Why Focus on Pediatrics?
- Almost 20% of all hospital admissions are for children
- Children are some of the most vulnerable patients
- Pediatrics not considered “high risk”
- Large verdicts in recent years often involve children
- Damage caps will help minimally
- Sympathy factor makes defense very problematic
CHILDREN: HEALTHCARE DEMOGRAPHICS

OVERVIEW

Children: Healthcare Demographics
Children: Unique Risks
NPDB: Child-Related Payments
OHIC: Pediatric Closed Claims
PIAA: Pediatrics Closed Claims
Pediatrics: Recent Large Losses
Pediatrics: Low Frequency/High Severity Cases
Pediatrics: Summary and Recommendations
## CHILDREN: HEALTHCARE DEMOGRAPHICS

- In 2006 there were 73.7 million children ages 0-17 in the US
- Children comprise 25% of the US population
- 18% of children (13 million) live in poverty as of 2005
- 8.4 million children are uninsured

<table>
<thead>
<tr>
<th>CHILDREN: HEALTHCARE DEMOGRAPHICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>18% of all hospital stays are for children</td>
</tr>
<tr>
<td>2/3 of children’s hospital stays are for newborns and neonates (children up to 30 days old)</td>
</tr>
<tr>
<td>• most of these stays are for births</td>
</tr>
</tbody>
</table>

“America's Children: Key National indicators of Well-being 2007”  
(www.childstats.gov/americaschildren/index.asp, p.1)
AHRQ’S MOST COMMON CAUSES OF PEDIATRIC HOSPITALIZATIONS

- Respiratory Disorders 23%
  - Asthma, Pneumonia, Acute Bronchitis
- Digestive Disorders 12%
  - Appendicitis, Gastroenteritis
- Nervous System Conditions 8%
  - Convulsions, Meningitis

AHRQ’s Kids’ Inpatient Database, Healthcare Cost and Utilization Project, Statistical Brief #33, p. 7, June 2007

CHILDREN: UNIQUE RISKS
**CHILDREN: UNIQUE RISKS**

- The rate of medical errors for hospitalized children ranges from 1.81 to 2.96 per 100 discharges*
- Chronically ill children or those dependent on medical technology “had significantly higher rates of… medical errors
- Children whose cases involved medical errors “had significantly higher death rates” and longer hospitalizations*


**CHILDREN: UNIQUE RISKS**

- USP Study: 6% of medication errors in children cause patient harm vs. 2.4% overall
- Most frequent pediatric medication error: wrong dose
  - Lack of standardized dosing regimens for children
  - Lack of accurate patient weight information

U.S. Pharmacopeia 2002 December 4 Press Release
**CHILDREN: UNIQUE RISKS**

- Children have limited ability to communicate with care-givers
  - Cannot describe symptoms
  - Cannot understand instructions

**CHILDREN: UNIQUE RISKS**

- Parent-provider communication problems are exacerbated if parents have:
  - Language barriers
  - Knowledge deficits
  - Limited parenting skills
CHILDREN: UNIQUE RISKS

Child’s limited capacity and judgment may result in:
- Falls
- Electric shock
- Crushing injuries
- Bumping or pulling IV’s or wound sites

CHILDREN: UNIQUE RISKS

Children require age and size appropriate equipment and medications:
- Airway management supplies
- Defibrillators
- Emergency and therapeutic drugs
- Anesthesia and sedation
FROM LITTLE . . .

TO BIG
**CDC SURVEY: PEDIATRIC EMERGENCIES**

- 90% of US hospitals admit pediatric patients but only 40% had separate inpatient pediatric units
- Half of the hospitals had on hand more than 85% of the recommended medical supplies for pediatric patients

**CDC SURVEY: PEDIATRIC EMERGENCIES**

- Fewer than 6% of hospitals had on hand all the pediatric supplies in the full range of sizes

Source: CDC press release February 28, 2006
THE 4 “DS” OF CHILDREN’S HEALTH CARE*

- Developmental Change
- Dependence on Adults
- Different Disease Epidemiology
- Demographic Characteristics

*Miller and Zhan, Pediatrics, June 2004 Vol. 113 pp. 1741-1746

CHILDREN: UNIQUE RISKS

- Risk Management Observations
- Before children enter healthcare facilities, they have unique psycho/social, economic, and physical challenges
- Children represent unique diagnostic and treatment challenges
- All aspects of children’s vulnerability must be considered in formulating risk management strategies
**NPDB: CHILD-RELATED PAYMENTS**

**Overview**
- Period: 2/1/04 to 12/31/05
- Ages: Birth thru 19 years old
- 14% of all payments made for children
- Significant geographic variability
- $1.73 billion in payments for children
- 95% were settlements; 5% were verdicts
- $422,000 average payment for children versus $247,000 for adults

* See Kain et.al., Pediatrics, Vol. 118, No. 2, August 2006
# PEDIATRICS: NPDB CLAIMS

NPDB Claims 2/1/04 – 12/31/05  
Frequency of Various Malpractice Payments and Median Amounts: Children

<table>
<thead>
<tr>
<th>Malpractice Group</th>
<th>Frequency, % (n)</th>
<th>Median Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obstetrics related</td>
<td>27.6 (1135)</td>
<td>$395,000</td>
</tr>
<tr>
<td>Anesthesia related</td>
<td>3 (105)</td>
<td>315,000</td>
</tr>
<tr>
<td>Intravenous treatment and blood products related</td>
<td>0.2 (8)</td>
<td>225,000</td>
</tr>
<tr>
<td>Diagnosis related</td>
<td>27.9 (1146)</td>
<td>195,000</td>
</tr>
<tr>
<td>Medication related</td>
<td>3.4 (140)</td>
<td>165,000</td>
</tr>
<tr>
<td>Monitoring related</td>
<td>3.0 (125)</td>
<td>195,000</td>
</tr>
<tr>
<td>Surgery related</td>
<td>10.2 (419)</td>
<td>115,000</td>
</tr>
<tr>
<td>Treatment related</td>
<td>21.5 (885)</td>
<td>97,500</td>
</tr>
<tr>
<td>Behavioral health related</td>
<td>0.7 (28)</td>
<td>70,000</td>
</tr>
<tr>
<td>Other miscellaneous</td>
<td>2.4 (99)</td>
<td>47,500</td>
</tr>
<tr>
<td>Equipment/product related</td>
<td>0.4 (17)</td>
<td>27,500</td>
</tr>
</tbody>
</table>

Source: Kain et al., Pediatrics, Vol. 118, No. 2, August 2006
OVERVIEW OF OHIC PEDIATRIC CLAIMS

- Number of claims by age group
- Indemnity by age group
- Injury severity by age group
- Claim allegations for hospitals and for physicians

AGE GROUPS FOR PEDIATRIC CLAIMS

- Neonatal (< 1 month)
- First Year (1 – 11 months)
- Child (1 – 9 years)
- Teenager (10 – 17 years)
### NUMBER OF OHIC CLAIMS BY AGE GROUP
**JANUARY 2000 – APRIL 2007**

<table>
<thead>
<tr>
<th>All Claims by Age Group</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal (&lt; 1 month)</td>
<td>515</td>
</tr>
<tr>
<td>First Year (1-11 months)</td>
<td>81</td>
</tr>
<tr>
<td>Child (1-9 yrs)</td>
<td>188</td>
</tr>
<tr>
<td>Teenager (10-17 yrs)</td>
<td>212</td>
</tr>
<tr>
<td>Young Adult (18-29 yrs)</td>
<td>741</td>
</tr>
<tr>
<td>Adult (30-64 yrs)</td>
<td>3,895</td>
</tr>
<tr>
<td>Senior (65+ yrs)</td>
<td>1,496</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>7,128</td>
</tr>
</tbody>
</table>

### OHIC Average Indemnity by All Age Groups Claims and Suits with Indemnity 2000 - 2007

<table>
<thead>
<tr>
<th>Claims with Indemnity by Age Group</th>
<th>Claim Count</th>
<th>Average Indemnity</th>
<th>Average Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neonatal (&lt; 1 month)</td>
<td>183</td>
<td>533,221</td>
<td>62,382</td>
</tr>
<tr>
<td>First Year (1-11 months)</td>
<td>20</td>
<td>557,478</td>
<td>79,229</td>
</tr>
<tr>
<td>Child (1-9 yrs)</td>
<td>57</td>
<td>273,629</td>
<td>69,785</td>
</tr>
<tr>
<td>Teenager (10-17 yrs)</td>
<td>57</td>
<td>278,809</td>
<td>28,259</td>
</tr>
<tr>
<td>Young Adult (18-29 yrs)</td>
<td>182</td>
<td>293,561</td>
<td>38,101</td>
</tr>
<tr>
<td>Adult (30-64 yrs)</td>
<td>888</td>
<td>264,628</td>
<td>36,108</td>
</tr>
<tr>
<td>Senior (65+ yrs)</td>
<td>451</td>
<td>129,390</td>
<td>27,986</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1,838</td>
<td>264,957</td>
<td>38,199</td>
</tr>
</tbody>
</table>
### Injury Severity for Pediatrics by Age Group

**OHIC Claims with Indemnity > $100**

<table>
<thead>
<tr>
<th>Severity of Injury (NAIC Severity Scale 1 - 9)</th>
<th>Neonatal (&lt; 1 month)</th>
<th>First Year (1-11 mo.)</th>
<th>Child (1-9 yrs)</th>
<th>Teenager (10-17 yrs)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 DEATH</td>
<td>178</td>
<td>40</td>
<td>44</td>
<td>35</td>
<td>297</td>
</tr>
<tr>
<td>8 PERMANENT GRAVE</td>
<td>62</td>
<td>5</td>
<td>4</td>
<td>8</td>
<td>79</td>
</tr>
<tr>
<td>7 PERMANENT MAJOR</td>
<td>66</td>
<td>7</td>
<td>8</td>
<td>9</td>
<td>90</td>
</tr>
<tr>
<td>6 PERMANENT SIGNIFICANT</td>
<td>61</td>
<td>6</td>
<td>20</td>
<td>15</td>
<td>102</td>
</tr>
<tr>
<td>5 PERMANENT MINOR</td>
<td>56</td>
<td>8</td>
<td>37</td>
<td>49</td>
<td>150</td>
</tr>
<tr>
<td>4 TEMPORARY MAJOR</td>
<td>18</td>
<td>5</td>
<td>27</td>
<td>53</td>
<td>103</td>
</tr>
<tr>
<td>3 TEMPORARY MINOR</td>
<td>16</td>
<td>2</td>
<td>23</td>
<td>13</td>
<td>54</td>
</tr>
<tr>
<td>2 TEMPORARY INSIGNIFICANT</td>
<td>7</td>
<td>3</td>
<td>10</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>1 EMOTIONAL ONLY</td>
<td>8</td>
<td>1</td>
<td>2</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>LEGAL ISSUE ONLY</td>
<td>15</td>
<td>1</td>
<td>6</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>*TOTAL</td>
<td>487</td>
<td>78</td>
<td>181</td>
<td>199</td>
<td>945</td>
</tr>
</tbody>
</table>

### Hospital Pediatric Claims with Indemnity
**NEONATAL AGE GROUP REMOVED**

- 84% of neonatal age group paid claims were for OB-related incidents
- The remaining OHIC slides do not include neonatal claims

**PEDIATRIC CLAIMS: OHIC INSURED HOSPITALS 2000 - 2007**

- Most common allegations
- Most common RM issues
ALLEGATIONS

- Top Allegations Against OHIC Hospitals:
- Pediatric Claims with Indemnity

OHIC HOSPITAL PEDIATRIC CLAIMS BY ALLEGATION

<table>
<thead>
<tr>
<th>Hospital Pediatric Claims by Allegation Sub-Category for Claims with Indemnity</th>
<th>Claim Count</th>
<th>Average Indemnity</th>
<th>Average Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>0510 - DIAGNOSIS-RELATED</td>
<td>19</td>
<td>775,703</td>
<td>97,131</td>
</tr>
<tr>
<td>0110 - MEDICAL TREATMENT (NON-OB)</td>
<td>11</td>
<td>68,591</td>
<td>51,289</td>
</tr>
<tr>
<td>0810 - PATIENT MONITORING</td>
<td>11</td>
<td>144,216</td>
<td>21,129</td>
</tr>
<tr>
<td>0310 - SURGICAL TREATMENT (NON-ANESTHESIA)</td>
<td>8</td>
<td>138,438</td>
<td>16,459</td>
</tr>
<tr>
<td>0210 - OBSTETRICS-RELATED TREATMENT</td>
<td>6</td>
<td>1,332,599</td>
<td>78,366</td>
</tr>
<tr>
<td>0730 - OTHER COMMUNICATION</td>
<td>6</td>
<td>257,500</td>
<td>189,609</td>
</tr>
<tr>
<td>1010 - FAIL TO PROVIDE SAFETY - SAFETY RELATED</td>
<td>3</td>
<td>36,667</td>
<td>6,295</td>
</tr>
<tr>
<td>1210 - SEXUAL MISCONDUCT</td>
<td>3</td>
<td>28,333</td>
<td>15,623</td>
</tr>
<tr>
<td>0930 - ADMINISTRATION ERROR</td>
<td>2</td>
<td>55,248</td>
<td>2,164</td>
</tr>
<tr>
<td>0920 - DISPENSING ERROR</td>
<td>1</td>
<td>1,500</td>
<td>0</td>
</tr>
<tr>
<td>0940 - IMPROPER MEDICAL MANAGEMENT</td>
<td>1</td>
<td>3,000</td>
<td>8,500</td>
</tr>
</tbody>
</table>
MOST FREQUENT ALLEGATIONS

#1 = Diagnostic Related
- Torsion testicle 16%
- Fever and dehydration 16%
- Meningitis 11%
- Pneumonia 11%
- Misc. 46% (appendicitis, hydrocephalus, torsion bowel, fracture, leukemia, intercranial bleed, etc.)

MOST FREQUENT ALLEGATIONS

#2 = Medical Treatment (non-OB)
- Improper treatment of traumatic injury 45%
- Managing hydration 27%
- Durabond glued eye shut 18%
- Misc. (retained sponge, leg fracture in PT, etc.) 10%
MOST FREQUENT ALLEGATIONS

#3 = Patient monitoring
- IV infiltration 27%
- Patient falls 27%
- Monitoring with equipment 18%
- Restraints 9%
- Misc. (failure to follow orders) 19%

TOP RISK MANAGEMENT ISSUES FOR OHIC INSURED HOSPITALS:

Pediatric Claims and Suits
OHIC HOSPITAL RISK MANAGEMENT ISSUES: PEDIATRIC CLAIMS WITH INDEMNITY

<table>
<thead>
<tr>
<th>Hospital Claims by Risk Management Issue for Pediatric Claims with Indemnity</th>
<th>Claim Count</th>
<th>Average Indemnity</th>
<th>Average Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>CJ1 - PATIENT ASSESSMENT ISSUES</td>
<td>38</td>
<td>660,773</td>
<td>94,153</td>
</tr>
<tr>
<td>AD3 - STAFF ISSUES</td>
<td>37</td>
<td>328,480</td>
<td>51,496</td>
</tr>
<tr>
<td>CJ2 - SELECTION AND MANAGEMENT OF THERAPY</td>
<td>21</td>
<td>369,685</td>
<td>89,579</td>
</tr>
<tr>
<td>CJ3 - PATIENT MONITORING</td>
<td>20</td>
<td>664,246</td>
<td>94,514</td>
</tr>
<tr>
<td>CO1 - COMMUNICATION AMONG PROVIDERS</td>
<td>20</td>
<td>628,074</td>
<td>56,244</td>
</tr>
<tr>
<td>AD5 - POLICY/PROTOCOL</td>
<td>19</td>
<td>524,224</td>
<td>40,079</td>
</tr>
<tr>
<td>DO3 - INSUFFICIENT/LACK OF DOCUMENTATION</td>
<td>17</td>
<td>772,765</td>
<td>105,173</td>
</tr>
<tr>
<td>CO2 - BETWEEN PATIENT/FAMILY AND PROVIDERS</td>
<td>16</td>
<td>319,666</td>
<td>92,853</td>
</tr>
<tr>
<td>TS4 - TECHNICAL PERFORMANCE</td>
<td>13</td>
<td>143,299</td>
<td>53,369</td>
</tr>
<tr>
<td>EN1 - FAILURE TO ENSURE A SAFE ENVIRONMENT</td>
<td>7</td>
<td>156,609</td>
<td>90,531</td>
</tr>
<tr>
<td>CJ4 - FAILURE/Delay IN OBTAINING CONSULT/REFERR.</td>
<td>7</td>
<td>871,429</td>
<td>111,748</td>
</tr>
<tr>
<td>CJ5 - FAILURE TO ENSURE PATIENT SAFETY</td>
<td>6</td>
<td>28,636</td>
<td>2,450</td>
</tr>
</tbody>
</table>

PATIENT ASSESSMENT ISSUES

- Lack of or inadequate assessment
- Failure to establish a differential diagnosis
- Failure or delay in ordering tests
- Failure to respond to patient concerns
PATIENT ASSESSMENT

ISSUES: TYPES OF CLAIMS

- Hydration with fever
  - Dehydration or Fluid
- Infectious diseases
  - Meningitis, Pneumonia, Septicemia, Hepatitis, Rocky Mt Spotted Fever, etc.
- Abdominal complaints
  - Appendicitis, bowel obstruction, volvulus, etc.
- Trauma
  - Foreign body, lacerated tendons, subdural hematoma, etc.

STAFF ISSUES

- Staff training
- Adequate staffing
- Administrative delay or mishandling of patient issues
STAFF TRAINING / EDUCATION: TYPES OF CLAIMS

Wide variety of cases – few trends

- Followed physician orders - cleaned wound with Hibiclens. Result was chemical cellulitis & ileus
- Failed to follow physician orders – infusion of IV fluid too rapid resulting in fluid overload
- Turned off vent alarm – brain damage to vent dependent quad

RISK MANAGEMENT OBSERVATIONS: OHIC HOSPITAL PEDIATRIC CLAIMS

- Most cases involve failure to diagnose
  - Not a nursing responsibility
- Hospital and staff pulled into the case
  - Inadequate assessments
  - Failure to monitor
  - Failure to notify physician
- Usually nursing care is appropriate
  - If documentation is deficient, the plaintiff is able to imply that the nursing care was inadequate
**RISK MANAGEMENT OBSERVATIONS: OHIC HOSPITAL PEDIATRIC CLAIMS**

- Nurses need to follow chain of command if they suspect an order is incorrect.
  - Medication orders
  - Inadequate fluid replacement
  - Physician failing to respond to patient concerns
  - Physician failing to respond to nurses’ concerns

---

**PEDIATRICS: PHYSICIAN TRENDS PIAA CLOSED CLAIMS**
PEDIATRICS:
PEDIA DESIGN CLAIMS

PIAA Data Sharing System

- PIAA is the Physician Insurers Association of America
- Cumulative Study dates back to 1985
- 225,000 closed physician claims
- Roughly 40 member companies report
- Most credible database for physician claims

PIAA NATIONAL PHYSICIAN SPECIALTY TRENDS

PIAA: Claims Closed Between 1985 and 2007
Comparative Claim Payment Analysis: All Specialties

<table>
<thead>
<tr>
<th>Specialty Group</th>
<th>Closed Claims</th>
<th>%Paid to Indemnity</th>
<th>Total Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>8,866</td>
<td>32.43</td>
<td>$636,193,819</td>
</tr>
<tr>
<td>Cardiovascular and Thoracic Surgery</td>
<td>6,960</td>
<td>23.59</td>
<td>205,739,943</td>
</tr>
<tr>
<td>Cardiovascular Diseases – nonsurgical</td>
<td>4,246</td>
<td>18.13</td>
<td>191,163,963</td>
</tr>
<tr>
<td>Dermatology</td>
<td>2,620</td>
<td>28.89</td>
<td>101,440,748</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>3,391</td>
<td>25.28</td>
<td>202,049,937</td>
</tr>
<tr>
<td>General Surgery</td>
<td>6,658</td>
<td>30.03</td>
<td>3,365,943,014</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>2,354</td>
<td>18.00</td>
<td>88,121,039</td>
</tr>
<tr>
<td>Gynecology</td>
<td>24,777</td>
<td>34.31</td>
<td>1,489,660,592</td>
</tr>
<tr>
<td>Hematology</td>
<td>2,795</td>
<td>30.13</td>
<td>732,066,088</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>2,206</td>
<td>29.06</td>
<td>653,993,558</td>
</tr>
<tr>
<td>Neurology – nonsurgical</td>
<td>3,356</td>
<td>21.20</td>
<td>245,989,868</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>3,431</td>
<td>28.11</td>
<td>471,770,521</td>
</tr>
<tr>
<td>Obstetrics and Gynecologic Surgery</td>
<td>31,486</td>
<td>33.11</td>
<td>3,086,138,311</td>
</tr>
<tr>
<td>Orthopedics</td>
<td>6,788</td>
<td>28.12</td>
<td>2,736,750,112</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>62</td>
<td>32.20</td>
<td>538,583</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>21,648</td>
<td>23.16</td>
<td>1,042,160,635</td>
</tr>
<tr>
<td>Other Neurological Specialties</td>
<td>2,234</td>
<td>22.98</td>
<td>95,777,958</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>3,813</td>
<td>31.40</td>
<td>241,644,324</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>1,659</td>
<td>28.33</td>
<td>112,847,595</td>
</tr>
<tr>
<td>Pathology</td>
<td>1,635</td>
<td>29.33</td>
<td>112,847,595</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>6,794</td>
<td>27.03</td>
<td>505,884,086</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>8,663</td>
<td>26.57</td>
<td>262,301,626</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>2,276</td>
<td>30.13</td>
<td>74,568,108</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>2,212</td>
<td>28.03</td>
<td>172,036,688</td>
</tr>
<tr>
<td>Radiology</td>
<td>12,970</td>
<td>29.20</td>
<td>736,139,369</td>
</tr>
<tr>
<td>Resident/Intern</td>
<td>1,300</td>
<td>32.31</td>
<td>4,109,822</td>
</tr>
<tr>
<td>Urology</td>
<td>5,377</td>
<td>29.41</td>
<td>285,762,182</td>
</tr>
</tbody>
</table>

TOTALS 230,624 29.59 $13,926,975,327 $204,268

Source: PIAA, 2008
PEDIATRICS: PIAA PHYSICIAN CLAIMS

- Pediatrics is the sole physician specialty represented in this section of PIAA data
- Pediatrics has the fifth highest average indemnity of all specialties
- Female pediatricians had a much higher percentage of claims versus female physicians in all other specialties: (26.6% vs. 8.3%)
  - There are a greater percentage of females in this specialty

PEDIATRICS: PIAA PHYSICIAN CLAIMS

Pediatrics
Claims by 10 Most Prevalent Patient Conditions

<table>
<thead>
<tr>
<th>Patient Condition</th>
<th>Total Claims</th>
<th>% Paid to Closed</th>
<th>Total Indemnity</th>
<th>Average Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brain Damaged Infant</td>
<td>594</td>
<td>28.47</td>
<td>$70,669,971</td>
<td>$441,687</td>
</tr>
<tr>
<td>Meningitis</td>
<td>349</td>
<td>44.38</td>
<td>$63,739,228</td>
<td>448,868</td>
</tr>
<tr>
<td>Routine infant or child health check</td>
<td>215</td>
<td>20.83</td>
<td>7,927,909</td>
<td>198,196</td>
</tr>
<tr>
<td>Respiratory problems in the newborn</td>
<td>193</td>
<td>16.67</td>
<td>7,847,603</td>
<td>270,607</td>
</tr>
<tr>
<td>Appendicitis</td>
<td>157</td>
<td>32.39</td>
<td>5,347,816</td>
<td>116,257</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>153</td>
<td>21.99</td>
<td>7,425,454</td>
<td>239,531</td>
</tr>
<tr>
<td>Specified nonteratogenic anomalies</td>
<td>135</td>
<td>41.94</td>
<td>9,708,836</td>
<td>186,708</td>
</tr>
<tr>
<td>Premature infant</td>
<td>111</td>
<td>14.15</td>
<td>4,050,368</td>
<td>270,025</td>
</tr>
<tr>
<td>Birth</td>
<td>89</td>
<td>14.10</td>
<td>3,150,480</td>
<td>286,407</td>
</tr>
<tr>
<td>Congenital anomaly of genital organs</td>
<td>90</td>
<td>23.38</td>
<td>3,066,250</td>
<td>170,347</td>
</tr>
</tbody>
</table>

TOTALS                                         | 2,086        | 28.39            | $182,933,915     | $336,276          |

Source: PIAA, 2008
PEDIATRICS: PIAA PHYSICIAN CLAIMS

Pediatrics
Claims by 10 Most Prevalent Medical Misadventures

<table>
<thead>
<tr>
<th>Medical Misadventure</th>
<th>Total Claims</th>
<th>% Paid to Closed</th>
<th>Total Indemnity</th>
<th>Average Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Errors in diagnosis</td>
<td>2,389</td>
<td>34.83</td>
<td>$201,521,813</td>
<td>$265,860</td>
</tr>
<tr>
<td>No medical misadventure</td>
<td>1,592</td>
<td>6.51</td>
<td>32,215,160</td>
<td>332,115</td>
</tr>
<tr>
<td>Improper performance</td>
<td>934</td>
<td>29.35</td>
<td>55,662,276</td>
<td>215,745</td>
</tr>
<tr>
<td>Failure to supervise or monitor case</td>
<td>675</td>
<td>35.83</td>
<td>72,958,941</td>
<td>324,262</td>
</tr>
<tr>
<td>Medication errors</td>
<td>351</td>
<td>31.13</td>
<td>17,158,988</td>
<td>173,323</td>
</tr>
<tr>
<td>Failure/delay in referral or consultation</td>
<td>221</td>
<td>44.85</td>
<td>22,249,234</td>
<td>265,736</td>
</tr>
<tr>
<td>Failure to recognize a complication of treatment</td>
<td>206</td>
<td>31.95</td>
<td>12,766,517</td>
<td>236,417</td>
</tr>
<tr>
<td>Not performed</td>
<td>200</td>
<td>43.09</td>
<td>16,893,992</td>
<td>208,568</td>
</tr>
<tr>
<td>Delay in performance</td>
<td>179</td>
<td>38.69</td>
<td>23,570,998</td>
<td>362,631</td>
</tr>
<tr>
<td>Failure to instruct or communicate with patient</td>
<td>121</td>
<td>22.22</td>
<td>2,033,981</td>
<td>92,454</td>
</tr>
</tbody>
</table>

**TOTALS**                                          | **6,868**    | **27.68**        | **$457,031,900**      | **$261,759**      |

Source: PIAA, 2008

---

PEDIATRICS: PIAA PHYSICIAN CLAIMS

Pediatrics
Claims by Medical Misadventure and Procedure/Condition

**Improper performance**

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Total Claims</th>
<th>% Paid to Closed</th>
<th>Total Indemnity</th>
<th>Average Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic interview, evaluation, or consultation</td>
<td>239</td>
<td>27.23</td>
<td>$13,552,509</td>
<td>$222,172</td>
</tr>
<tr>
<td>General physical examination</td>
<td>85</td>
<td>29.11</td>
<td>6,385,105</td>
<td>277,613</td>
</tr>
<tr>
<td>Miscellaneous nonoperative procedures</td>
<td>79</td>
<td>40.00</td>
<td>5,661,777</td>
<td>188,726</td>
</tr>
<tr>
<td>Prescription of medication</td>
<td>77</td>
<td>37.88</td>
<td>4,452,158</td>
<td>176,096</td>
</tr>
<tr>
<td>Injections and vaccinations</td>
<td>68</td>
<td>32.31</td>
<td>4,117,753</td>
<td>196,083</td>
</tr>
</tbody>
</table>

**TOTALS**                                          | **548**      | **31.43**        | **$34,169,302**     | **$213,558**      |

Source: PIAA, 2008
## Pediatrics: PIAA Physician Claims

### Errors in diagnosis

<table>
<thead>
<tr>
<th>Condition</th>
<th>Total Claims</th>
<th>% Paid to Closed</th>
<th>Total Indemnity</th>
<th>Average Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meningitis</td>
<td>188</td>
<td>52.87</td>
<td>$40,945,211</td>
<td>$445,057</td>
</tr>
<tr>
<td>Appendicitis</td>
<td>111</td>
<td>37.00</td>
<td>4,861,317</td>
<td>131,387</td>
</tr>
<tr>
<td>Specified nonteratogenic anomalies</td>
<td>84</td>
<td>50.00</td>
<td>7,512,884</td>
<td>197,707</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>65</td>
<td>18.97</td>
<td>4,359,500</td>
<td>396,318</td>
</tr>
<tr>
<td>Brain Damaged Infant</td>
<td>60</td>
<td>38.60</td>
<td>7,387,677</td>
<td>335,804</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>508</strong></td>
<td><strong>43.01</strong></td>
<td><strong>$65,066,589</strong></td>
<td><strong>$325,333</strong></td>
</tr>
</tbody>
</table>

Source: PIAA, 2008

### Claims by 10 Most Prevalent Procedures Performed

<table>
<thead>
<tr>
<th>Procedure Performed</th>
<th>Total Claims</th>
<th>% Paid to Closed</th>
<th>Total Indemnity</th>
<th>Average Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic interview, evaluation, or consultation</td>
<td>2,962</td>
<td>28.36</td>
<td>$232,499,622</td>
<td>$297,314</td>
</tr>
<tr>
<td>General physical examination</td>
<td>1,172</td>
<td>29.51</td>
<td>88,595,120</td>
<td>284,872</td>
</tr>
<tr>
<td>Prescription of medication</td>
<td>723</td>
<td>33.49</td>
<td>44,430,799</td>
<td>206,655</td>
</tr>
<tr>
<td>No care rendered</td>
<td>370</td>
<td>9.40</td>
<td>7,086,725</td>
<td>214,749</td>
</tr>
<tr>
<td>Injections and vaccinations</td>
<td>347</td>
<td>29.19</td>
<td>23,457,925</td>
<td>249,552</td>
</tr>
<tr>
<td>Miscellaneous nonoperative procedures</td>
<td>226</td>
<td>24.15</td>
<td>10,592,718</td>
<td>211,854</td>
</tr>
<tr>
<td>Miscellaneous manual examinations and nonoperative procedures</td>
<td>142</td>
<td>32.00</td>
<td>6,036,385</td>
<td>150,910</td>
</tr>
<tr>
<td>Respiratory therapy</td>
<td>124</td>
<td>31.93</td>
<td>9,785,237</td>
<td>257,506</td>
</tr>
<tr>
<td>Advice given to patient, without treatment being rendered</td>
<td>114</td>
<td>40.59</td>
<td>14,577,726</td>
<td>355,554</td>
</tr>
<tr>
<td>Cardiopulmonary resuscitation</td>
<td>105</td>
<td>8.91</td>
<td>2,668,066</td>
<td>296,452</td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>6,285</strong></td>
<td><strong>27.91</strong></td>
<td><strong>$439,730,323</strong></td>
<td><strong>$272,616</strong></td>
</tr>
</tbody>
</table>

Source: PIAA, 2008
**PEDIATRICS: PIAA PHYSICIAN CLAIMS**

**Risk Management Observations: Pediatricians**
- AAP 2001 survey: 2/3 of pediatricians said that the hospital was the site of events resulting in claims
- Meningitis claims are the chief concern of PIAA
- Pediatricians are more vulnerable to claims involving patient assessment and advice by telephone

---

**RECENT LARGE PEDIATRIC LOSSES**
### RECENT LARGE PEDIATRIC LOSSES

<table>
<thead>
<tr>
<th>Location</th>
<th>Verdict</th>
<th>Date</th>
<th>Pediatric Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hartford, CT</td>
<td>$12.5M</td>
<td>April-04</td>
<td>Failure to diagnose spinal tumor</td>
</tr>
<tr>
<td>Milwaukee</td>
<td>$19M</td>
<td>October-04</td>
<td>Failure to diagnose volvulus</td>
</tr>
<tr>
<td>California</td>
<td>$11M</td>
<td>April-06</td>
<td>Triplets-Failure to dx and treat ROP (settlement)</td>
</tr>
<tr>
<td>New York City</td>
<td>$31.5M</td>
<td>May-06</td>
<td>Inadequate respiratory monitoring in the NICU</td>
</tr>
<tr>
<td>Philadelphia</td>
<td>$30M</td>
<td>June-06</td>
<td>Negligent administration of TPA</td>
</tr>
<tr>
<td>Columbus, OH</td>
<td>$17.8M</td>
<td>July-06</td>
<td>Negligent administration of anesthesia</td>
</tr>
<tr>
<td>Atlanta</td>
<td>$16.5M</td>
<td>August-06</td>
<td>Failure to diagnose congenital anomaly</td>
</tr>
<tr>
<td>Suburban</td>
<td>$20M</td>
<td>November-06</td>
<td>ROP: child lost to follow-up after NICU discharge</td>
</tr>
<tr>
<td>Philadelphia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Los Angeles</td>
<td>$15.4M</td>
<td>July-07</td>
<td>Failure to diagnose and treat Kernicterus</td>
</tr>
<tr>
<td>Florida</td>
<td>$38M</td>
<td>April-08</td>
<td>Failure to diagnose ROP: twins</td>
</tr>
</tbody>
</table>
RECENT LARGE PEDIATRIC LOSSES

Endurance Specialty
Stand-Alone Pediatric Hospital Losses Excess of $5M* **

- $7,865,000 - Post Op Bleeding
- 5,054,000 - Infant Death, Drug Overdose
- 15,409,496 - Failure to diagnose post operative hyperkalemia
- 6,023,054 - Relapse of acute lymphocytic leukemia
- 5,654,704 - Failure to diagnose meningitis
- 15,000,000 R - Paralysis after surgery
- 12,000,000 R - Brain damage-improper shunt management
- 9,750,000 - Delay in treatment of spinal cord compression
- 9,000,000 - Cauda Equina cut – ortho surgery
- 8,000,000 - Group A Strep – permanent brain damage
- 7,829,940 - Drug Overdose
- 5,359,915 - Cause unknown
- 7,340,904 - Oral Electrolyte Overdose – arrest and brain damage
- 5,725,543 - Death of newborn with congenital heart defect
- 6,312,481 - Improper intubation

* Information is from loss runs valued within the past 12 months (ending 12/31/06). Loss runs reflected 10-years of loss history.

** All information provided is from Endurance Specialty Insurance, Ltd. Claims database. Loss information was reviewed for 19 stand-alone pediatric hospitals.

LOW FREQUENCY! HIGH SEVERITY PEDIATRIC CASES
LOW FREQUENCY | HIGH SEVERITY PEDIATRIC CLAIMS

- Retinopathy of Prematurity
- Kernicterus
- Meningitis
- Torsion of the Bowel and Volvulus

LOW FREQUENCY | HIGH SEVERITY CASES

**Retinopathy of Prematurity**
- Is a disease of the vasculature of the eyes in low-birthweight premature infants
- Most serious cases result in retinal detachment and blindness
- The disease process requires appropriate eye exams at proper times to detect changes
- Requires coordination between neonatology and ophthalmology services
- Communication with parents is critical, both verbally and in writing, especially follow-up eye exams after NICU discharge*

LOW FREQUENCY|HIGH SEVERITY CASES

Retinopathy of Prematurity: Recurring Claims Issues
- Babies discharged before follow-up date after initial exam
- Babies transferred to other facilities
- Eye exams not performed in the NICU because child too ill or in surgery
- Parents claim they were not told of the importance of post-discharge eye exams, especially timelines
- Poor communication between providers
- Responsibility for follow-up in the ROP care process is inadequately defined and/or poorly executed

Risk Management Observations: ROP
- Create system-based policies and procedures to ensure timely initial exams and especially follow-up for babies at risk
- See Ophthalmic Mutual Insurance Company’s risk management protocol: “Retinopathy of Prematurity – Creating a Safety Net” *
- Careful coordination between neonatology and ophthalmology services with ongoing monitoring
- Careful documentation of parental communication especially the urgency of follow-up eye exams

*www.omic.com/
LOW FREQUENCY\|HIGH
SEVERITY CASES

Kernicterus:

- Defined: A rare type of brain damage that occurs in newborns with severe jaundice
- Increased risk for babies with co-morbidities: prematurity, asphyxia, infection, hypoglycemia, etc.
- Two JCAHO Sentinel Events Alerts*
- NQF/AHRQ termed Kernicterus a “Never Event”
- Plaintiff’s lawyers have Kernicterus websites


LOW FREQUENCY\|HIGH
SEVERITY CASES

Kernicterus: Recurring Issues*

- Lack of concern for neurotoxic potential of bilirubin
- Limitations on visual recognition of jaundice to estimate severity
- Failure to recognize severity of hyperbilirubinemia corrected for age in hours
- Failure to educate parents on newborn jaundice signs
- Failure to ensure follow-up 1-2 days after early discharge
- Delay in intensive or timely intervention pre-discharge or at readmission

Source: Johnson, Brown, Bhutani, Pediatrics, April 2002
LOW FREQUENCY/HIGH SEVERITY CASES

Risk Management Observations: Kernicterus
- Create system-based policies and procedures to ensure follow-up for babies at risk
- Limit reliance on visual recognition of jaundice
- Family education programs, especially breast-feeding mothers
- All newborns assessed prior to discharge*
- All newborns scheduled for follow-up visit within* 3-5 days of age

*JCAHO SEA_31

LOW FREQUENCY/HIGH SEVERITY CASES

Meningitis:
- Definition – inflammation of meninges
- Bacterial – the cause of most claims
  - pneumococcal,
  - haemophilus influenzae type b
- Viral
- Fungal (cryptococcal) - rare
LOW FREQUENCY/HIGH SEVERITY CASES

Meningitis:
- Difficult to diagnose
  - Symptoms often mimic influenza or upper respiratory infections
  - At onset, distinct symptoms may not be present
- Symptoms include:
  - High fever
  - General lethargy
  - Drowsiness
  - Emesis
  - Stiff neck

LOW FREQUENCY/HIGH SEVERITY CASES

Meningitis – Claims
- Death resulted in 60.3% of claims
- An initial diagnosis of meningitis was made in only 12.3% of cases
- Primary misadventure (70% of cases)
  - Failure to diagnose
  - Delay in diagnosing

(PIAA Meningitis Claims Study 2000)
**LOW FREQUENCY/HIGH SEVERITY CASES**

**Risk Management Observations: Meningitis**
- Listen carefully to patient or their caregiver regarding changes experienced by the patient
  - Telephone triage is problematic
  - Multiple calls or visits should raise concern
- Maintain a high index of suspicion when examining patients who present with flu-like symptoms
  - Nurses must report changes in vital signs
  - Don’t discharge patients with abnormal vitals without informing the physician

---

**LOW FREQUENCY/HIGH SEVERITY CASES**

**Risk Management Observations: Meningitis**
- Document all complaints, observations, findings and recommendations for care
  - Assessments
  - Response to test results
- Provide clear follow-up instructions including symptoms that warrant immediate medical attention
  - If condition worsens or does not improve
LOW FREQUENCY\|HIGH
SEVERITY CASES

Volvulus and Malrotation of the Bowel

Definition

- Abnormal twisting of the intestine causing obstruction and restricted blood flow to the tissues
- May result in necrosis of the bowel

Incidence of cases

- Wide range of pediatric patient ages
- 75 – 90% of cases occur in children less than one year of age
- OHIC cases included children from 4 days to 15 years of age
**LOW FREQUENCY/HIGH SEVERITY CASES**

Volvulus and Malrotation

- Symptoms: No unique signs
- Infants
  - Biliary vomiting, feeding intolerance and distended abdomen
  - May not vomit, but show other symptoms i.e. anorexia, constipation, bloody stools and failure to thrive

---

**LOW FREQUENCY/HIGH SEVERITY CASES**

Volvulus and Malrotation

- Symptoms: No unique signs
- Older children
  - Intense abdominal pain and cyclic vomiting
  - Acute symptoms may last less than 24 hrs.

Note: An abrupt change from feed tolerance to vomiting and irritability at any age is cause for suspicion of volvulus
VOLVULUS AND MALROTATION

Risk Management Observations: Volvulus and Malrotation
- Investigate intense abdominal pain even if it resolves
- Investigate reoccurring episodes of abdominal pain and vomiting
- Obtain abdominal radiographs
- Provide parent/patient instructions

PEDIATRICS: NO SMALL RISK

Summary and Recommendations
**PEDIATRICS: NO SMALL RISK**

**Summary**

- Children represent unique diagnostic and treatment challenges
- Younger pediatric patients have a higher incidence of serious and life-threatening patient safety events
- Failure to diagnose and delay in diagnosis are the most common allegations
- Cases involving children are more volatile and more expensive to resolve
- Trial bar is focusing on low frequency/high severity cases, especially ROP, kernicterus, and meningitis
  - Consider use of special counsel to defend high-damage claims involving children

**Recommendations**

- Evaluate the environment where care to children is provided
- Ensure that all sizes and types of pediatric equipment and supplies are available
- Create system-based policies and procedures for timely treatment of children with defined disease progression
- Nurses have an important role helping physicians identify significant pediatric symptoms along with changes in patients’ conditions
- Provide clear and documented instruction for parents
  - Symptoms requiring return for care
  - Communicate urgency of timely follow-up care
PEDIATRICS: NO SMALL RISK

Recommendations (continued)

- Provide clear and documented instruction for parents
  - Symptoms requiring return for care
  - Communicate urgency of timely follow-up care
- Utilize many available resources for managing risk in the pediatric patient population including materials from ECRI, AAP, AHRQ, PIAA, AAFP, ACEP, etc
- Follow published treatment guidelines from AAP and other professional organizations or document rationale for deviations

QUESTIONS AND DISCUSSION
PEDIATRICS: NO SMALL RISK

YOU KNOW THE RISKS IN PEDIATRICS. .......
GO DIVE IN!!!!

Eric Peterson / The Livingston Enterprise
Claims Strategies for Pediatric Cases

Unique Challenges:
• Clinical vulnerability of pediatric cases
• Lifetime care considerations
• Sympathetic and emotional jury response
• Cost of care drives parents to seek alternatives
• Sought after cases by plaintiff attorneys
Claim Strategies

Claims Process:
• Media management, internal communication
• Notice to Insurance carriers, excess considerations
• Investigation
• Coverage issues
• Early expert reviews prior to litigation
• Early involvement of defense counsel
• Mitigation, bill write offs, disclosure, parent conferences and support
• Statute of limitations

Claim Strategies

Claim Management:
• Litigation management, best lawyer for the facts
• Litigation guidelines, case may not fit the mold
• Expert reviews
• Liability analysis
• Reserving, determining case value
• Determine claim strategy as early as possible, settle or defend
**Claim Strategies**

Determining case value:
- Liability analysis
- Damages analysis
- Time factor - neonates may have to wait until developmental milestones
- Life expectancy, rated age
- Cost of future care, and/or lifetime care
- Life care plan cost
Claim strategies

Negotiations:
Mediation
Arbitration
Civil system, settlement conference and trial

Claim Strategies

Mediation
• Parents present
• Parents voice, what do they want for the child
• Choice of mediator
• Build settlement around the needs of the child
Claim Strategies

Settlement negotiations

Annuity or structured settlement expert
Updated life care plan
Focus on needs of child

Claim strategies

Trial:
Best defense counsel
Preparation of witnesses and defendants
Presence at trial
Negotiations at trial
Claims Strategies

Claim file closure:
Proper documents
• Minors compromise
• Annuity information
• Final Billing
If non litigated, statute ran or no activity