have a significant impact on the prevention of adverse events and injuries and could increase the incidence of litigation.

The Hospital Corporation of America reported in 2011 that the incorporation of patient safety programs in labor and delivery as recommended by the Institute of Medicine have shown a reduction in reported claims from 12/per 10,000 live births in 1999 to 4/per 10,000 live births in 2009.[14]

The Boston Medical Center began a series of interventions in 2004 to improve patient safety and satisfaction in labor and delivery by a coordinated medical and legal review of complications and reserved funds for the potential legal defense and potential settlements. Simultaneously the hospital initiated safety improvement steps including dealing with sleep deprivation, use of obstetric drills, standardized electronic fetal heart monitoring courses, dedicated obstetric quality assessment and improvement committee, cultural competency training, and team training. The Boston Medical Center reduced the rate of reserved claims by approximately 20% per year for 5 years.[15]

Similarly, the Obstetrics and Gynecology Department at Weill Cornell Medical Center (New York, NY) was able to reduce their legal compensation payments of $27,591,610/year for the years 2003-2006 to $2,550,136/year for the years 2007-2009. Sentinel events dropped from 1.04 per 1000 deliveries in 2000 (5) to 0.0 per 1000 deliveries (0) in 2008 and 2009 by progressive introduction of safety measures and drills, protocols, and early identification and indemnification of potential obstetric liability cases.[16]

Reporting of errors and definitions of errors need to be standardized to enhance compliance and collection of meaningful data. Milch et al[17] reported on medical errors, adverse events, and

near misses in 26 nonfederal acute care hospitals with integrated electronic medical records and showed a very wide range of rates of reported errors, 9 to 99 per 1000 in-patient days, a significantly wide rage. The 2012 Department of Health and Human Services Inspector General Report, titled Hospital Incident Reporting Systems Do Not Capture Most Patient Harm, demonstrated 27.1% of hospitalized Medicare patients experienced adverse events during their hospitalization; half were substantial events. Hospitals failed to report 86% of events to incident reporting systems, often because of misperceptions about what constitutes patient harm.[18]

Medical systems need to learn from errors and adverse outcomes, encourage improved practice patterns and behavior, and should be an integral part of the patient safety and liability prevention matrix. Richard Thaler and Cass Sunstein, authors of *Nudge*, suggest a modification of behavior by using a nudge, a choice architecture that alters people's behavior in a predictable way without forbidding any options or significantly changing their economic incentives.[19] Kathryn Schulz[20] discusses human error in *Being Wrong: Adventures in the Margin of Error*. A common response to error is that I was wrong and then insert an explanation, or excuse that basically removes the error or responsibility for the unwanted outcome. What starts out be an admission of error shifts blame or responsibility to others or the system.

With all the patient safety work in progress, there is concern that physicians are working against themselves in the area of the physician-patient relationship. According to Verghese, [21] there are 2 approaches to patient care. The traditional patient approach (the body is text, a text that is changing and must be frequently examined) vs a second, more expedient way. Both are patient centered, but in the second model the patient is a computer icon, the iPatient, examined in a room with glowing computer monitors. Patient discussions and rounds are conducted by computer terminals rather than at the bedside. When bedside clinical skills are lost, patients recognize the deficiency in care, a process that diminishes trust and confidence in the caregivers.

This point was reemphasized in the February 2011 New York Times editorial by Verghese[22] entitled "Treat the Patient, Not the CT Scan" and the April 2012 Newsweek article by Shannon Brownlee[23] entitled "The Doctor Will See You—If You're Quick." The Association of American Medical Colleges (AAMC) is planning to revise the Medical College Admission Test by incorporating more social science with the addition of 2 new sections: one covering social and behavior sciences and a second on critical analysis as well as ethics and cross-cultural studies.[24] The AAMC contends that increasing premedical social science knowledge will bring in medical students who do not just understand science but also understand people.

There is no question that the dynamics of patient care and the delivery of medical care are changing. The current patient safety movement has promising long-term goals, which should enhance patient outcomes and reduce adverse events while concomitantly reducing litigation and inappropriate physician behavior. The data and practice guidelines that are derived should be instrumental in setting practice standards for legal challenges as well.

I strongly believe that malpractice prevention should be an integral part of a comprehensive health care and patient safety matrix, and increased financial support as well as attention by physician advocacy groups and professional societies should direct their resources to this end. I know members of our society will continue to have a leadership role in enhancing patient safety and reducing situations that create liability risk. ■

REFERENCES

1. Oregon Supreme Court, Lakin v. Senco Products, Inc. CC 9211-07901; CA A83575; SC S4410.

2. Oregon Supreme Court, Clarke v. OHSU, 343 Or 581, 2007.

3. Kohn LT, Corrigan JM, Donaldson MS, eds. To err is human. Washington, DC: National Academy Press; 1999.

4. Nance JJ. Why hospitals should fly. Bozeman, MT: Second River Healthcare Press; 2008.

5. Gawande A. The checklist manifesto. New York, NY: Henry Holt and Co; 2009.

6. Pronovost P, Vohr E. Smart patients, smart hospitals. New York, NY: Hudson Street Press; 2010.

7. Pronovost P, Colantuoi E. Measuring preventable harm. JAMA 2009;301:1273-5.

8. Pronovost P, Deedham D, Berenholtz S, et al. An intervention to decrease catheter-related bloodstream infections in the ICU. N Engl J Med 2006;355:2725-32.

9. Institute of Medicine of the Nation Academies 2011 Update report: the learning health system and its innovation collaboratives, roundtable on value, and science-driven health care. Washington, DC: Institute of Medicine; 2011.

10. Mason DJ. To forgive is divine. Am J Nurs 2005;105:11.

11. Weiss PM, Koch S. Medical errors: disclosure and apology. Contemp Ob Gyn 2012; June:40-5.

12. Thurman A. Institutional responses to medical mistakes: ethical and legal perspectives. Kennedy Inst Ethics J 2001;11:147-56.

13. Greenberg MD, Haviland AM, Ashwood JS, Main R. Is better patient safety associated with less malpractice activity? Technical report. Santa Monica, CA: Rand Institute for Civil Justice; 2010:1-21.

14. Clark SL, Meyers JA, Frye DK, Perlin JA. Patient safety in obstetrics: the Hospital Corporation of America experience. Am J Obstet Gynecol 2011;204:283-7.

15. Inverson RE, Heffner LJ. Obstetric safety improvement and its reflection in reserved claims. Am J Obstet Gynecol 2011;205:398-401.

16. Grunebaum A, Chervenak F, Skupski, D. Effect on a comprehensive obstetric patient safety program on compensation payments and sentinel events. Am J Obstet Gynecol 2011;204:97-105.

17. Milch CE, Salem DN, Pauker SG, Lundquist TG, Kimar S, Chen J. Voluntary electronic reporting of medical errors and adverse events. J Gen Intern Med 2006;21:165-70.

18. Department of Health and Human Services, Office of Inspector General. Hospital Incident Reporting Systems Do Not Capture Most Patient Harm. January 2012: OEI-06-09-0091.

19. Thaler RH, Sunstein CR. Nudge. New Haven, CT:Yale University Press; 2008.

20. Schulz K. Being wrong: adventures in the margin of error. New York, NY: Harper Collins Publishers; 2010.

21. Verghese A. Culture shock—patient as icon, icon as patient. N Engl J Med 2008; 359:2748-51.

22. Verghese A. Treat the patient, not the CT scan. New York Times. The Option Pages. February 27, 2011: WK10.

23. Brownlee S. The doctor will see you—if you're quick. Newsweek. April 23 and 30, 2012. Medicine Section: 46-50.

24. Rosenthal E. Pre-meds new priorities: heart and soul and social science. New York Times Educational Life Section. April 13, 2012:ED20.