Citation

Davies JM, Posner KL, Cheney FW, Domino KB: Anesthesia Malpractice Claims for Newborn Brain Injury in the 1990s. *Anesthesiology* 105: A7, 2006.

Abstract

Introduction

In most cases of newborn brain injury the cause cannot be determined, yet obstetricians and anesthesiologists remain vulnerable to litigation. Litigation for newborn brain injury, particularly cerebral palsy (CP), is frequently based on emotional suffering of the patient and family, rather than evidence of harm.[1] We analyzed claims for newborn brain injury from the ASA Closed Claims database, looking at factors which possibly contributed to the neonatal and liability outcome.

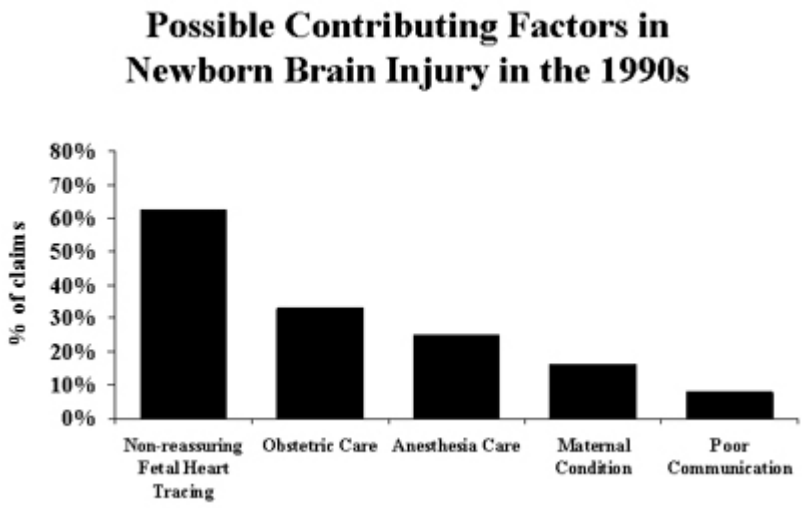
Methods

Anesthesia claims from the ASA Closed Claims Project contain standardized summary data on closed malpractice claims from throughout the U.S.[2,3] Forty-eight claims for newborn brain injury from 1990 to 2000 were examined for factors which may have contributed to the injury, including non-reassuring heart tracing, anesthesia and obstetric care, maternal condition, and poor communication. The proportion of cerebral palsy cases, mode of delivery, and payment data were also recorded. Associations were tested with Fisher's Exact Test with $p<0.05$ considered statistically significant.

Results

Nineteen of the claims (40%) were associated with the diagnosis of cerebral palsy. In over 60% of all claims, a non-reassuring fetal heart tracing was documented, with cesarean section delivery in 80% of claims. Obstetric and anesthesia care may have contributed to fetal outcome in less than one third of claims (Figure). In 50% of the claims in which anesthesia may have contributed to fetal outcome, some delay by anesthesia was alleged ($p<0.05$) compared to delay alleged in 12% of claims with no anesthesia contribution. Maternal condition and poor communication were possibly involved in 16.7% and 8.3% of claims respectively (Fig.1). In 60% of claims, the anesthesiologist was either dismissed or dropped from the case or no payment was made. Payment was more likely to be made by anesthesia in claims in which anesthesia may have contributed to the neonatal outcome; 71% paid compared to 13% paid when anesthesia did not contribute ($p<0.05$).

Figure



Discussion

The findings of this analysis show that anesthesia care is often not in question, reflected by the proportion of claims resulting in no payment. Alleged anesthesia delay is usually based on the 30-minute decision to delivery rule, which may not have been applicable in all the claims. In 2003, the ACOG Task Force introduced modified criteria to help define the causal relationship between acute intrapartum events and cerebral palsy.4 Hopefully, these new criteria will be positively reflected in future malpractice claims.

References

1. JAMA 2005; 294:1688
2. JAMA 1989; 261:1599
3. Anesthesiology 1991; 74:242
4. Obstet Gynecol 2003; 102:628