Prepare a defense of CP and other malpractice claims—*before* the lawyers get there

Your day in court can start as soon as the patient begins prenatal care. Here's 1 way to prepare for it.

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CASE Two years after emergency cesarean, you are served

M.K., age 29 years, presents at term and in labor to the state-of-the-art hospital where you practice. During labor, transient slowing of the fetal heart rate (FHR) is detected, and you perform an urgent cesarean section, with successful delivery of the infant. Cord blood shows no evidence of acidosis, and the Apgar score is 8 at 1 minute and 9 at 5 minutes.

Two years later, after the child is diagnosed with ataxic cerebral palsy (CP), the parents file a $10 million lawsuit that names you as defendant.

Could you have done something to avoid litigation?

Absolutely! But the best preventive strategy has nothing to do with the science of medicine.

Because of the near certainty of being sued—usually, without merit—over the course of one's career, an ObGyn has little choice but to practice defensive medicine. Until true tort reform is passed, we believe that physicians should rely on contract law to avoid lawsuits such as the one described above. The best defense begins at the patient's first appointment, when she should be asked to sign a basic agreement. This article describes how such a strategy can greatly bolster your case should a lawsuit eventually be filed.

Avoiding the "death knell"

Until recently, a diagnosis of CP coupled with a lawsuit sounded the proverbial death knell for an obstetrician. The high stakes, long statute of limitations, and availability of "experts" willing to testify about standard-of-care violations all but guaranteed an early settlement. No obstetrician could risk presenting his or her case to a jury likely to be sympathetic to the plaintiff. The settlement of such cases was usually substantial—in the high 6 or low 7 figures—and the physician's name was subsequently entered into the National Practitioner Data Bank. These settlements fueled high professional liability premiums, which remain extreme across the country.

Causes of CP are now more clearly understood

In 2003, the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics published a report, "Neonatal encephalopathy and cerebral palsy: Defining the pathogenesis and pathophysiology"

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Tracing the (possible) origin of a case of CP

"Neonatal encephalopathy and cerebral palsy: Defining the pathogenesis and pathophysiology" (NEACP),[1] the report published jointly by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics, was created to educate patients, physicians, and the public about the causes of cerebral palsy (CP) and provide a deeper understanding of what used to be called "birth asphyxia."

The report also set out to identify cases in which intrapartum events can be implicated in the development of CP, with the aim of preventing them. According to the NEACP report, CP can be attributed to an intrapartum event when 4 "essential criteria" are present:

- evidence of metabolic acidosis in fetal umbilical cord arterial blood obtained at delivery (pH <7 and base deficit ≥12 mmol/L)
- early onset of severe or moderate neonatal encephalopathy in infants born at or beyond 34 weeks' gestation
- cerebral palsy of the spastic quadriplegia or dyskinetic type
- exclusion of other identifiable causes, such as trauma, coagulopathy, infection, or genetic disorders

In addition, 5 other nonessential or nonspecific criteria may have a bearing on the timing of events leading to CP:

- a sentinel (signal) hypoxic event occurring immediately before or during labor
- a sudden and sustained fetal bradycardia or the absence of FHR variability in the presence of persistent, late, or variable decelerations, usually after a hypoxic sentinel event when the pattern was previously normal
- an Apgar score of 0 to 3 beyond 5 minutes
- onset of multisystem involvement within 72 hours of birth
- early imaging study showing evidence of acute nonfocal cerebral abnormality.

According to these criteria, fewer than 30% of CP cases are caused by a lack of oxygen to the fetus during labor and delivery. Most cases apparently are caused by events that disrupt normal brain development before labor.

Given these criteria, it is critical to obtain cord blood gases and perform early imaging of the newborn brain to help define the cause of encephalopathy in a newborn. Also crucial is a thorough investigation of other potential causes, especially in view of the relative rarity of intrapartum events capable of causing this devastating condition.

(NEACP),[1] that challenged a number of long-held assumptions—among them the belief that electronic FHR monitoring can highlight fetal distress in time to prevent intrapartum fetal asphyxia and lower the number of cases of CP. (For the findings of this report, see "Tracing the origin of a case of CP," above). Sadly, electronic fetal monitoring has had no impact on the rate of CP, despite a dramatic increase in cesarean deliveries. A study by Nelson et al[2] found that nonreassuring FHR patterns had a 99% false-positive rate for predicting CP.

The overall conclusion of the NEACP report: Most cases of CP are not the result of intrapartum events.

Unreliable testimony propels many cases

The NEACP report is an important, peer-reviewed document, and although it could be labeled as self-serving, it does provide a road map for documenting, with evidence, how intrapartum events can indeed cause CP.

It can be argued that CP lawsuits unsupported by any of the NEACP criteria do not belong in court.

Frivolous cases often proceed with frivolous expert testimony, which can be defined as testimony that a majority or respectable minority in the field would not utter. Put a different way, if the expert is the only person holding a particular view, that unique opinion probably does not define the standard of care.

What can physicians do?

There are remedies available to physicians worried about frivolous lawsuits. The most effective strategy, we believe, is to be proactive: **Have the patient sign a**

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And justice for all (including ObGyns)

Q&A with Jeffrey Segal, MD, founder and chief executive officer, Medical Justice Services

Q. What is Medical Justice Services? How does it work?

A. Medical Justice Services is a company designed to keep physicians from being sued for frivolous reasons by holding proponents of such suits accountable along several avenues. Our core mission is 3-fold:

- keep meritless suits from being filed in the first place
- engage in early intervention so that, if a suit without merit is filed, it gets dropped sooner rather than later
- give physicians workable, cost-effective remedies if they are sued.

Q. Will you give an example of how your service works?

A. Say a woman experiences a difficult labor and delivery, necessitating emergency cesarean section and immediate treatment of the infant in the neonatal intensive care unit, with lasting central nervous system damage. She blames her obstetrician and files a lawsuit against him. In response, Medical Justice Services sends a letter to the plaintiff and her attorney, notifying them that they may very well be sued if the allegations are found to be frivolous. Many meritless lawsuits end right there with a dismissal, sometimes as quickly as 1 to 3 weeks. But if the lawsuit goes to trial and the physician wins, other obstetrician members of Medical Justice Services will review the case. If they determine that the case was indeed frivolous, each and every proponent of the lawsuit can be countersued, and expert witnesses are at risk to face possible sanctions from their professional society.

That example is an oversimplification, but it conveys the essence of what we do.

Q. How did you come to start the company?

A. Although I practiced neurosurgery in Indiana, a state that is very friendly to physicians, we had our own professional liability crisis in the late 1970s. Fortunately, the governor at the time was also a physician, and he implemented substantive tort reform. Nevertheless, it became quite clear that, in my specialty, as in ObGyn medicine, we faced a heightened risk for malpractice lawsuits. And it seemed important to me to find a way to avoid just being on the receiving end of litigation, to stop being a pawn in a system that was poorly understood.

That was 5 years ago. We've been able to grow the organization fairly rapidly based on demand. The awful truth is that, if you practice long enough, your exposure to a lawsuit in most specialties is almost an actuarial certainty.

Q. How many plan members do you have, and what percentage are obstetricians?

A. We have approximately 1,600 members. I can't tell you exactly how many are obstetricians, but I can say that obstetrics and gynecology is 1 of the 5 most common specialties, along with neurosurgery, orthopedic surgery, general surgery, and plastic surgery.

Q. What issues do ObGyns face that make protecting them especially challenging?

A. The most important thing is the fact that, in most states, there is a "long tail." In contrast to other specialties, for which there is a relatively short statute of limitations, the length of time that an ObGyn case can linger out there as a potential case seems infinite. That's because these cases usually involve an infant, who will not reach the age of majority for many years.

Q. Do ObGyns have to pay more to be a plan member?

A. We narrow our universe to 3 areas of risk: low, medium, and high. ObGyns fall into the highest-risk category, but with good company—namely, every surgical specialty.

Q. You mentioned 3 objectives for Medical Justice Services: deterrence, early intervention, and ample support should a lawsuit be filed. How do you go about deterring claims?

A. We engage in a contract with the patient, who is already in the habit of signing contracts for health care, as in the case of HIPAA, for example. We simply ask that a contract contain 2 additional clauses—that the patient will not sue the physician for a frivolous reason and that, if she does sue, she will use, as an expert, a board-certified physician in the same specialty who is a member of that specialty's

professional society and who follows that society's code of ethics. We use more sophisticated language in the contract itself, of course, but it is easily understood by the patient.

Our experience has been that virtually every patient is happy and comfortable signing such a document.

Q. What does early intervention in a case involve?

A. We see what we can do to get a case dropped sooner, rather than later. We send notification to the opposite side that our plan member has the finances and expertise to legitimately file countersuits and counterclaims.

Q. When you do have to prosecute the other side, how do you go about it?

A. Prosecution means holding the opposite side accountable in a number of different venues. If appropriate, we pursue remedies against expert witnesses primarily through medical specialty societies after a case is terminated. Many of these societies, including ACOG, have panels that review testimony from members who have served as experts in court. They then make a determination as to whether this testimony supports or violates the code of ethics. And if they believe it violates the code of ethics, they may take any of several actions, from sending a letter of reprimand to expelling them from the society.

That's not the only venue where a physician can find redress with an expert witness. One could also package a complaint before the state medical society, a hospital credentialing committee, and so on.

The next area where redress can be had is in court. We are prepared to file a countersuit against the attorney who brought the frivolous case forward. Although we can also go after the plaintiff, if need be, it is our opinion that the plaintiff usually doesn't understand how he or she got into the legal case—that is, the patient is almost always a pawn in the system with the attorney driving the process.

Q. Are your services separate from liability insurance?

A. Yes, we stand separate from professional liability insurance. Although we can provide value to physicians who have no coverage whatsoever, by and large what we offer is synergistic with, or complementary to, traditional medical malpractice insurance.

Q. How does tort reform affect what you do?

A. It varies. California is the largest state to have implemented substantive tort reform, and I practiced there briefly, so I understand the local dynamics quite well.

The beauty of tort reform, at least in California, is that it keeps medical malpractice premiums lower than in other states by putting caps on pain and suffering. So it lessens the severity of a lawsuit. But what we have seen is that the frequency of lawsuits in places like California is not any lower than in other states. In fact, it's higher.

And so the only rational conclusion you can draw is that plaintiff's attorneys make up the difference in volume. In other words, tort reform has succeeded quite well in terms of keeping premiums down, but not nearly so well at keeping the frequency of lawsuits down.

Q. Can residents join Medical Justice Services?

A. We do have a plan for residents. We give them coverage, often with no charge, with the expectation that they will become bona fide plan members when they finish their training.

Q. How much does it cost an ObGyn to sign up with Medical Justice Services?

A. For an individual physician who desires go-forward coverage, the range is $1,250 to $1,900 a year—certainly far less than what he or she is paying for professional liability coverage, often by 2 orders of magnitude.

For "backward" or retroactive coverage, there is an additional 1-time cost that ranges from $2,800 to $4,500. And for coverage of an open malpractice case at the time they join, the 1-time additional charge ranges from $2,000 to $5,000.

The plan member is covered for legal expenses—generally, up to $100,000 a year—and has access to the company's network of skilled attorneys.

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contract well before delivery in which she agrees not to sue indiscriminately in certain circumstances. Such a contract can include language requiring the patient to follow reasonable procedural guidelines if she does decide to sue.

If handled correctly, contract law can protect physicians. A reasonable contract does not ask the patient to forego all legal remedies; it does leave her with recourse in the event of negligence. Having a patient sign a blanket release would be considered an "abuse of power," and the courts would probably dismiss such an agreement.

An enforceable contract has to withstand legal challenges. The contracts used by Medical Justice Services, the organization we established to protect physicians from frivolous lawsuits, define the expectations regarding resolution of concerns. For example, the patient agrees that the physician cannot be sued for a frivolous reason. It does not bar litigation for any reason—just for a frivolous reason. Should a legitimate dispute arise, both the patient and physician agree to use experts who are members of, and follow the code of ethics of, the physician's professional specialty society—in this case, ACOG. The goal is to ensure that experts are reputable and accountable.

Breach of contract should also be defined in the document. For example, in obstetric and gynecologic cases, a conclusion by the ACOG ethics committee that court testimony is "frivolous" might be listed in the contract as a determinant of breach. Definitions and rules of procedure are often embedded in contracts.

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Will such a contract hold up?

An unenforceable contract is described as "unconscionable." In a recent legal case,[3] the court determined: "To be unconscionable, 'the contract must be such as no sensible man not under delusion, duress, or in distress would make, and such as no honest and fair man would accept.'"

The 2 provisions of the Medical Justice agreement—the promise not to bring a frivolous lawsuit and the mutual promise to use an expert in the same specialty who follows the code of ethics of his or her specialty society—would probably not be considered unconscionable. The first promise is already the law in every state and is reflected in numerous statutes; when addressed in a contract, such a statute is easier to enforce. The second promise focuses on the procedures for advancing a legitimate case.

As a reputable treatise on contract law points out, "There is a growing tendency for courts to uphold the right of parties to prescribe certain rules of evidence should a lawsuit arise out of the bargain between them, so long as it does not unduly interfere with the inherent power and right of the court to consider relevant evidence."[4] Therefore, those who sign contracts have some latitude to determine, in advance, how procedures might vary from general courtroom standards.

It is well established that patients and physicians can contract to use arbitration. Arbitration asks the plaintiff to forego her right to trial by jury in the presence of a judge. Imposing reasonable conditions for the use of expert witnesses is clearly less restrictive than requiring arbitration.

In 2 recent cases,[2,5] the courts relied on several factors to determine that the contracts in question were not unconscionable:

- Contractual provisions weren't hidden but were instead highlighted, and the contract was otherwise easy to read and understand
- The patient had the opportunity to read the contract fully and ask questions
- There was no effect on the physician's duty to provide reasonable care
- The contract did not limit the liability of the provider to the patient.

What if the infant becomes the plaintiff?

An important question in obstetric-related lawsuits is whether the child is bound

by the terms of a contract signed by the mother. Falling back on the arbitration analogy, there are ways to hold individuals who haven't physically signed the contract—including a minor child and any attorney the patient hires—to the terms it spells out. A child can be bound by the mother in an agreement to arbitrate entered into during the prenatal period. In one case, a court interpreted the arbitration clause to apply to any claim arising from services under the agreement, even though the plaintiff had not been born when the agreement was signed.[6] This case is of particular interest to ObGyns because it established a precedent that limits the right of children to sue even though they themselves never signed the agreement.

In another case,[7] a spouse who did not sign the contract filed a lawsuit for loss of consortium due to a physician's negligence. The court found that all claims arising from the alleged malpractice must be arbitrated when a patient signs a contract agreeing to arbitrate claims of negligence. Similarly, heirs in a wrongful death action were found to be bound by the decedent's agreement to arbitrate when the contract required that claims by the "member's heir or personal representative" be arbitrated.[8]

Can a contract be enforced retroactively?

ObGyns often have long-term relationships with patients. Or they may wish to implement the provisions described above after 1 or several prenatal visits. Is it possible to design a new contract to address past actions?

Maybe.

In California, there is a precedent for retroactive activation of an arbitration agreement. In 1993, the California Court of Appeals upheld an arbitration agreement that was defined for both future and retroactive treatment.[9]

Will a patient sign such a contract?

The short answer is "Yes." Patients sign contracts all the time. They agree to pay their bill. They agree that records can be sent to referring physicians. They agree that they have made an informed decision about their care.

Medical Justice Services has a long track record of promoting such contracts as part of the physician–patient relationship. We have found that most patients are comfortable signing a contract that limits their right to sue to cases with clear merit and requires them to use reputable and accountable experts if there is a legitimate dispute. In this way, patients who deserve a remedy have full access to the courts.

Bringing up the topic of a contract before care is initiated is no more likely to create tension than a traditional informed consent discussion would. Most patients believe themselves to be reasonable and cannot imagine filing a lawsuit for an illegitimate reason.

By deterring unjustified litigation, the widespread use of contracts can help stabilize professional liability premiums, minimize the cost of health care, and preserve access to health care. In cerebral palsy litigation, where the stakes are high, 1 of the better ways to control the legal outcome is by means of a contract, especially when there is minimal or no evidence of NEACP criteria. ■

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6. See Wilson v. Kaiser Found Hospital, 190 Cal Rptr. 649, 651 (Cal. Ct. App. 1983).
7. See Gross v. Recabaren, 253 Cal. Rptr. 820, 821 (Cal. Ct. App. 1988).
8. See Herbert v. Superior Court, 215 Cal. Rptr. 447, 478 (Cal. Court. App. 1999).
9. See Coon v. Nicola, 21 Cal. Rptr. 2d 846, 849 (Cal. Ct. App. 1993).

Sound like a solution?

Have you asked the patient to sign an agreement limiting her right to sue in certain circumstances?

Do you think the approach is reasonable—or likely to be circumvented by the plaintiff's attorney?

Drop a line and let us know your experiences and thoughts. Email your comments to OBG@dowdenhealth.com, and we may publish them in a future issue.

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