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Professional Liability Primer:
What Every Midwife Should Know About Professional Liability Insurance

Ashley Woodruff, MSN, CNM, Mamie Guidera, MSN, CNM, FACNM, William F. McCool, PhD, CNM, FACNM, and the ACNM Professional Liability Section

INTRODUCTION

In a recent survey, one-third of practicing members of the American College of Nurse-Midwives (ACNM) reported being named in a lawsuit during the course of their professional careers.¹ Midwives must be willing to protect their assets against liability claims or face severe financial loss. There are several ways for midwives to purchase liability insurance, but regardless of the source, the midwife is responsible for knowing the type of professional liability coverage purchased and that premiums are paid and current. The midwife should keep a copy of the face or summary sheet, if not the entire policy, for each year in practice. If a claim should arise years later, it is the midwife’s responsibility to produce evidence of coverage for the period in question.

The term “medical malpractice insurance” is often used interchangeably with “professional liability insurance.” However, these types of insurance are not the same. Medical malpractice refers to coverage for injury to a patient. Professional liability refers to the obligation to compensate others for negligent injury resulting from the performance of professional services. Professional liability provides additional coverage for other allegations, such as slandering a physician or inadequately training a subordinate. Professional liability covers acts, errors, and omissions in the performance of professional services (including injury to patients), while medical malpractice covers only the bodily injury to patients.

THE INSURANCE POLICY

An insurance policy is a contract between the insurance company (the “insurer”) and the person protected by the policy (the “insured”). Through the insurance policy, the insurer assumes a defined financial risk on behalf of the insured and agrees to make payments on behalf of the insured. In exchange for this coverage, the insurer receives payment (the “premium”) from the insured. The contract covers a limited amount of time specified in the policy, which is typically one year.

The insurer is responsible for expenses related to defending a midwife against a professional liability claim, including investigation costs, attorney fees, and expert witness costs. If a claimant successfully proves malpractice against a midwife, the insurer is responsible for paying the claim (an indemnity payment), which could be determined by an agreed-upon settlement or a judicially-based judgment. A claim is called a settlement if an agreement is made before a trial. It is called a judgment when awarded by a judge or jury after a trial takes place.
SOURCES OF PROFESSIONAL LIABILITY COVERAGE

**ACNM insurance services**

The ACNM Board of Directors and staff have worked for several decades to negotiate a nationwide program that offers professional liability coverage tailored to certified midwives and certified nurse-midwives (CMs/CNMs). As of 2014, ACNM supports Contemporary Insurance Services, Inc. (CIS), a broker insurance firm that negotiates with insurance companies to offer liability coverage to midwives.²

**Self-insurance**

If a midwife is employed by a large hospital, university, or health maintenance organization, coverage may be offered through the employer’s self-insurance program. Self-insured organizations set aside money to pay future claims, then invest the capital themselves, earning sufficient investment income to pay future claims. Self-insurance is the joining of similarly situated individuals and institutions to purchase insurance coverage uniquely tailored to their circumstances. Self-insuring through hospitals and large group practices generally results in strong administration, risk-limiting oversight, and close scrutiny of practice guidelines.

**Joint Underwriting Associations**

In some states, professional liability insurance is available through a Joint Underwriting Association (JUA). JUAs are chartered to provide insurance when it is not obtainable from other sources. They are collectives of commercial companies compelled by states to offer insurance. An arguable downside to JUAs has been lack of a central corporate identify. No specific company within the JUA has an identifiable stake in reducing claims or injuries.

**Federal Tort Claims Act**

Midwives employed at federal community health centers and government installations, such as military hospitals and Indian Health Service hospitals, generally have professional liability coverage through the Federal Tort Claims Act, depending on the terms of their employment.³

**TYPES OF INSURANCE POLICIES**

There are two very different types of professional liability insurance: occurrence and claims-made policies. For some midwives, claims-made is the only type of insurance available.

**Occurrence policies**

Occurrence policies are ideal and provide the most comprehensive type of professional liability insurance. Occurrence policies cover events that occurred during the policy period regardless of the date of discovery or the date the claim is filed, even if the claim is made years after the event occurred or the midwife discontinued clinical practice. Occurrence coverage is typically the most expensive type of liability insurance.

**Claims-made policies**

Claims made policies are more limited in scope than occurrence policies. A claims-made policy will only cover a claim if it is filed while the policy is active (during the policy period), which is why these policies are less expensive. Once the policy period ends, the midwife is no longer covered for events that happened while the policy was active. For this reason, the midwife will need to obtain an extending reporting period (ERP) endorsement, more commonly known as tail coverage. The tail may be purchased when a midwife ends a claims-made policy or leaves her position of employment, and it provides future coverage for events that occurred during the policy period. Because of this added protection, the purchase of tail coverage tends to be
expensive for the individual midwife or the organization through which she was practicing.

Tails vary between insurance companies. Some offer tails that will provide a limited amount of extended coverage, 5 years for example. However, some states permit liability claims for adverse health outcomes experienced by newborns to be filed as long as 23 years after the birth. The statute of limitations for an adverse outcome experienced by the mother at a birth or by a woman receiving health care in general is usually 2 years in most states. Therefore, depending on the state, a tail limited to 5 years would leave the midwife without coverage and unprotected from liability for as long as 18 years after the birth of a newborn. Some insurers offer an unlimited tail; once an unlimited tail is purchased, the midwife will be covered regardless of when a claim is filed in the future.

While tail rates vary among insurers, a typical cost can be 1.5 times to 2 times the annual premium. This is an issue that should be addressed by the midwife during the negotiation period at the start of new employment. For example, an employer may offer to purchase the tail if a midwife agrees to stay in a position for 4 years or to pay 75%/50%/25% if the midwife stays for 3/2/1 years respectively. The tail typically must be paid in one lump sum within 30 days after the claims-made coverage has ended. Tail coverage is essential for financial security; therefore, the midwife should request an unlimited tail and that the premium is part of the written insurance quotation. Once the policy is issued, the midwife must review it to ensure that the tail is included in the written policy.

While claims-made policies have lower premiums initially, it is important to note that the costs of the tail and annual premium increase. Typically, the premium is lowest in the first year of coverage and increases annually until the fifth year of coverage, after which it remains stable. This is due to increased exposure to claims after longer time in practice.

**Slots policies**

Slots policies share characteristics of occurrence and claims-made policies. With a slots policy, the employer purchases a certain number of slots, typically at a rate slightly greater than the 5-year claims-made rate. Each midwife in the practice is assigned to a slot and receives an individual policy with his or her own liability limits. In some cases, part-time midwives can share a single slot.

If the midwife who is occupying slot 1 leaves the practice, no tail is due unless the practice closes the slot, in which case the normal tail rate applies. However, if the midwife is replaced upon leaving the practice, the new midwife occupies slot 1. The previous midwife remains covered for the period during which the slot was occupied as with an occurrence policy. Switching to a slot program requires some remodeling of a practice’s budget; it can produce significant cost savings for some practices over time but may result in increased payout overall for other practices.

**Shared limits policies**

Shared limits policies are a variety of the slots policy in which the whole practice shares a single policy with defined limits. Each midwife receives an annual insurance coverage face sheet that lists the limits of professional liability coverage for the group per incident and per policy period. If two midwives sharing the policy are sued, they share the limits of coverage. In this case, each of the two would have access to only half of the limits listed on the face sheet.

With shared limits policies, the carrier prices the policy depending on the size of the group and the risk of lawsuit, but tails do not need to be paid when midwives leave the practice. Therefore, the shared limits policy can be thought of as a single slot policy.
LIMITS OF
PROFESSIONAL LIABILITY

Professional liability policies have two sets of limits: a per claim or incident limit and the aggregate limit that the insurer will pay during the policy period (usually one year). The per incident limit and the aggregate limit are often indicated as two dollar amounts divided by a slash. Therefore, $250,000/$750,000 indicates that the company will pay no more than $250,000 for a single claim and no more than a total of $750,000 during the policy period.

TABLE 1. Advantages and Disadvantages of Liability Insurance Policies by Type of Policy

<table>
<thead>
<tr>
<th>Policy Type</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occurrence</td>
<td>Most protective policy. Events that occurred during a policy period are covered in the future. Does not require a tail.</td>
<td>Greater cost. May not be an option in smaller practices due to greater expense or may not be offered by some employers because of the increased cost to the organization.</td>
</tr>
<tr>
<td>Claims-made</td>
<td>Premium typically is less expensive than occurrence insurance policies. Premium is lowest during the first year of coverage.</td>
<td>Need to purchase a tail, which can be expensive. Midwife will often pay more during the length of the policy when accounting for tail coverage. Premiums increase annually. Only covers events that occur while the policy is active unless a tail is purchased.</td>
</tr>
<tr>
<td>Slots</td>
<td>Budgeting is more predictable. No need for the midwife to cost share (pay for portion of tail) if she leaves the practice sooner than expected. Decreases the price of turnover, which is beneficial for small practices.</td>
<td>For practices where most of the staff are paying the third-year claims-made rate or less (in terms of years covered under the policy) and are expected to stay at least that much longer, the slot program may be more expensive.</td>
</tr>
<tr>
<td>Shared limits</td>
<td>Premiums and settlements tend to be lower.</td>
<td>Some hospitals and payers will not accept this type of coverage. Each individual midwife may have access to a limited amount of money per incident and a lower total amount per policy period. There may be cases in which the interests of the various parties covered by the single policy differ.</td>
</tr>
</tbody>
</table>

Insurance policies may also limit actions that the insurer perceives as risky. Some examples of policy exclusions include home birth and the use of recording or photographic equipment in the birth room. Insurers do not always limit actions based on scientific evidence, and they may change limits when presented with data demonstrating the safety of certain actions or practices (eg, home birth for low-risk pregnant women).

THE INSURANCE AGENT

Insurance agents are typically independent distributors of insurance services; they often represent more than one
insurance company, sell more than one type of insurance, and earn commissions from sales and premiums. The choice of agent is one of the most important factors to consider when purchasing professional liability insurance. The agent is a key source of knowledge related to liability protection products and state laws regarding liability insurance.

Select an experienced agent who specializes in professional liability insurance for health care providers, preferably for midwives. In the best case scenario, the midwife has contacted 2 or more agents experienced with professional liability insurance and has received written premium quotations from each.

THE INSURANCE COMPANY

Select an insurer that is admitted to do business in your state. To be admitted, an insurance company’s policies and premiums must be approved by the state’s Department of Insurance. In some circumstances, states allow non-admitted insurers to do business within the state. Unless there is no other option, choose an admitted insurer. The agent will know whether the insurer is admitted or not. Next, examine the financial stability of the insurer. This information also can be provided by the agent. One recommended source of information on insurance companies is Best’s Insurance Reports issued by A.M. Best. A.M. Best, an independent organization that receives no funding from insurance companies, was the first insurance rating organization and is still recognized as the industry leader.

A.M. Best rates insurers on the basis of their perceived financial ability to pay claims: Superior (A++, A+), Excellent (A, A-), and Very Good (B++, B+). Be wary of selecting an insurer with a rating less than Very Good. Insurers without sufficient capital and investment income to pay out claims may go out of business, leaving a midwife without coverage or the opportunity to buy tail coverage.

A consideration related to the insurer’s financial stability is the length of time the insurer has been providing professional liability coverage. Try to avoid companies that have recently entered the market because conditions are favorable and profits are likely. Find an experienced insurance company that is more likely to weather an insurance crisis than a newer, start-up company with low capital reserves. Newer companies will often lure in new policy holders by offering low, competitive rates. The midwife should proceed with caution in these cases for the following reasons:

- Newer companies will often offer low rates for insurance for the first year or 2 and then raise rates considerably in later years to build capital for the company. In the end, the midwife will pay as much if not more than with a more established insurance company.
- More expensive insurance companies may be costlier because they provide greater services and support to policy holders faced with lawsuits. For example, some companies support entire teams of experts whose only focus is defending lawsuits that involve adverse outcomes for newborns or pregnant women. If a midwife is named in such a suit, the insurer will go to great lengths to defend the midwife’s actions if those actions were in accordance with the standard of care. Newer companies do not always have the resources to mount such a strong defense.
- Newer companies with more limited capital than longstanding companies have difficulty surviving financial crises or if a large number of claims are made against policy holders. The midwife may be without insurance for a lawsuit that could arise as long as 23 years after the adverse event.

DETERMINATION OF THE PREMIUM RATE

Professional liability premiums are calculated from several pieces of information, some of which are related to the applicant’s characteristics and some of which are related
to the insurer and the industry. The following items factor into the determination of the premium rate:

- The state and region in which you practice. Generally, premiums will be higher in densely populated urban areas because the incidence of real or perceived injury is higher.
- Your practice setting (site of birth, type of hospital) and scope of practice. Practices that provide obstetric care pay higher premiums than those that offer gynecology care only.
- Your number of years in practice and malpractice history.
- Your longevity with the insurer.
- Your former coverage.
- The frequency and severity of claims against the company’s insured pool.
- The administrative and marketing expenses of running a business in a competitive field.
- Investment income on the insurer’s capital.
- Corporate taxes and profits.
- State insurance regulations.
- The amount and nature of insurance competition.

Due to the complexity of these factors, an insurance company is likely to ask you to fill out an application before providing a quote. If you apply for insurance, do so well in advance of the current policy expiration date to ensure that the insurance company will have adequate time to evaluate your practice characteristics. This process may require personal dialogue with the midwife and typically takes 30 or more days to complete.

**INSURANCE PROVIDED BY THE EMPLOYER**

It is crucial to discuss professional liability insurance during contract negotiations. Once employment has started, bargaining power is lost. Regardless of the type of coverage offered, midwives should be able to answer the following questions:

- Will I be covered under the employer’s policy, or will the employer pay the premium for an individual policy?
- Does the employer use an insurance company, or is the employer self-insured? Does the self-insured organization have sufficient capital to cover claims? If an insurance company is used, how does it rate with A.M. Best? How long has the insurer been in business?
- If I leave employment and I was covered by a claims-made policy, will the employer pay for tail coverage? Will the employer put this statement in a written contract? If the employer will not purchase tail coverage, will I have that option with the insurance company that the employer uses? What would the cost of tail coverage be?
- Is the employer willing to provide a copy of the certificate of insurance? If the employer is not willing to provide written proof of insurance, it may not exist.
- Does the employer’s coverage provide me with separate limits of liability or would I share in group liability limits? Other group members may exhaust liability limits, leaving no coverage available for claims made against the midwife.
- If there is a claim, will the employer’s coverage provide legal counsel to represent my interests? In claims made against multiple members of the same group, do individual midwives and physicians have different attorneys to represent their individual interests?
- Will the employer advise employees before settlement offers are made to claimants who are suing? Will I have the ability to approve or reject a settlement offer before it is made? This is especially important because agreed upon settlements and judicial system judgments result in a midwife being
reported to the National Practitioner Data Bank (NPDB). The attorney handling the case is paid by the insurance company and thus primarily supports the interests of the insurance company. The company may want to settle a claim in order to reduce overall costs for a specific lawsuit, but this will result in the midwife being listed in the NPDB.

- Will the liability policy cover all midwifery work performed during the policy period (e.g., volunteer work at a nearby free clinic) or only work performed for a specific employer?

**Purchasing additional coverage**

Adequate professional liability insurance is crucial to your career. The coverage provided by an employer may be insufficient in scope or limits of liability. Even if you are covered by your employer, you may want to consider purchasing individual coverage. You should consider a number of factors when deciding whether to purchase additional coverage:

- Consider the scope of practice and autonomy in the practice. The more independence a midwife has in decision making, the greater the potential exposure for liability claims.

- Consider the frequency of claims in your rating region, current settlement and judgment amounts, and your existing financial resources. If your employer provides liability insurance with $250,000/$750,000 limits, you might want to consider paying additional premiums or purchasing another policy to provide coverage to $1,000,000/$3,000,000.

**Read the policy contract**

Many professionals who carry professional liability insurance do not familiarize themselves with their obligations, rights, and responsibilities under the contract until a claim is filed against them. It is important to obtain a copy of the liability policy contract and carefully review its provisions. If you have any questions regarding coverage and conditions after reading the contract, have them answered by your agent or the company. Having a personal attorney review any contract is most often beneficial in helping you to understand the nuances of the contract, including liability coverage.

The critical elements of the liability contract include the named insured(s), definitions, exclusions, other limitations to coverage, matters related to reporting of claims or incidents, record keeping, cooperation in claims management, and alternative coverage. Most insurance policy contracts are relatively brief, but they contain numerous provisions that may be confusing unless they are reviewed in a methodical manner. If you are provided with an offer of employment, you may wish to consult a contract attorney to review the professional liability coverage on your behalf prior to accepting a position. In most cases, it is acceptable to say, “That sounds wonderful. I will discuss it with my family and respond to you within 48 hours.”

Critical elements of the contract include the coverage limits and the obligations of the company and the insured midwife. The policy will list exceptions of coverage. You must be aware of the circumstances in which practice falls outside of the bounds of contract coverage. Some insurers limit policy coverage when the midwife has additional or alternative insurance that would also cover the claim.

The contract may require that the insurance company is notified of adverse outcomes or claims within a certain time period. If the insurer is not notified according to contract specifications, the claim may be denied. Some companies require written notification of incidents that might lead to a claim, such as a difficult birth after which the newborn is transferred to a neonatal intensive care unit. Contract details vary from policy to policy. Carefully review the policy details, requirements, limits, and conditions to ensure that you fully understand everything contained in the contract.

Consideration of all these elements may seem overwhelming. However, signing a well-written contract with
clearly identified malpractice insurance coverage can be one of the most important aspects in realizing a high-quality, well-protected career. Coverage benefits the midwife, the women for whom the midwife cares, and the employer for whom the midwife works.

REFERENCES


Disclosure and Communication

Nicole Lassiter, CNM, MSN, WHNP

DISCLAIMER: Nothing herein is or is intended to be legal advice. All the suggestions and recommendations stated herein are subject to the guidance and advice of any legal counsel who have been retained to represent the caregiver/institution.

INTRODUCTION

Although it is unfortunate, clinical adverse events and outcomes do occur in health care. An adverse event is an injury caused by medical management (which includes all aspects of health care, not just the actions of midwives, nurses or physicians) rather than underlying disease that may or may not result from an error but nonetheless results in harm. As a result of adverse events, patients, families, medical and non-medical staff, the community, and the organization may experience physical and/or psychological harm. Whether such events are caused by error or accident, disclosure is a necessary process through which the provider at fault has a timely, straightforward, and transparent conversation with the patient and/or family members about the event. A medical error is the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. This may include serious errors, minor errors, and near misses and may or may not cause harm. A medical error that does not result in harm does not result in an adverse event.

Disclosure is an open and honest response that can help provide resolution for the patient, family, and medical professionals involved. When a provider makes an error, acceptance of responsibility is directly correlated with successful healing, professional growth, and improved quality care. The multi-step process includes revealing the facts with empathy, apologizing, and facilitating on-going communication and support for the patient and family and involved staff, clinicians, and providers. Ideally, personnel in a health care system will be aware of and trained in this process, which helps them cope with adverse events.

Many researchers claim that the process of disclosure leads to improvement in patient safety, quality assurance, and system operations. Furthermore, even though disclosure can be a difficult process, patients, families, and medical providers report value from disclosure programs. Providers experience significant emotional and professional challenges after adverse events, preventable or not, and need support. For example, providers may experience significant psychological repercussions, including shame, self-doubt, anxiety, and guilt. In a medical culture focused on blame, some providers resort to coping mechanisms such as denial, distancing, and reducing the significance of the error. This approach not only diminishes the opportunity to learn from the event, but also may exacerbate the distress. While the process of disclosure starts with the individual patient and family and the medical providers involved, ideally, the process would extend system-wide to support affected individuals and to help prevent future occurrences. In this ideal scenario, disclosure coaches would be available for peer support and guidance during times of stress, critical events, or crises.

Many insurance carriers and institutions have found that disclosure efforts reduce malpractice liability claims.
and costs and time to resolution.10,12,13 However, according to some researchers, sufficient information is not available to make such claims.12,14 Even so, at the center of disclosure and apology programs are behaviors that exemplify good practice, ethical care, and “the right thing to do.”15-17 Disclosure follows principles promoted by national efforts to reform medical care and improve patient safety by providing patient-centered and informed care and honoring transparency, equity and continuity in the patient-provider relationship.11,12,18

Significantly, the process of disclosure may uncover many of the shortcomings of our legal system.12,18,19 As a result of the disclosure process, the patient and/or family may choose 1 of 3 options: drop a claim, receive settlement payments from the health system or insurance carrier, or file a lawsuit. Patients retain the right to legal action, but the focus of disclosure programs is to make a tort claims the option of last resort.13,18

**NATIONAL EFFORTS**

Full disclosure has been at the forefront of the national health care movement for some time and is considered an integral component of ethical behavior, patient safety, and health care improvement initiatives.1,7,17,20 Supported by some state governments, health care organizations, and insurance carriers, there is an increasing awareness and interest in the disclosure process.1,17

In 2000, the Institute of Medicine (IOM) published *To Err is Human: Building a Safer Health System* to highlight the frequency of medical errors and related deaths and principles commensurate with the disclosure process.21 The IOM highlighted many disclosure principles, including the need to create a culture of safety and the need to include patients in communication regarding all aspects of their care. The purpose of the 2001 IOM report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, was to further the national focus on improving patient safety in 6 focus areas: safety, patient-centeredness, timeliness, equity, efficiency, and effectiveness.21

Professional organizations have also followed suit. In 2010, the American Medical Association (AMA) stated that in the event of an adverse outcome in which there are significant complications or harm due to a physician’s mistake, the physician is ethically required to inform the patient, include all known facts, and ensure patient understanding.22 Also in 2010, the Institute for Healthcare Improvement (IHI) published a white paper on managing serious adverse events, including many of the tenants and components of disclosure.3

**DISCLOSURE IN PRACTICE**

While some disclosure programs have been operating successfully since the late 1980s, disclosure has only come to the forefront of clinical practice in the past few years.1 According to some experts, disclosure may be uncommon in many areas of practice, support systems are limited or non-existent, and often harmful errors remain undisclosed.5,23

Full disclosure and apology when appropriate are drastically different from the more commonly practiced risk approach.12,17 In many institutions, the familiar and traditional response to an adverse event is a self-protective approach wherein the provider and staff are encouraged to lessen communication or withdraw from the situation. If a medical malpractice claim is filed, the institution’s risk management department and attorneys coordinate the response. As a result, the relationship between the plaintiff (the patient and/or family) and the defendant (the provider and/or institution) often becomes adversarial, and punitive damages are sought.24 If the plaintiff and the defendant each hire an attorney, the relationship between them is necessarily adversarial because of the nature of the U.S. legal system. Both parties must heed carefully the advice of their legal counsels. Leaders of
reform efforts are questioning the effectiveness of the tort and medical liability systems.\(^\text{18}\)  

**What many patients want regarding disclosure**  
In general, researchers have shown that after an adverse event, patients desire full and timely disclosure from their health care providers.\(^\text{25}\) Whether the adverse event is minor or severe, patients want a response in which the medical professional(s) takes responsibility for the error. In addition, they want clear and factual explanations about what happened and why it happened with a sincere expression of empathy and sympathy from those involved. They want apologies and reassurance that those responsible are doing what they can to prevent recurrences in the future.\(^\text{17,26}\)  

**Disclosure: what it is and what it is not**  
Disclosure is not the same as blaming oneself or someone else. While the provider and/or hospital may recognize and admit fault, many adverse events are not preventable, and fault may be debatable or unfounded. Within the disclosure process, it is recognized that honest, competent, and compassionate people make mistakes, including medical professionals. Disclosure is not a shunning of responsibility, but inherent in the disclosure process is the efficient resolution of cases that necessitate settlement.\(^\text{27}\)  

Disclosure is not a justification for or an effort to excuse reckless, incompetent, or grossly negligent behavior. Disclosure is not a protective process for those who exhibit egregious negligence or intentionally or repetitively hurt others.\(^\text{19}\) The goal is to develop what TJC has identified as a “just culture” in health care, one that focuses on learning from errors and accepting accountability.\(^\text{18}\)  

**Cost of disclosure and settlement**  
It remains debatable whether or not disclosure will increase or decrease liability costs.\(^\text{32}\) However, researchers found that patients were less likely to sue if they received honest, sincere disclosures.\(^\text{12,27,28}\) Patients’ perceptions of their relationships with their providers can be key components in their decisions regarding whether or not to file claims. If the patient suspects a “cover-up,” perceives that the provider is not taking responsibility, or feels the provider is not empathetic, the patient is more likely to experience anger, a desire for revenge, and to sue.\(^\text{10,24}\) However, if the care provider acknowledges the adverse event in a timely manner, arranges for appropriate compensation, expresses sincere empathy, and ensures follow-up to prevent recurrence of the error, the relationship has a better chance of staying intact, and the patient is less likely to file a claim.\(^\text{19}\)  

This disclosure and offer approach is significantly more cost effective than large punitive judgments that include preparation of the lawsuit, associated litigation, court judgments, and trial settlements. Furthermore, contrary to popular belief, plaintiffs’ attorneys often support disclosure-related settlements. Finally, the patient and/or family will often receive compensation from a settlement in a more timely manner than from an award from a lawsuit.\(^\text{17,27,30}\)  

While litigation is appropriate and necessary in some cases, it is often an unnecessary, costly, painful process for patients, families, and providers.\(^\text{27,31}\) Litigation is an inherently adversarial process that undermines the patient-caregiver relationship, creates a defensive medical culture, increases the cost of medical care, delays patient safety improvements, and delays or prevents healing for the patient and the medical professionals involved.\(^\text{13,18,27}\) Liability insurance premiums have reached exorbitant levels in this country, and they cost the health care system valuable dollars. Without disclosure and fast and fair compensation, medical professionals and their attorneys work harder to counter claims, which increases litigation costs, delays insurance payments for legitimate malpractice claims, and hinders the process of healing for the
providers and the patient/family. Disclosure and apology is an alternative to this “deny and defend” approach.17,32

**Lack of support for disclosure**

There are many barriers to disclosure, including the following:

- Shame and blame culture,
- Fear of judgment from colleagues, peers, and patients,
- Fear of damage to or loss of reputation,
- Retributive action from licensure boards,
- Medico-legal threats,
- Lack of training, comfort, or belief in the disclosure process, and
- Self-judgment or difficulty admitting failure or mistake.5,8,12,25

The effect of disclosure on litigation remains largely unknown. A hypothetical and remote risk exists that a detailed discussion of the error could implicate those involved in a malpractice case. However, one solution is for institutions to address disclosure in quality improvement programs.5 To date, researchers have not shown a direct correlation between disclosure and the risk of litigation; instead, they have demonstrated reduced blame and increased willingness to settle when the provider apologizes for an error.16,28 In fact, the expectations of a medical culture focused on perfection may be more of an influence on whether or not providers disclose and/or apologize than the fear of risk of litigation.19,33,34

**Support for disclosure**

In many parts of the country, hospitals and insurance carriers have published and promoted disclosure guidelines and support systems. Well established programs include but are not limited to Harvard Hospital’s When Things Go Wrong Consensus Statement and guidelines,32 The Massachusetts Alliance for Communication and Resolution Following Medical Injury (MACRMI) program,13 and the 3Rs Program from COPIC Insurance Company.35

The importance of legal protection for providers who report errors is recognized on a national level.21 The Patient Safety and Quality Improvement Act (PSQIA) passed by Congress in 2005 offers federal protection to providers who voluntarily disclose errors.11 Some states have protective legislation in support of apology and disclosure that makes them inadmissible in the legal process.16 For example, in Colorado and Nebraska, the “I’m Sorry” law was passed in 2003 and 2007, respectively, enabling the health care provider to express empathy and apologize with assurance that the communication cannot be used against him or her in a legal setting.

The COPIC Three 3Rs program is notable for a successful record in reaching closure before state licensing boards or the National Provider Data Bank (NPDB) become involved.35 In 2000, COPIC (the medical liability carrier in Colorado and Nebraska) launched an early intervention program focusing on early disclosure, transparency, apology, and patient benefits with the support of the Colorado Board of Medical Examiners and Colorado’s Commissioner of Insurance. The Three 3Rs program priorities include the following: (1) prompt and fair compensation for injured patients; (2) reduction in wasted resources by the tort system; (3) error prevention; and (4) support of the provider-patient relationship.11 To facilitate honesty and promote a culture of transparency and improvement, some institutions, such as the University of Michigan Health System, offer financial support to clinicians, help them protect their personal assets, and help them prevent personal financial risk.27

On the other hand, reporting requirements of many state medical and nursing licensing boards and the NPDB may put the disclosing provider at increased risk of reprobation, even when the verdict has not been settled. Disciplinary action may discourage providers and clinicians from disclosing. Thus, it is necessary for the medical
practitioner to know the current status of state law before deciding on how to make an “I’m sorry” statement and to seriously consider the specific advice of legal counsel on what exact words are suitable. At the same time, the disclosure movement is growing, and efforts to assist state licensing boards and the NPDB with reform are underway. For example, the PSQIA affords protection to providers who disclose by blocking the release of patient safety content from certified data collection from legal discovery. Many hospital systems and insurance carriers are supportive of the disclosure process in addition to patient advocacy groups, safety experts, ethicists, policy makers, accrediting organizations, and professional groups and organizations.

COMMUNICATION

Good communication is key to effective, successful disclosure. Interpersonal communication skills have become an essential component of patient care and positive provider-patient relationships. Relationship building, a major component of the disclosure process, is also dependent upon good communication. For most, communication is difficult in the presence of conflict; it is even more difficult when an adverse event occurs. Good communication includes but is not limited to sincere, clear, and honest disclosure in which the person speaking takes responsibility and listens. During disclosure, communication starts with the adverse event and continues as long as necessary, often until after the event and the patient has been discharged.

Communication dos

- Remain calm and relaxed; this will help you think, behave, and respond clearly.
- Maintain eye contact.
- Use supportive/helpful body language. Sit down in a manner that conveys openness (arms and legs uncrossed, try to avoid nervous twitches). Be more aware than usual of behaviors and signals, as stress and discomfort affect the way we treat and receive others.
- Speak slowly on the same educational level as the patient and/or family.
- Be sincere and only say what you truly mean. When you say “yes” or “I understand” be sure not to say “Yes but” or “I understand but.” Patients need to be able to see, hear, and feel that the delivered message is sincere.
- Give appropriate amount of information: too little or too much may be disconcerting to patients and can create confusion.
- Sustain sympathy and empathy throughout, even if you are accused.
- Respect silence.
- Maintain transparency and share the facts as they are known at the time.
- Allow the patient and/or family to “vent” as long as there is no threat to anyone’s physical safety. Acknowledge frustration, helplessness, and anger. It may be appropriate, however, to suggest that blame is premature until an investigation is implemented and completed.
- Address all questions and concerns.
- Try to be aware of cultural influences that may significantly affect meaning, interpretation, and communication.
- Promise follow-up if you do not know the answer at the time.
- Provide reassurance that the process of communication and support will be ongoing and offer specifics as to how this will be done.
- Provide referral for financial resources and assistance and offer to contact the appropriate person for the patient and/or family if requested.
- Before leaving the room, ask if there’s anything else they need, want to say, or ask.
Communication don’ts36,37

- Don’t approach the patient or family if you are emotionally unstable.
- Don’t blame yourself or anyone else.
- Don’t take responsibility if you believe you did not make an error.
- Don’t behave defensively.
- Don’t focus on your own emotions.
- Don’t talk too much or try to “fill the space” with talking or chatting.
- Don’t use medical jargon when more simple language is appropriate.
- Don’t ask for mercy or forgiveness.
- Don’t speculate or make suggestions as to what might have gone wrong or could have been done to prevent the error/injury when you do not know for sure. Stick to the facts.

The American Society of Healthcare Risk Management (ASHRM) has noted the following:

The next wave of activity around disclosure will involve determining how to integrate the concept of open communication into all aspects of the healthcare environment. This will include moving from ‘disclosure policies’ to ‘communication policies’; from concern about discoverability and liability to concern about accountability and fair compensation before the start of litigation; and from concern about accountability and fair compensation before the start of litigation; and from concern about whether to disclose to concern about what patients need to know in order to best partner in directing their care.”36

THE DISCLOSURE PROCESS

While the specifics of the disclosure process will vary depending on the health care agency or organization, some of the basic principles are listed below. Each medical professional should become familiar with appropriate institutional policies and support systems. This will ensure efficient access during times of need. Providers can also offer suggestions for improvement. The following suggestions and recommendation are subject to the guidance and advice of legal counsel who have been retained to represent the caregiver and/or institution.

1. Assessment: While disclosure and apology are part of a process that should occur as efficiently as possible, there are some preliminary questions to ask before approaching the patient and/or family: Do you have the facts? What do you know about the event and the consequences? Who are the participants? Is the patient and/or family willing to have a discussion? Is the patient conscious, stable if medicated, and rested enough to process the information?

2. Setting: Chose a quiet environment to say “I’m sorry” and have the discussion. The location should be private, free of interruption, and all pagers and cell phones should be turned off.

3. Preparedness: If you do not feel prepared or able to communicate effectively or safely with the patient and/or family, contact supportive resources. The support system can help prepare you to communicate and apologize, if applicable. If you are unable, a representative can be sent in your place.

   If a group of medical professionals was involved and will approach the patient together, the group must first identify the core intention, what will be discussed, and who will take the lead in the discussion.

4. “I’m sorry”: Depending on the institution and advice of legal counsel, this step may come after #5. Prepare the patient and family by communicating your intention and purpose of the meeting. As soon as possible after the adverse event (ideally within a few hours, and less than 24 hours), sincerely and compassionately recognize the patient and/or family’s injury with an empathetic response (“I’m so sorry this happened,” “I’m sorry this happened and that you are in
pain,” or “I’m sorry this happened and that your baby is in the NICU”). Most importantly, be empathetic and acknowledge the event as soon as possible. If the adverse event was not clear or if the unanticipated outcome is due to an ambiguous cause, express appropriate regret. If the adverse event was clearly caused by a medical error or system failure, explain what happened and apologize.

5. **Care provider support:** Depending on the institution, this step may come before #4. Before or immediately after “I’m sorry” is issued, the medical professional should seek help, support, and guidance from the hospital risk management department, insurance carrier, and defense attorneys.

6. **The facts:** When disclosing or apologizing, deliver a simple, explicit statement about what occurred, why it occurred, and how to prevent a future occurrence if applicable. Include the known consequences for the patient’s future health and well-being.

7. **Support for patient and family:** Acknowledge all of the concerns of the patient’s family: physical, emotional, and financial. Offer available support to the family as needed, including a chaplain or other spiritual services, counseling and social services, patient-family relations, or risk management. Patients and families should be made aware that they have and reserve the right to retain legal counsel and file a claim at any time.

8. **Availability:** Ensure that the patient and/or family is able to get in touch with you or another contact person if they have questions or concerns.

9. **Compensation:** As a result of the adverse outcome, additional treatment or rehabilitation may be necessary. Voluntary support and compensation may include corrective medical or surgical treatment, assistance with filing for disability, or monetary compensation, in which case swift and fair compensation is recommended. Provide the patient and family with the appropriate contact information for those authorized to take care of such issues.

10. **Continuity of patient care:** If applicable, reassure the patient and/or family that you and/or other institutional members will continue to provide care. If your care is refused, graciously accept the decision, comply, and identify another provider if so desired. Otherwise, continue to support, care for, and advocate for the patient, as this is your primary role.

11. **Prevention:** Assure the patient and/or family that an investigation will take place as to why the event occurred, and that sincere efforts will be made to determine how it can be prevented in the future.

12. **Continuity of disclosure:** Assure continued involvement in the disclosure process and investigation of the adverse event. Assure transparency and explanation of the facts as they become available. Initial and ongoing contact should also be maintained with the plaintiff’s attorney if applicable and under appropriate conditions and circumstances. The attorney should be made aware of the voluntary nature of the disclosure process. This is necessary to achieve an equitable settlement when applicable. If you and/or your institution is represented by legal counsel, any contact with the plaintiff’s attorney will have to be made through your attorney. It can be a violation of state bar rules for an attorney to communicate directly with opposing counsel’s clients.

13. **File:** Submit a safety report if applicable. Risk management and/or legal counsel should review the report before finalization.

14. **Follow-up:** Ensure that all actions discussed and promised take place or are in motion.

15. **Understand:** Disclosure may not be received with gratitude or relief. In fact, it may not be well received at all. Patients and families may be angry, grieving, or may “shut down” after an adverse event. It may take
time for the relationship to continue in a positive way. Make follow-up attempts as appropriate.

16. **Documentation:** Record the date, time, location, and participants involved in the discussion in the medical record. Provide a simple summary of the facts and events that took place and state with whom the events were discussed. Include plans for follow-up and support. Do not document conversations with the disclosure coach or risk management support team. Access risk management and legal support services for assistance on documentation as needed and give risk management and legal counsel the chance to provide guidance on what is needed and appropriate.

17. **Debrief:** Ideally, the medical professional(s) will have a debriefing huddle and post-incident discussion to review the event and plan next steps. If risk management resources and legal counsel are available, then they should be involved.

## CONCLUSION

Adverse outcomes are an inevitable and unfortunate component of health care. The processes of disclosure and apology are integral to effective, safe, and quality patient care. Institutional and national support for disclosure have grown significantly in the past several years, and organizational support and provider participation are crucial determinants of successful disclosure programs. A legal and regulatory environment supportive of disclosure will help create a more humanistic and realistic health care environment for all involved.

## REFERENCES


INTRODUCTION

Part 3 of the Professional Liability Resource Packet provides Midwives with necessary information for implementing legislative changes to improve the professional liability insurance issues affecting midwifery practice. This type of legislative change is called tort reform.

Proposed tort reform can take place on the federal or the state level. State legislation typically occurs faster than federal legislation. However, federal legislation has the potential for more comprehensive reform than might be possible at the state level.

On the federal and state level, bills proposing tort reform are frequently introduced and may be amended and debated but not passed. This chapter provides a brief overview of examples of tort reform and some tools to assist in making change in your state.

STATE LEGISLATION

Effective tort reform that directly addresses the practice of midwives has been passed in several states. State legislation has the potential to significantly affect the premiums for professional liability insurance, amounts paid out in court settlements, prescriptive authority, and independent practice.

In states with independent practice, certified nurse-midwives (CNMs) are not required to have a written collaborative agreement, physician supervision, or practice condition requirements to practice.


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INDEPENDENT PRACTICE FOR CNMS

Who has been affected by recent legislation related to professional liability?

- A 2009 survey of members of the American College of Nurse-Midwives (ACNM) showed that 32% had been named in at least one lawsuit.¹
- Nebraska is currently working to revise *Nebraska Revised Statute 38-613*, which currently prevents CNMs from attending home births.²
- California’s *Assembly Bill No. 154* was passed in 2013. This bill allows CNMs to perform first trimester aspiration abortions.³
- In 2013, Massachusetts and Michigan were added to the states that allow CNMs to practice independently.
- North Carolina currently has a bill in the state house, which if passed, will allow CNMs to practice independently.
- Oklahoma, Florida, and Virginia recently had tort reform pertaining to the certification of expert witnesses.
- In 2013, Pennsylvania passed a law preventing benevolent gestures from being used against defendants as long as fault was not admitted.

FEDERAL LEGISLATION

Medical liability reform is important to the practice of CNMs and certified midwives (CMs). Cost containment and health care reform cannot be achieved without effective medical liability reform. Reform should include strengthening patient safety efforts and providing alternative dispute resolution mechanisms.

In 2013, the *Affordable Care Act* mandated health care for all United States citizens.⁴ Subsequently, CNMs, clinical nurse specialists, nurse practitioners, and physician assistants may receive the same Medicare reimbursements for primary care visits as their physician counterparts.

SUGGESTED TORT REFORMS

Below is a short list of tort reforms, including reforms passed or suggestions made by the American Tort Reform Association to ease the financial burden of litigation.

Tort reforms passed at the state level

EXPERT AFFIDAVIT

Any claim filed in court or an alternate dispute resolution must be accompanied by an affidavit from an individual qualified to be an expert witness asserting that the claim has merit.

- "Florida: Medical Liability Reform: Expert Evidence: H.B. 7015 (2013) provides that a witness qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion as to the facts at issue in a case under certain circumstances. It requires the state to interpret and apply the principles of expert testimony in conformity with the United States Supreme Court’s decision in the Daubert case.⁵"
- "Michigan: Medical Liability Reform: Prejudgment Interest Reform: S.B. 1118 (2012) ensures that a full 91-day period is given to defendants who submit an affidavit of meritorious defense and ends the practice of prejudgment interest being awarded on attorney fees and costs in medical liability cases.⁶"

LIMIT ON NON-ECONOMIC DAMAGES

- "North Carolina: Medical Liability Reform: Noneconomic Damages Reform: SB 33 (2011); N.C. Gen. Stat. § 90-21.19 limits noneconomic damages in medical liability cases to $500,000 against all defendants. The limit is subject to adjustments every
three years starting on January 1, 2014 based on the
Consumer Price Index. The legislation does provide
for an exception to the limit if (1) the plaintiff suf-
f ered disfigurement, loss of use of part of the body,
permanent injury or death; and (2) the defendant’s
acts or failures, which are the proximate cause of
the plaintiff’s injuries, were committed in reckless
disregard of the rights of others, grossly negligent,
fraudulent, intentional or with malice.”

PROPOSED REFORMS

■ Special obstetric rule for drop-in patients: If a health
care professional has not previously treated a patient
in pregnancy, the level of proof required for finding
fault should be higher than that of most civil cases,
eg, clear and convincing evidence rather than pre-
ponderance of evidence.

■ If damages are greater than $100,000, payment will
be made periodically rather than all at the same time.

■ Mandatory offsets for collateral sources:
Unintentional damages payments should be reduced
based on amounts already paid to the plaintiff.

■ Proportionate liability among all parties: Paid out
damages should be proportional to the fault of the
defendant(s).

■ Statute of limitations: Two years should be allowed
to discover that an event has occurred and 4 years
allowed for obtaining necessary evidence. There is
a special exception to the statute of limitations for
minors, which would allow up to 4 years for children
less than 6 years of age to initiate claims.

WAYS TO ENACT CHANGE

Every midwife needs to take an active role in addressing
the issue of professional liability. Communicating with
community leaders and elected officials is often a good
place to start. Communication (letter, mail, or phone call)
should describe how the issues have affected access to
health care services and providers for individuals. Public
officials need to be informed of how issues related to pro-
fessional liability affect their constituents. When commu-
nicating with elected officials, the following recommenda-
tions may be included:

■ Establishment of limits on non-economic damages
■ Mandating offsets for collateral sources
■ Limitations on contingency fees
■ Creation of periodic payment of future damages
■ Reduction of the statute of limitations
■ Establishment of alternative dispute resolutions

Information to Include
when Lobbying for Tort Reform

These points can be used in email, phone calls, or appoint-
ments when speaking to community leaders and policy
makers about supporting tort reform.

BACKGROUND

■ Since the 1970s, obstetric and gynecologic health
care professionals have been faced with increasing
overhead costs, decreasing reimbursement for
services, and decreasing availability and affordability
of liability insurance. Thus, many professionals have
been forced to move to states with effective mal-
practice reform or to retire early. As a result, many
women are left without access to health care services
and professionals.

■ Dramatic jury awards and frivolous lawsuits have
pushed the insurance industry to drive up premiums
to unaffordable levels.

■ The consequences of the professional liability crisis
are limiting women’s access to needed services.

TALKING POINTS: WHAT CAN AN
ELECTED OFFICIAL DO TO ENACT TORT REFORM?

■ Enact professional liability legislation (tort reform)
that promotes women’s access to high-quality, cost
effective midwifery and obstetric and gynecologic care.

- Ensure that patients affected by professional negligence have the opportunity to be compensated.

- Support regulatory initiatives that
  - Include all licensed health care professionals, eg, certified nurse-midwives, certified midwives, and advanced practice nurses.
  - Establish limits on non-economic damages for pain and anguish.
  - Mandate offsets for collateral sources of compensation for injuries.
  - Limit contingency fees.
  - Create periodic payments of future damages.
  - Reduce the statute of limitations to sue in the field of midwifery, obstetrics, and gynecology.
  - Establish alternative dispute resolutions.

REFERENCES


What to Do If You Are Named in a Lawsuit

Christina Jacobson, CNM, WHNP, Mamie Guidera, MSN, CNM, FACNM, and William McCool, PhD, CNM, FACNM

INTRODUCTION

The purpose of this chapter is to address the professional, personal, and practical strategies that midwives can employ to cope with the emotional upset and stress that usually accompany being named in a lawsuit. The information presented here is based on survey data, qualitative interviews, and a review of the literature for strategies suggested in the fields of midwifery, obstetrics, family practice, and psychiatry. The most common stressors experienced by practitioners faced with litigation are repeatedly identified as lack of control over the litigation process, lack of knowledge about the steps involved in the process, and a myriad of emotional responses.

PROFESSIONAL STRATEGIES FOR COPING WITH THE LITIGATION PROCESS

Know that professionally you are not alone. Malpractice suits are generally about money, not about your competence, integrity, or practice. It is helpful to remember that 75% of obstetricians-gynecologists and 50% of family practice physicians are eventually named in a lawsuit. In the last nationwide survey of ACNM members 32% of the respondents had been named in a lawsuit at least once.

Contact your claims representative immediately. Ask your malpractice insurance claims representative to review with you the steps involved in litigation, the role you will need to play in each phase, and the timeline that can be anticipated. Learning as much as possible about the legal system, particularly as it is manifested in your state or community, can increase your sense of control over the events related to the lawsuit.

Make sure you feel comfortable with your appointed attorney. Your first encounter with the insurance company’s attorney is no different from an initial meeting you would have with any professional from whom you are seeking counsel. You need to feel comfortable conversing with the individual and feel confident that the person has your best interests in mind. If you are concerned after this initial encounter, you can request a different attorney.

Hire your own attorney. The appointed attorney ultimately represents the insurance company, not you. If you are concerned about this individual’s attention to defending your interests, consider retaining the services of your own attorney. The attorney for the insurance company will still be involved defending the company’s interests, but you will also have your attorney working at each step of the litigation process to defend your case.

Invest time and energy in teaching the defense team about the clinical aspects of the claim. Your defense team does not necessarily include a health care practitioner, especially a midwife, and the team will likely need education about the latest clinical evidence concerning the particulars of your case. Think of yourself as a part of the
team, as the member who supplies the clinical knowledge surrounding the case. This sharing of knowledge can increase the potential for a positive outcome. It is important to know that any malpractice case is decided on the standard of care that existed at the time of the event. While research evidence may have led to a change in practice guidelines or standards by the time litigation was initiated, the legal system is more interested in what the standard of care was at the time of the incident.

Know that the majority of malpractice suits go to settlement. This is not an admission of guilt; it is an agreement between two parties to resolve their dispute in exchange for a cash payment.

PERSONAL STRATEGIES FOR COPING WITH THE LITIGATION PROCESS

Talk with your family and friends to reduce emotional isolation. Do not discuss the clinical or legal aspects of the suit. You will be asked by the plaintiff’s attorney if you discussed the case with anyone. If you have, then that individual can be called to give testimony about what you said. However, you can tell them about the allegations, possible publicity, potential time and financial commitments, and any stress that you are experiencing from having been named in a lawsuit.

Contact a counselor. Formal counseling is non-discoverable in the litigation process, and the expression of one’s feelings and experience can be paramount to the successful coping. Professional counseling is an effective and safe but underutilized strategy for dealing with litigation. Many employers provide formal Employee Assistance Programs (EAPs) that can offer counseling services free of cost, particularly if the counseling is related to an event that occurred as a part of your work. In practices without EAPs, the business plan of the practice may have built in funds to pay for counseling services after an adverse outcome occurs or whenever an individual in the practice is named in a lawsuit.

Discuss your feelings and your emotional responses with professional colleagues. This can be therapeutic. Claims managers and defense attorneys often advise against speaking to anyone about the case for fear that those with whom you talk could later be subpoenaed for testimony about what was discussed. However, non-clinical discussions are encouraged, especially when focusing on how you feel rather than the clinical facts surrounding the case.

The details of the case can be discussed within an institution's formal mechanism for reviewing any adverse outcomes. These most often are called “morbidity and mortality” or “M and M” sessions. The details of M and M discussions are not admissible in litigation cases and are constructed so that all of the practitioners involved in the discussion can learn from the series of events that preceded any adverse outcomes. Typically, however, cases that involve adverse outcomes are discussed in M and M meetings that occur soon after the event itself and not when any resulting lawsuit is put forth.

Allow yourself to experience shock, denial, shame, loss of control, depression, and physical symptoms. Know that these are normal responses to being named in a lawsuit, just as nausea, ambivalence, and anxiety are normal responses to any stress-provoking experience.

Work at staying in control of your personal and professional life. To counter balance the emotional upset and feelings of loss of control that often accompany involvement in litigation, it is helpful to keep the rest of your daily living experience under your control. Spend time with family and friends. Research the issue being litigated so that you are best able to defend the case that occurred.
PRACTICAL STRATEGIES FOR COPING WITH THE LITIGATION PROCESS

Write a narrative of all the clinical particulars that you remember occurring around the event that led to litigation. This is not for the medical chart; it is for your attorney and is privileged information. However, since a lawsuit can occur years after a related adverse event, some midwives take notes about an adverse outcome shortly after it occurs, whether or not it eventually leads to a lawsuit. While this may be therapeutic for the individual practitioner, you need to know that what you write could later be admissible evidence in the case. What is important after any adverse outcome is that you write a factual accounting of the events as they occurred in the medical record, devoid of any judgmental or emotional statements.

Stay actively involved in your case by working closely with your attorney. Be proactive in communicating with your attorney and be sure that you are aware of any actions you should be taking in support of the case.

Take care of yourself. Maintain healthy eating, exercising, and working. It can take a number of years for a lawsuit to be filed after an adverse outcome, and once litigation is begun, it typically takes from 1 to 4 years for a lawsuit to resolve. Therefore, you need to continue with your daily life and not allow fear to dominate your ongoing activities.

Know that the vast majority of suits do not go to trial. And if they do, most decisions ultimately on behalf of the defendant.

Speak with confidence and stay calm when talking with the plaintiff’s attorney, no matter how angry or defensive you feel. Any attorney you are working with will prepare you for this before you have any contact with the plaintiff’s attorney.

Try not to work around times of a deposition and/or trial. Take time off for these actual legal encounters so that you can meet with your attorney and review your case. Be certain that your employer or practice director knows about the suit. If the case goes to trial, it will become your temporary full-time job, and any employer or colleagues with whom you work should support you during this time.

ADDITIONAL STRATEGIES

Important first steps in coping with malpractice litigation are to understand that it happens regardless of whether or not negligence actually occurred and to acknowledge that being sued can be a truly traumatic experience. Midwives and physicians report a myriad of physical and emotional symptoms, from sleeplessness and loss of appetite to anger and depression. Support from family, friends, midwifery/physician colleagues, and/or practice directors is crucial. Attempting to “go it alone” or “talk to no one” has proven to increase isolation and depression about the suit. Given the current prevalence of malpractice litigation, it is likely that you know a colleague who has been sued. Someone who has been through the litigation process can be a strong source of support during this time.

During a malpractice suit, the very traits that serve us well as midwives can also make us susceptible to an exaggerated sense of responsibility, feelings of guilt, or self-doubt. Under stress, we may be more likely to accept unwarranted guilt or blame. These traits can result in your being a poor defendant in your own malpractice case. During depositions, answer questions factually and take care during each particular encounter not to express the very human feelings that otherwise serve us well in our profession. Statements such as “I felt really sorry for what the woman went through” can be taken out of context to imply unwarranted guilt. Work hard to stick to the clinical facts.
Whether your case is dropped, settled, or comes to trial, examination of your clinical practice merits attention. If you did indeed err in practice, you must examine the causes and ways to prevent future occurrences. Midwives and physicians have reported that researching the issue being tried can be helpful on many levels.\textsuperscript{1,5} First, a sense of mastery helps one cope with the feelings of loss of control associated with the litigation process. Second, clinical information that was supportive of your practice at the time of the event should be shared with attorneys representing you. Third, a thorough knowledge of the clinical issues surrounding the event serves as a learning experience if a mistake was made.

Understanding the steps in the legal process, the amount of time each step requires, and the associated emotional responses that can occur have been reported to decrease feelings of lost control.\textsuperscript{6}

**STAGES IN THE LITIGATION PROCESS**

**Complaint/summons**

The initial step in a malpractice lawsuit is the filing of a complaint by the plaintiff, who could be the woman you cared for, her infant if the case involved a pregnancy or birth, and/or her family or significant others who felt that they were affected adversely by the outcome of care received. The complaint details allegations filed against the defendant, you the midwife and/or other professionals involved in the event at the time of its occurrence. Allegations specify what the defendant did or did not do to allegedly cause injury during the case being presented. The plaintiff files the complaint with the local court, and the defendant is summoned and given a copy of the complaint. The complaint can come directly to you or may be passed along by someone else also named in the complaint, such as a practice director, a collaborating physician, or a hospital administrator. There is usually a time requirement associated with filing an answer to the complaint. If this is the case, the defendant must respond within the stated time, or a default judgment is made against the defendant.

At the time of being served with a complaint, the midwife should notify the medical malpractice insurance carrier’s claim consultant, and then an attorney will be assigned to the case by the insurer. If the midwife feels that a personal attorney is also needed, this is the optimal time for retaining one. A public notice regarding the allegations may accompany the issuance of the complaint.\textsuperscript{6}

**Discovery**

The purpose of the discovery period is for the plaintiff and the defense to gather information and facts relevant to the case. The length of time for the discovery period is difficult to predict, since attorneys may negotiate with the court for varying lengths of time based on the complexities of the case, or the plaintiff may decide at some point to drop the case.

The midwife should consult with the assigned or self-hired attorney before giving oral and/or written information requested by the plaintiff. Common discovery procedures include interrogatories, notice to produce, and deposition.

- An interrogatory involves written questions proposed by the attorney for either the plaintiff or the defense. The plaintiff’s attorney will likely request documents from the defendant, such as medical records and insurance policies that may contain evidence relevant to the case. The defendant’s attorney will often ask questions of clarification regarding the complaint(s).
- The notice to produce is akin to a subpoena of materials (eg, hospital records or personal notes) relevant to the case that can be extremely broad in scope.
- The deposition is essentially an oral testimony given under oath in the presence of a court reporter and the attorneys involved in the case. Depositions usually involve only one witness at a time. Information
gathered may be used in court proceedings. Expert witnesses from both sides of a case may participate in depositions and offer information that might eventually be used during the trial.\textsuperscript{3,6}

\textbf{Settlement, arbitration, or trial}

A settlement may occur via monetary or other agreements before the trial is scheduled to begin. It is important to note that less than 10% of medical malpractice lawsuits eventually proceed to trial,\textsuperscript{3} and it takes an average of 3-6 years for a case to proceed to trial after the original complaint has been filed. While settlements most often do not contain an admission of fault or guilt by the defendant, they result in the midwife being listed in the National Practitioner Data Bank (NPDB), a federal government-mandated compilation of practitioners who have been involved in a lawsuit that resulted in settlement or a finding against the defendant in trial or arbitration. The withdrawal of a complaint or a finding in favor of the defendant prevents the midwife from being listed in the NPDB.

In some states, a case that has not settled may be heard by an arbitration panel established to help alleviate the large number of lawsuits awaiting trial. The proceedings are similar to those of a trial, but there is no jury involved and the findings of the arbitration panel can be final with no opportunity for appeal depending on individual state laws.\textsuperscript{9}

You, the defendant, do have some say in whether or not a case proceeds to trial. You may want to settle before trial simply to put the case behind you. However, it is important to remember that this will result in your name being listed in the NPDB, which could affect future job opportunities or obtainment of clinical privileges at a health care facility, such as a hospital. On the other hand, you may want the case to go to trial because you believe your clinical practice was in accordance with the standard of care at the time of the adverse outcome, and you want the opportunity to have your voice heard regarding this matter. In general, any decision you make regarding how the case proceeds will be made in accordance with advice from the attorney representing you.

It needs to be repeated that in a majority of cases, the attorney with whom you are working, unless you hire your own counsel, is employed by the insurance company representing you. The insurance company’s view on how the case should be resolved may be counter to your personal interests regarding resolution of the case. Although this situation occurs infrequently, if it does arise, you should consider hiring your own attorney. However, in general the attorneys for the midwife and the insurance company want the best outcome for the midwife and the malpractice company and usually work together toward this goal.

\textbf{Post-trial motions}

The losing side in a lawsuit that was not settled before trial may make requests following the verdict and closure of the trial. Such motions are not considered a retrial. Requests include setting aside a verdict or reducing damages. An appeal can also be filed when the losing side would like to review the trial record to ensure it met the intent of the law.\textsuperscript{6}

\textbf{CONCLUSION}

Midwives have reported that lawsuits are exceedingly stressful on personal and professional levels. It is important to keep in mind that the strategies mentioned herein can be useful in coping with the litigation process. When used in combination with your knowledge of the case’s legal framework and the steps involved in the legal proceedings, these strategies can effectively reduce stressors that accompany being named in a lawsuit. Know that you are not alone, as the prevalence of malpractice litigation has increased steadily over the years: not just for midwives but for all health care professionals. Midwives can use the experience and knowledge gained from being involved in
the litigation process to improve practice and potentially reduce the risk of being named in a lawsuit in the future.

REFERENCES


Malpractice Insurance for Midwives Who Don’t Attend Births

Mamie Guidera, CNM, MSN, FACNM, ACNM
Professional Liability Section and Jaclyn Janis, BSN,
University of Pennsylvania

Frequently, members of the American College of Nurse Midwives (ACNM) are curious about how much malpractice insurance policies cost for certified nurse-midwives or certified midwives (CNMs/CMs) who do not attend births. This question may be complicated by the fact that some midwives working in non-birth settings are nurse practitioners (NP) and some are not. We recently asked representatives from Trans Service Insurance and Contemporary Insurance Service (CIS) the following questions:

How do insurance premiums differ for CNMs/CMs who work solely in outpatient settings and do not attend births?

With some malpractice insurance carriers, if a midwife works in a non-birth setting the insurance premium may be 75% less than if the midwife attends births. For example, if a midwife has been in full-scope clinical practice for 15 years, works in Philadelphia, and was named in a claim once 5 years ago but was dropped from the case, that midwife can expect to pay approximately $11,750 the first year of claims-made coverage. If that same CNM takes a job at Planned Parenthood or another non-birth setting, the premium will be approximately $2900. Both of these costs represent the first year of practice and will nearly double by the fifth year.

What are the variables in these premiums—by state or by company?
The variables named here, location of work, years in practice, and claims history, all affect the premium.

Does it matter whether this CNM has an NP certification as well?
No, according to CIS. A provider is covered according to highest degree or level of education in most states. CNM trumps NP, so when practicing in a non-birth setting, you will still be charged a CNM rate. Representatives from Trans Service added, “As far as the outpatient setting—no deliveries—carriers will typically give credits (determined by carrier at the time of underwriting) on a policy because deliveries are not being performed, but that is at the discretion of the carrier and is handled on a case-by-case basis.”

How do premiums for CNMs/CMs working solely in outpatient settings differ from those for NPs working in the same setting? Is having certification as a CNM or CM a disadvantage in this case?
The rates for an NP are also determined by county of practice and required premium limits. NPs may be required by their states to have limits in place of at least $1 million per claim and $3 million aggregate. Many of the carriers will not insure an NP on a stand-alone basis, only in an insurance policy linked to a collaborating physician. The
territories for rating purposes are typically the same as a CNM. An NP can expect to pay between $725 and $2500 for coverage in the first year of practice for an occurrence policy.

So according to CIS, a CNM will pay more for a malpractice premium than an NP working in the same non-birth or outpatient setting. However, CIS pointed out that an NP and a CNM are not the same; women receive a different kind of care with a CNM. Also, CIS does not insure NPs; their policies are geared toward CNMs.

In summary, if you are a CNM working in a non-birth setting, your malpractice premium will be much less than if you are attending births. As a CNM, your premium will likely be higher than that of an NP, even if you are licensed as both NP and CNM. Is this a disadvantage? Not if you attend births and practice full-scope midwifery during the course of your professional lifetime.
Tail Insurance:
Negotiating for Continued Coverage

Mamie Guidera, MSN, CNM, FACNM

The only limiting factor in any negotiation is the lack of flexibility or creativity between 2 parties. How to negotiate for appropriate malpractice insurance seems to be the most frequently asked question of the Professional Liability Section these days.

If you are lucky enough to have occurrence malpractice insurance, this is not your issue. Occurrence insurance covers you for any incident that occurs while you are insured by the company, even after you leave your job and/or are no longer insured by that carrier. For example, if you have an adverse outcome in 2010 while covered by an occurrence policy, and you are sued for the outcome in 2015, you will be covered by that insurer, even if you no longer have that insurance plan. On the other hand, claims-made insurance covers you for claims that occur only while you are covered by that insurer. So you or your employer needs to purchase a tail to follow you wherever you work in the future. In this case, if you have an adverse outcome in 2010, change insurance companies in 2012, and get named in a resultant suit in 2015, if you have a tail, you are covered. Without a tail, your malpractice coverage ended when you changed insurance carriers, and you are no longer covered.

More and more employers are offering claims-made insurance because it is less expensive, but somebody needs to purchase the tail. Your employer should! A tail is expensive and can cost up to 115% of your premium. If your annual premium is $19,000, a tail will cost $22,000 when you leave your job or change insurers. For most midwives, providing tail coverage is a deal breaker when negotiating for a job. Who pays this large sum, when and how? There are several creative ways to work this out with your employer:

- In the best case scenario, the employer pays for your tail when you exit the position. If you move to a job with the same insurance company, this is not necessary, but you will still need to negotiate with your new employer as to who will pay the tail.
- Have the employer pay the full tail amount if you stay for 5 years, 80% of the tail if you stay for 4 years, 60% if you stay for 3 years, and so on. Many tail negotiations are aimed at promoting retention.
- Have the employer pay all the tail after 3 years of employment.
- Have your employer withhold a portion of the estimated value of the tail with each paycheck instead of paying a lump sum once per year.

If you have claims-made insurance, you need a tail; without one, you risk going without coverage when you change employers or policies. This is not something you should be expected to pay on your own in one lump sum unless you are in self-owned, solo practice. Whether a potential employer offers tail coverage is an important point of when negotiating a new job as a midwife. But the only limiting factors to making this happen are lack of creativity or flexibility on the part of the midwife or the employer.

Good luck negotiating!
Ten Questions Midwives Should Ask When Looking For Professional Liability Insurance

Israel Teitelbaum

1. What is professional liability insurance, and what types are available for midwives?

Professional liability insurance, commonly referred to as malpractice insurance, is a type of insurance policy that offers financial protection to a health care provider when an adverse outcome or lawsuit occurs. There are two main types of policies available for midwives: occurrence and claims-made.

An occurrence policy covers the midwife for life for any claim filed for an adverse event that occurred while the midwife was practicing under that policy. For example, a midwife had an adverse birth outcome in the year 2000 while covered by occurrence policy A. Sometime later, after changing jobs and insurance companies, the midwife is sued for the event that occurred in 2000. Insurance policy A will cover any expenses or losses that occur as a result of that lawsuit, even though the midwife is no longer covered by that occurrence policy.

A claims-made policy is one in which the midwife is covered for any lawsuits that are filed only while that policy is active. For example, a midwife is covered by claims-made policy B during the year 2000 and has an adverse outcome. If the midwife is sued later but is still practicing under policy B, any expenses or losses that occur will be covered. However, if the midwife changed insurance companies before the lawsuit was filed, the expenses related to the 2000 adverse event will not be covered unless the midwife purchased tail coverage.

Typically, occurrence coverage is more expensive than claims-made coverage because the insurance company assumes financial responsibility for a much longer period of time. For additional information see www.medmalinsuranceblog.com/index.php/2009/10/

2. What is tail coverage, how does it work, and do I really need it?

Liability claims are often made long after the incident or event that caused the injury. Many liability policies are written on a claims-made basis, which means the insurer pays only claims that are received during the policy period. In that case, tail coverage is needed to protect against claims that have not been made before the end of the policy period. For example, a midwife is covered under claims-made policy B but then switches to another insurer, retires, or allows the policy to lapse. A claim is made 6 months later for an event that occurred while the midwife was insured under policy B. In order to have protection for this occurrence, the midwife must have purchased tail coverage some time before the end of policy B.

Midwives should look for coverage with companies that offer unlimited duration tail coverage rather than coverage that lasts only a few years after a policy is cancelled.
The statute of limitations for bad outcomes at birth can exceed 21 years.

So do midwives need to purchase tail coverage? The safest answer is “yes.” While there are no legal requirements to carry tail coverage, failure to do so may affect your future employment opportunities or personal finances. Some insurance companies may provide prior acts coverage.

3 What is prior acts coverage?
Prior acts coverage means that your new policy will cover past incidents/claims that were not previously reported under a prior insurance policy. It is less expensive to purchase prior acts from a new company than to buy a tail from the old company.

4 Does the policy offer free tail coverage at the time of my retirement, disability, or death?
Some companies will offer free tail coverage under certain circumstances. A tail can be quite expensive and is purchased on retirement if you are unable to practice midwifery, or if the new policy does not offer prior acts coverage. The midwife’s policy should address who will pay for tail coverage when the policy ends.

5 How do I know if the insurance company is legitimate?
There are three indicators that midwives should consider when evaluating a professional liability insurer: the company’s rating, how long it has been providing professional liability insurance to midwives, and the number of midwives it insures.

- **Rating.** In the insurance industry, A.M. Best assigns a rating to liability insurers on the basis of their ability to pay claims. These ratings are available to the public following a free registration on the A.M. Best website (http://www.ambest.com). The top three rating classes are
  - Superior: A++ and A+
  - Excellent: A and A-
  - Very good: B++ and B+

Most hospitals require that midwives purchase policies rated at least excellent, although some will accept a very good rating. You should be wary of companies that are not rated by A.M. Best. It is unlikely that a company that qualifies for a good rating would decline to accept it.

- **Years insuring midwives.** Sometimes companies enter the midwifery malpractice market attracted to the high premiums but often abandon the market after 3 or 4 years when they experience the types of claims that can develop from delivering infants. If companies abandon the market, this can force midwives insured by those companies to purchase expensive tail insurance or to not carry insurance (go bare) for the period during which they were insured by these companies.

- **Number of midwives insured.** Experience defending physicians is not the same as experience defending midwives. To get the best possible defense, it is recommended that midwives insure with companies that have significant experience representing midwives.

6 What will be covered by my malpractice insurance policy?
Generally, professional liability insurance policies provide coverage for actual or alleged errors, omissions, negligence, and breach of duty, misleading statements, and similar claims resulting from the performance or non-performance of professional services. Most policies cover defense costs (eg, attorney fees, court costs) and settlements.
or judgments. Intentional wrongdoing is typically not covered.

7 What are exclusions, and could they exist in my malpractice policy?
Exclusions are clinical practices or situations that your professional liability insurance company may choose not to cover, and these should be stated explicitly in the policy. For example, breech deliveries, out-of-hospital vaginal births after cesarean (VBACs), and home births are sometimes excluded from coverage by liability insurers.

In addition, insurance companies can deny or cancel malpractice coverage under certain conditions, such as a history of high payouts from prior lawsuits, HIV-positive status, or a history of substance abuse.

8 Is there a deductible, and if so, how much per year could I have to pay out-of-pocket for claims?
Some malpractice insurance companies may have a deductible similar to that of a health insurance deductible. It is wise to ask for this information before signing a professional liability policy agreement. The deductible may be structured as a business expense, or you may request that your employer pay the deductible.

9 If I change to a different insurance policy, how can I compare the new professional liability policy to my current policy for similarities and differences?
The most efficient way to compare this information is to ask the insurance company representative or broker to do this comparison for you.

10 What other questions should I ask when looking for professional liability insurance?
- Does the insurer offer different rates or discount premiums based on where I practice or live? Some companies will offer discounts for midwives practicing in rural areas.
- If a lawsuit occurs, will the attorneys who will defend me have prior experience working with midwives? Will I be allowed to request different representation if I am not satisfied with the attorney who was chosen for me?
- If a lawsuit occurs, does the policy cover the costs of investigations, expert witnesses, and payment for my earnings lost during this time?
- Will the policy provide me with legal representation if I must appear before a licensing board in relation to the case?
**Supplemental Materials**

**Glossary**

**Affidavit:** a written or declared statement of facts made voluntarily and under oath.

**Alternative dispute resolution:** alternatives to resolving conflicts in a courtroom or through litigation.

**Benevolent gesture:** an act or offer of kindness not intended to admit fault or cause of injury.

**Beyond a reasonable doubt:** the highest level of proof (of evidence) needed in order for a person to be declared guilty. It is often required in criminal cases. This level of proof requires almost absolute certainty.

**Claim:** a demand for monetary compensation.

**Claims-made insurance coverage:** a contract that covers a claim only if the incident occurs and the claim is made during the policy period.

**Claims representative:** a representative of the medical malpractice carrier with whom you will meet to review the events surrounding the claim and to prepare a testimony (along with the defense attorney).

**Clear and convincing evidence:** the level of proof requiring that presented evidence is highly likely to have occurred. This level of proof is used in both civil and criminal cases. This level of evidence is greater than preponderance of evidence and less than beyond a reasonable doubt.

**Collateral damage:** indirect or unintentional losses that happen as a result of an event.

**Compensatory damages:** monetary compensation designed to return an individual to their economic position prior to the injury or alleged negligence.

**Complaint:** a formal and specific statement of the allegations and the grounds for relief (typically, monetary damages) against a defendant.

**Contingency fee:** a set proportion of the awarded settlement given to the lawyer.

**Defendant:** a person against whom the legal action has been brought; in medical malpractice cases, this is typically the midwife or other practitioner.

**Defense team:** the practitioner, defense attorney(s), and the claims consultant.

**Deposition:** when an individual gives testimony under oath before the plaintiff and defense attorneys. The information gathered here may be used during the trial.

**Discovery:** materials relevant to a lawsuit sent from one of legal representative to the other.

**Duty:** the legal obligation of the midwife to provide the appropriate standard of care to patients.

**Extended reporting period (ERP):** also known as tail coverage. A contract that extends the coverage of a claims-made policy into the future to cover all claims after the basic claims-made coverage period.
**Economic damages:** tangible items of damage such as past and future lost earnings, past and future medical expenses, and cost of care. These damages may represent losses resultant from a damaged newborn.

**Indemnity:** compensation provided to a claimant in a malpractice case.

**Injury:** harm resulting from a midwife’s actions or failure to act.

**Insurance broker:** An insurance agent or agency that negotiates for, or sells to, an individual or organization insurance that is offered by a separate insurance company. A broker acts as a conduit between an insurance company and the individual or organization that is insured by that company.

**Interrogatories:** written questions prepared by one party’s attorney and given to the other party’s attorney regarding facts believed to be relevant to the case.

**Joint Underwriting Association (JUA):** a consortium of insurance companies mandated by law in some states to underwrite malpractice insurance to assure its availability.

**Malpractice:** professional negligence, including those acts that involve a departure from the prevailing standard of care.

**National Practitioner Data Bank (NPDB):** a databank created to monitor the occurrence of medical malpractice legislation in order to improve the quality of health care. It is a flagging system that facilitates a comprehensive review of all health care providers’ credentials, including medical malpractice payments and adverse action histories.

**Negligence:** a legal principle that establishes liability for one who breaches a duty owed to another when that breach of duty causes a compensable injury.

**Non-discoverable:** evidence that is not subject to disclosure to an opposing party, typically for reasons of privilege (e.g., attorney’s notes, internal legal documents, etc.).

**Notice to produce:** a formal request to send items of discovery to the opposing legal party.

**Occurrence insurance coverage:** a contract that covers all claims, whenever filed, arising out of care rendered during the policy period.

**Offset:** a reduction in the amount to be paid by the party found at fault. This deduction is based on debt owed to the plaintiff(s) by the party found at fault.

**Plaintiff:** one who begins the lawsuit to obtain a remedy for injury to his or her rights; in a medical malpractice case, this is usually the patient and/or family.

**Preponderance of evidence:** the level of proof required for evidence in most civil cases. This level of proof requires that the incident is more likely to have occurred than not.

**Punitive damages:** these are not related to the plaintiff’s injury but may be assessed against the defendant as a punishment for intentional malfeasance or gross negligence.

**Reasonable discovery:** all found evidence that a non-expert sees as foreseeable or anticipated.

**Settlement:** in this case a malpractice claim, an agreement to settle a dispute with monetary payment.

**Standard of care:** The degree of care a reasonably prudent person, with the same qualifications, should exercise under the same or similar circumstances. This is often based on the prevailing set of professional performance...
expectations established by published standards, the consensus of published literature, and the content of expert testimony.

**Statute of limitations:** a time limit after which rights cannot be enforced by legal action or offenses punished.

**Statute of repose:** A statute of limitation relating to the amount of time in which legal action can be taken following the event.

**Subpoena:** a written order commanding a person to appear in court under penalty for failure to appear.

**Summons:** informs the defendant of the time requirements to file an answer to a complaint.

**Tail coverage:** see extended reporting period.

**Tort:** a wrong or injury.

**Tort reform:** making changes in current laws to reduce money paid resulting from litigation.

*Note: Some definitions taken from Black's Law Dictionary at http://thelawdictionary.org/*
Dear _________________,

Currently, I receive care from PROVIDER'S NAME, a certified nurse-midwife (CNM)/certified midwife (CM) at __________ in CITY, STATE. PROVIDER'S NAME receives reimbursement from Medicaid, Medicare, ____________, ____________ , and ____________. The CNM/CM currently collaborates with Dr. ____________, who is available for consultation, collaboration, and transfer of care if needed.

As a woman, I value the philosophy and access to care that I receive from PROVIDER'S NAME. However, I fear that the current crisis involving professional liability insurance for health care providers will decrease, if not eliminate, my access to women’s health care and my choice to obtain services from a CNM or CM. As a resident of CITY, STATE, and your constituent, I am requesting that you ensure that my access to health care will not be compromised by enacting effective tort reform.

PROVIDER'S NAME, CNM/CM is a highly trained licensed professional who is experienced in providing clinical care for low-risk women, health education, and follow-up care for mothers and their families. My midwife provides safe, cost-effective and patient-responsive health care that produces good outcomes and high levels of patient satisfaction. The costs associated with midwifery care are lower as a result of fewer technological interventions, fewer cesarean births and other surgical procedures, and shorter hospital stays. I do not want to lose my access to cost-effective health care.

It is my belief that tort reform is essential so that I (and all your constituents) can receive the health care that I want and need in the future. Your immediate attention to this issue is appreciated.

Sincerely,

______________________________

CC: Your midwife and her/his collaborating physician
Supplemental Materials

Additional Resources

In addition to the references provided with each chapter, the following resources may be useful for the midwife considering professional liability issues.

The ACNM website www.midwife.org provides updates on professional liability issues, tort reform, and other issues related to professional liability.

Information about tort reform

- Health Coalition on Liability and Access: www.hcla.org
- The Doctors Company: www.thedoctors.com
- Common Good: www.cgood.com
- American Tort Reform Association: www.atra.org


Cristol J, Johnson T. Professional issues discussion and ACNM update. Lecture presented at: University of Pennsylvania School of Nursing; December 10, 2013; Philadelphia, PA.


Supplemental Materials

Related Articles from the Journal of Midwifery & Women’s Health

This section contains reprints of four previously published articles from the *Journal of Midwifery & Women’s Health (JMWH)* pertaining to professional liability and medical malpractice cases.

*JMWH* is an online, peer-reviewed journal that presents new research and current knowledge on a broad range of clinical and interdisciplinary topics. ACNM members can gain unrestricted access to all *JMWH* articles by logging in to the members area only at www.midwife.org and locating the entry point of the journal in the “professional resources” section.
Midwives and Liability: Results from the 2009 Nationwide Survey of Certified Nurse-Midwives and Certified Midwives in the United States

Mamie Guidera, CNM, MSN, William McCool, CNM, PhD, Alexandra Hanlon, PhD, Kerri Schuiling, CNM, PhD, Andrea Smith, SNM, BA, BSN

**Introduction:** In partnership with the American College of Nurse-Midwives (ACNM), the authors conducted a survey of ACNM members to examine the incidence of lawsuit involvement, the outcomes of the litigation in which they were involved, and coping mechanisms among midwives who had been involved in a lawsuit.

**Methods:** In the spring of 2009, a nationwide Web-based survey was completed by ACNM members. In addition to using chi-square tests and nonparametric testing in data analysis, a logistic regression model was used to evaluate predictors of lawsuit involvement.

**Results:** Among 1340 midwives responding to the survey, 32% had been named in a lawsuit at least once. The median number of years in practice when the event leading to lawsuit occurred was 6. The majority of midwifery lawsuits involved hospital births and were settled prior to going to court. Three variables were statistically significant for involvement with litigation: the midwife’s age, the number of births attended, and the ACNM region of practice in the United States.

**Discussion:** Lawsuits among midwives were significantly related to exposure to births over time. Practice patterns and job security were not greatly affected by the experience of a lawsuit. Future cyclic surveys are needed to track the frequency of litigation and the outcomes that lead to lawsuits and to better define the relationships between midwifery practice and medical malpractice litigation.


**Keywords:** lawsuit, litigation, malpractice insurance, midwife

**INTRODUCTION**

In 2005, McCool et al1 conducted the first US nationwide survey assessing the involvement of certified nurse-midwives/certified midwives (CNMs/CMs) in litigation. The survey collected data regarding midwives’ experiences with lawsuits in their practices, the incidence and outcomes of lawsuit involvement by respondents, and coping mechanisms that were used by those who had been sued. Other health care professional organizations have reported on the involvement of their members in litigation matters, including the American College of Obstetricians and Gynecologists (ACOG), which has been tracking liability matters within their profession approximately every 3 years since 1983.2

To continue the tracking and analysis of the effect of litigation on midwifery practice, the current authors, working in partnership with the national office of the American College of Nurse-Midwives (ACNM), conducted a second liability-focused survey of the ACNM membership in 2009. This article presents findings of the 2009 Midwifery Litigation Survey.

**LITERATURE REVIEW**

Since the Midwifery Litigation Survey of 2005, the litigious environment surrounding obstetrics and midwifery has remained both pervasive and hostile.3–5 No new data-based research on the state of liability and midwifery in the United States has been reported since 2005. Recent related literature has common themes: practicing obstetrics or midwifery based on fear rather than evidence and risk management strategies to decrease the likelihood of litigation.3,5,6 Quality health care for women suffers when practice is defensive and not evidence based.3,7

The 2009 ACOG Survey on Professional Liability, which had a response rate of 18%,7 found that 59% of respondents had changed their practices due to the affordability of professional liability insurance or fear of litigation.7 Thirty percent of obstetrician respondents decreased the number of high-risk patients for whom they cared, 29% increased the number of cesarean births performed, and 26% stopped offering trials of labor after cesarean. Of the ACOG respondents, 91% reported having been named in at least 1 professional liability claim during their careers, an increase from 89% in 2006. Neurologically impaired infant claims were the most frequent for obstetricians, followed by stillbirth or neonatal death. Of the claims made against obstetricians, approximately half were settled without a payment to the plaintiff (case dropped or found in favor of the defendant) and half required a payment (settlement or case lost at trial).7 In the most recent ACOG survey, when obstetricians were queried about who their defendants were when sued, CNMs were named in 3.9% of lawsuits experienced by respondents. This represents an increase from 2.6% in the last several ACOG surveys.4

Practice changes related to fear of litigation and affordability of malpractice insurance apply to CNMs/CMs as well.
as to their obstetrician colleagues. Birth centers, staffed almost exclusively by midwives, saw a 189% rise in the cost of their malpractice insurance premiums between 2006 and 2007, largely related to insurance company investment losses on the stock market. The rise in malpractice premiums, coupled with a plateau in health care insurance reimbursements, has contributed to the closure of birth centers and maternity services nationally.

The current litigious environment has led to a tendency toward fear-based practice, wherein the traditional clinical practice or “standard of care” is maintained, regardless of whether or not it is evidence based. It has been suggested that the unnecessary use of technology and intervention is characteristic of defensive clinical practice and thrives in a professional environment influenced by risk management and fear of litigation. Symon found that fear of litigation negatively affects midwives' confidence and alters decision making, as did Johansen, who found that a culture of fear was disempowering to normally competent practitioners.

As early as 1991, the Harvard Medical Practice studies identified strategies to decrease the risk of litigation. With minimal variation, these same risk management strategies are encouraged today: provide evidence-based care, design and implement safe systems, improve supervision of employees, listen to patients, educate and involve patients in their care, improve charting, work as a team, and be professional in commenting on the care given by others. With nominal change in suggested strategies to decrease lawsuits, have the rates of litigation against midwives changed? For what reasons are midwives sued? How are midwives coping with the stress of litigation? With these issues in mind, the authors conducted the second national Midwifery Litigation Survey in the spring of 2009.

METHODS
Incorporating comments received anonymously from respondents to the 2005 Midwifery Litigation Survey and suggestions by a member of the ACOG Professional Liability section regarding the language of recent ACOG Surveys on Professional Liability (N. Wilson, oral communication, March 2008), a Web-based survey was created in 2009 to re-explore the extent to which adverse obstetric and gynecologic practice outcomes resulted in litigation proceedings for CNMs/CMs. Using principles described by Couper, Fink, and Fowler, a descriptive survey of 75 closed-ended, purposeful, concrete questions was formulated for distribution to a nationwide sample of CNMs/CMs. While all questions were in a forced-choice format, some allowed respondents to supply additional information under the heading “Other” as 1 possible response. Human participants’ approval for the survey and its content was received from the institutional review board at the University of Pennsylvania, and the ACNM national office granted permission to solicit members as participants.

Eligible participants were CNMs/CMs who were members of ACNM (student and associate [non-midwife] members were excluded from the sample) and had an active e-mail address on record with ACNM. E-mail invitations to complete the online survey were sent in March 2009. The survey program was designed so that each potential respondent could respond only once.

The survey was made available online using Vovici, Inc. software. Prior to distribution, beta testing of the survey was conducted. Survey questions addressed demographics; current liability information; past claims; and changes in practice related to cost of liability, fear of suit, or past litigation. Confidentiality of the identity of the respondent was maintained using encrypted password procedures. At the completion of data collection, data that were exported to the primary investigators for analysis did not include personal identifiers. All the statistical analysis was performed using SPSS, version 17.0 (SPSS Inc., Chicago, IL).

Descriptive statistics were used to characterize the sample of survey respondents; specifically, means and standard deviations were used to describe continuous variables, while frequencies and percentages were used to describe categorical variables. Comparisons by litigation involvement were accomplished using 2-sample t tests, or the nonparametric Mann-Whitney U test when normality was in question, and chi-square statistics, as appropriate. A multiple logistic regression model was estimated to regress litigation involvement on variables significant at the 0.10 level in bivariate models (age of midwife respondent on a continuum, overall number of births attended on a continuum, and region of practice). It should be noted that for the logistic regression model, region of practice was entered according to respondents’ location of practicing at the time of the survey. Age and overall number of births attended were examined for multicollinearity prior to estimating the final model using the Pearson correlation coefficient. The methodology of the 2009 survey was very similar to that of the 2005 survey in terms of inclusion and exclusion criteria, survey distribution, and statistical analysis. The 2 surveys included nearly identical questions, with the 2009 survey adding questions about practice changes based on fear or affordability of malpractice insurance. Although there has been no statistical comparison of the findings from the 2005 and 2009 surveys, interpretative comparisons are made when appropriate.

RESULTS
Demographics of Survey Respondents
E-mail invitations for the surveys were sent to a total of 7121 CNMs/CMs, and 1332 of these were returned as undeliverable. Of the 5789 ACNM-eligible members who received the e-mail invitation to participate in the survey, 1340 actually took the Web-based survey, which represents a 23% rate of return. This is a typical return rate for Web-based surveys and is greater than the 18% response rate received during the first litigation survey conducted in 2005. Participant solicitation via e-mail was the same for both surveys. The mean age of respondents was 36.6 years, and 98% were female. The ACNM organization is broken geographically into 6 regions that are outlined in Table 1, which also portrays the proportion of respondents according to ACNM region.

Survey respondents were asked which type of malpractice insurance covered their practices (see Box 1 for definitions of malpractice insurance types). The largest proportion (n = 362; 31%) had occurrence, 182 (16%) had claims-made only, 289 (25%) had claims-made with tail coverage, 297 (26%) did not know what type of coverage they had, and 32 (3%) chose “Other.” No write-in explanations of “other” were provided.
One-third of respondents (n = 425; 32%) have never been named in a lawsuit during their careers. Of those who have been involved in litigation, 33% have been involved in 2 or more lawsuits.

**Demographics of Midwives Named in Lawsuits**

The mean age of respondents who reported involvement in litigation was 53.8 (standard deviation [SD] 7.6) years at the time of the survey. For those who had never been named in a lawsuit, the mean age (SD) at the time of the survey was 49.1 (10.8) years. There was a significant difference in age between midwives who had and had not been involved in a lawsuit (P < .0001). The median number of years that midwives had been in practice before involvement in an adverse event that resulted in litigation was 6.0.

The mean number of estimated births attended in their careers by midwives who had been involved in lawsuits was nearly double that of midwives who had not been involved in litigation (1650 vs 885; P < .0001). There were too few male midwives to give an accurate assessment of how frequently they are involved in litigation. When the ACNM regions were examined in terms of those CNMs/CMs who had experienced 1 or more lawsuits, significant differences were found (Table 1). When we compared survey respondents who were ever involved in a lawsuit to those who were not, according to region of practice, Region II (the Northeast, Puerto Rico, and the Virgin Islands) had a significantly higher proportion of respondents involved in litigation than expected, while Region V (the Southwest and Midwest) had a disproportionately lower proportion of respondents involved in litigation (Table 1).

**Table 1. Distribution of Survey Respondents and ACNM Membership by ACNM Region of Practice**

<table>
<thead>
<tr>
<th>Region</th>
<th>Survey Respondents</th>
<th>ACNM Members</th>
<th>Litigation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Involved in</td>
<td>All Survey</td>
<td>Practice</td>
</tr>
<tr>
<td></td>
<td>(n = 425)</td>
<td>(N = 1340)</td>
<td>Locations</td>
</tr>
<tr>
<td></td>
<td>n (%)</td>
<td>n (%)</td>
<td>n (%)</td>
</tr>
<tr>
<td>Region I</td>
<td>37 (9)</td>
<td>133 (10)</td>
<td>665 (12)</td>
</tr>
<tr>
<td>Region II</td>
<td>112 (26)</td>
<td>238 (18)</td>
<td>861 (15)</td>
</tr>
<tr>
<td>Region III</td>
<td>77 (19)</td>
<td>206 (15)</td>
<td>1021 (18)</td>
</tr>
<tr>
<td>Region IV</td>
<td>86 (20)</td>
<td>293 (22)</td>
<td>1233 (21)</td>
</tr>
<tr>
<td>Region V</td>
<td>53 (13)</td>
<td>265 (20)</td>
<td>1080 (19)</td>
</tr>
<tr>
<td>Region VI</td>
<td>56 (13)</td>
<td>202 (15)</td>
<td>911 (16)</td>
</tr>
<tr>
<td>Missing data</td>
<td>4 (&lt; 1)</td>
<td>3 (&lt; 1)</td>
<td>0</td>
</tr>
</tbody>
</table>

**Table 2. Results of Logistic Regression Model Exploring Factors Associated with Involvement in Litigation (N = 1340)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>OR (95% CI)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1.035 (1.019-1.051)</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>Number of births attended</td>
<td>1.054 (1.039-1.068)</td>
<td>&lt; .001</td>
</tr>
<tr>
<td>ACNM region of practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Region I</td>
<td>1.084 (0.683-1.828)</td>
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<td>1.691 (1.098-2.604)</td>
<td>.017</td>
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<td>.541</td>
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<td>Reference category</td>
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Abbreviations: ACNM, American College of Nurse-Midwives; CI, confidence interval; OR, odds ratio.

* ACNM regions:
  - Region I: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, non-US locations.
  - Region II: Delaware, New Jersey, New York, Pennsylvania, Puerto Rico, Virgin Islands.
  - Region III: Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee.
  - Region IV: District of Columbia, Illinois, Indiana, Kentucky, Maryland, Michigan, Ohio, Virginia, West Virginia, Wisconsin.
  - Region V: Arizona, Colorado, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, South Dakota, Texas, Utah, Wyoming.

**BOX 1. Types of Malpractice Insurance Coverage**

**Occurrence:** Occurrence insurance provides coverage for any events that occur while the provider is practicing with this insurance coverage as well as in the future. For example, in the event that a case is brought against the provider when they no longer have that insurance, they will still be covered. Occurrence insurance is similar to claims-made insurance with tail coverage.

**Claims-Made:** Claims-made insurance provides coverage only for claims made against a provider while he or she is employed at the practice covered by this insurance and does not cover the provider for any claims made after leaving the practice.

**Tail:** Tail insurance is additional coverage purchased at the end of a claims-made policy to insure the provider for any claims made during some specified period of time (eg, 5 years, 21 years, lifetime) following expiration of the original policy.

One-third of respondents (n = 425; 32%) have never been named in a lawsuit during their careers. Of those who have been involved in litigation, 33% have been involved in 2 or more lawsuits.

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  - Region V: Arizona, Colorado, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, South Dakota, Texas, Utah, Wyoming.
practicing in Region II (the Northeast, Puerto Rico, and the Virgin Islands) have 1.69 times the risk of being involved in litigation than those in Region VI ($P = .017$). Conversely, the odds of being in litigation for CNMs/CMs practicing in Region V (the Southwest and Midwest) are 0.581 that of CNMs/CMs practicing in Region VI ($P = .018$).

### Practice Settings

Most midwives (70%) were working in a hospital setting when they were involved in an adverse outcome that resulted in their involvement in a lawsuit, while 5% were in birth centers or homes (Table 3). The majority of CNMs/CMs (90%) who were involved in a lawsuit reported that the adverse outcome was related to pregnancy or newborn care. Two-thirds of pregnancy-related lawsuits involved intrapartum care (65%). Fewer than 5% of lawsuits were related to gynecologic care.

### Lawsuit Outcomes

Among the 425 CNMs/CMs who reported involvement in at least 1 lawsuit, 67% gave depositions, and 11% were required to testify in court. With regard to the final outcomes of litigation cases, 25% of the midwives reported having been dropped from the case individually, and 15% had the entire case itself dropped without a settlement. Thirty-five percent of midwives had settlement of the case before a court hearing or arbitration occurred. Of the 13% of cases that went to trial or arbitration, 59% had a decision that favored the plaintiff, and 41% resulted in a decision that favored the midwife defendant. Overall, the final outcome of litigation involving respondents was closely divided: outcomes favored the midwife (case dropped or decided in favor of midwife) for 44% of the respondents and did not favor the midwife (settled or decided against the midwife) for 42% of respondents. The remaining 14% of CNMs/CMs involved in litigation did not yet know the outcome of the lawsuit at the time of the survey.

### Changes Related to Involvement in or Fear of Litigation

The question of the effect of litigation—either feared or experienced—on a CNM/CM remaining in the profession is one often asked by midwives themselves. Of the 1340 respondents to the total survey, 32% reported that they were not attending births. When asked the principal reason for no longer attending births, only 12 individuals (3% of those not attending births) listed fear of lawsuits or a negative experience with litigation. Similarly, when all survey respondents were asked what changes they had made in their professional practices as a result of the risk or fear of professional liability claims or litigation, 44 midwives (3%) reported that they had stopped attending births.

The majority of midwives (66%) who experienced a lawsuit made no change in practice (Table 3). Half of all survey respondents and did not favor the midwife (settled or decided in favor of midwife) for 44% of the respondents and did not favor the midwife (settled or decided against the midwife) for 42% of respondents. The remaining 14% of CNMs/CMs involved in litigation did not yet know the outcome of the lawsuit at the time of the survey.

### Coping with Litigation

Once CNMs/CMs have been named in a lawsuit, several personal and professional changes in their lives are likely to occur. To assess coping with involvement in the litigation process, respondents who had been named in a lawsuit were asked to name all the factors that contributed to their abilities to handle the situation. The most frequently identified sources of support were practice partners and professional colleagues, an attorney, and family and friends (Table 3).

---

**Table 3. Practice Settings, Changes in Practice, and Sources of Support and Coping for Midwives Involved in Lawsuits (n = 425)**

<table>
<thead>
<tr>
<th>Practice setting when lawsuit occurred</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>293 (69)</td>
</tr>
<tr>
<td>Private office</td>
<td>78 (18)</td>
</tr>
<tr>
<td>Health center</td>
<td>29 (7)</td>
</tr>
<tr>
<td>Freestanding birth center</td>
<td>16 (4)</td>
</tr>
<tr>
<td>Home</td>
<td>7 (2)</td>
</tr>
<tr>
<td>Missing data</td>
<td>2 (&lt; 1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Changes in practice as a result of the experience of a lawsuit</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Made no changes in professional practice</td>
<td>282 (66)</td>
</tr>
<tr>
<td>Decreased the number of high-risk patients cared for</td>
<td>33 (8)</td>
</tr>
<tr>
<td>Increased the number of referrals made for probable cesarean births</td>
<td>27 (6)</td>
</tr>
<tr>
<td>Changed protocols or guidelines for practice</td>
<td>26 (6)</td>
</tr>
<tr>
<td>Reported feeling less confident or fearful in practice</td>
<td>12 (3)</td>
</tr>
<tr>
<td>Improved documentation</td>
<td>12 (3)</td>
</tr>
<tr>
<td>Were more quick to consult with collaborating physician</td>
<td>9 (2)</td>
</tr>
<tr>
<td>Missing data</td>
<td>24 (6)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sources of support and coping with the litigation process*</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice partners and professional colleagues</td>
<td>264 (62)</td>
</tr>
<tr>
<td>Attorney</td>
<td>261 (61)</td>
</tr>
<tr>
<td>Family and friends</td>
<td>234 (55)</td>
</tr>
<tr>
<td>Recreational activities</td>
<td>92 (22)</td>
</tr>
<tr>
<td>Midwives outside of practice</td>
<td>90 (21)</td>
</tr>
<tr>
<td>Formal counseling or therapy</td>
<td>32 (8)</td>
</tr>
<tr>
<td>Found a new midwifery position</td>
<td>32 (8)</td>
</tr>
<tr>
<td>Changed to a career other than midwifery</td>
<td>13 (3)</td>
</tr>
<tr>
<td>Prayer or faith</td>
<td>7 (2)</td>
</tr>
</tbody>
</table>

* Percentages total greater than 100 because respondents could choose multiple answers.
**DISCUSSION**

**Demographics**

Demographically, the respondents to the 2009 Midwifery Liability Survey are very similar to the overall ACNM membership. The ACNM membership survey conducted in 2008 reflected the mean age of members as 50.7 years and reported that 98% were female. Similarly, the respondent demographics by region are comparable to the location of overall ACNM members (Table 1).

With regard to litigation, the involvement of midwives clearly is related to exposure. Age of a midwife, number of births attended, and region of practice where an adverse outcome occurred were 3 variables associated with being named in a lawsuit. Older CNMs/CMs, those who have attended more births, and midwives practicing in Region II were most likely to have been involved in litigation, while CNMs/CMs in Region V were less likely to be involved in litigation (Table 2). Two of these variables are directly related to the amount of exposure midwives have to clinical practice. The mean age of midwives named in a suit was 5 years older than the age of those never named. The more births one had attended, the greater was the incidence of litigation.

One may wonder if this rise in litigation that occurred as midwives became more experienced had to do with changing practice style over time to allow for more high-risk patients and procedures. In other words, does broadening one’s “circle of safety”12 in practice result in increased incidents of litigation? While this is a possibility, survey variables such as location in the country suggest that midwives may have little control over being involved in a lawsuit.

The third predictor variable was ACNM region of practice. Midwife respondents who practiced in Region II (the Northeast, Puerto Rico, and the Virgin Islands) were significantly more likely to be named in a suit than those who practiced in Region V (the Southwest and Midwest). It is hard to imagine that midwives in Region II practice in a style that strongly encourages litigation or that the practice of midwives in Region V discourages litigation. More likely, the Northeast is an area of the country more litigious than others. This appears to be supported by the ACOG 2009 Professional Liability Survey, which found a disproportionately higher rate of litigation in the same area.16 Additionally, there appears to be little variation in maternal and infant outcomes by region.17,18

In the 2005 Midwifery Litigation Survey,1 the percentage of respondents who self-identified as being named in a lawsuit was 25%. By 2009, the percentage of respondents who stated that they had been named in a lawsuit was 32%. In the 4 years between the 2 surveys, the mean age of respondents increased from 47.2 to 50.6 years.1 The profession has aged nearly 4 years, incurring 4 more years of birth exposure. This leads one to question whether this is truly a significant rise in the number of midwives being named in lawsuits or a

---

**Table 4. Changes in Midwives’ Practices, Finances, or Employment as a Result of Malpractice Insurance Affordability or Availability (N = 1340)**

<table>
<thead>
<tr>
<th>Changes in practice</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Made no changes in professional practice</td>
<td>721</td>
</tr>
<tr>
<td>Stopped offering or attending vaginal birth</td>
<td>176</td>
</tr>
<tr>
<td>Were quicker to consult or refer patients</td>
<td>168</td>
</tr>
<tr>
<td>Decreased the number of high-risk pregnant women cared for</td>
<td>73</td>
</tr>
<tr>
<td>Increased the number of referrals made for probable cesarean birth</td>
<td>54</td>
</tr>
<tr>
<td>Other</td>
<td>104</td>
</tr>
<tr>
<td>Missing data</td>
<td>44</td>
</tr>
</tbody>
</table>

**Changes in finances or employment**

| Reduced own salary by greater than 10% to fund increasing malpractice insurance premiums | 77 (6) |
| Reduced the amount of liability coverage in order to continue practicing                 | 49 (4) |
| Retired from clinical practice                                                               | 53 (4) |
| Left own practice to join a group practice                                                   | 45 (3) |
| Stopped attending births                                                                     | 40 (3) |

*Percentages total greater than 100 because respondents could choose multiple answers.*
reflection of the increase in exposure that comes with the passage of 4 more years of practice. This aging of the profession also may explain ACOG’s reported rise in the number of lawsuits involving midwives from 2.6% in 2003 to 3.9% in a more recent survey by the organization.6 On the other hand, given the recent reported increase in obstetrician lawsuits from 89% to 91%,16 it is possible that litigation has increased across professions despite the exposure factor.

Practice Settings

Similar to the findings in the 2005 Midwifery Litigation Survey, this survey found that no setting in which midwives practice is immune to lawsuits. Midwives who worked in hospitals, birth centers, health centers, and in home birth practices all were named in lawsuits. Statistical analyses comparing location of adverse outcomes resulting in litigation to the workplace of CNMs/CMs was not possible, because midwives reported working in more than 1 setting.14 The majority of midwives who reported having been named in a lawsuit were working in hospital settings at the time, and in 2009, the majority of CNMs/CMs were practicing in hospital settings (G. Hamilton, ACNM Director of Membership, oral and written communication, November 2009).

Although patient risk level may not have contributed to litigation, some midwives reported changes in their practices specifically related to risk as a result of being named in a lawsuit. Midwives reported decreasing the number of high-risk patients for whom they cared, referring more of their patients to obstetric services, and decreasing the number of VBACs offered. If the risk of being named in a lawsuit is related to exposure, making changes related to fear of litigation is not likely to have much impact on the frequency with which midwives are sued.

Results of Midwifery Litigation

Although the majority of litigation cases involving CNMs/CMs were dropped prior to settlement or going to trial/arbitration, one-third of cases resulted in a settlement in which the plaintiff received a pay-out. In the small number of cases that went to trial or arbitration, the majority of decisions were found in favor of the plaintiffs. Financial pay-outs to plaintiffs most likely resulted in the midwife’s name being entered in the National Practitioner Data Bank (NPDB). The NPDB is a nationwide flagging system run by the US Health Resources and Service Administration (HRSA).19,20 The NPDB was developed, in part, to protect the public from health care practitioners who were sued multiple times and merely moved from state to state to escape the banning of practice or a poor reputation. According to the HRSA’s NPDB Guidebook, appearance of an individual in the NPDB should not be used as the sole criterion for judging that practitioner’s clinical practice. A payment made in a settlement of a malpractice claim or a trial should not be construed as a presumption that malpractice has occurred.18 However, some malpractice insurance companies will raise midwives’ malpractice premiums if their names appear in the NPDB (I. Teitelbaum, President of Contemporary Insurance Services, oral communication, March 2009).

It bears repeating that more than half of the surveyed midwives who were named in a lawsuit experienced no financial settlement against them. Midwives involved in litigation were often dropped from the suit, or the case itself was dropped. In the current litigious environment, this finding is reassuring. Clearly, a CNM/CM’s risk of experiencing a financial settlement when named in a lawsuit is less than that of the midwife being exonerated from any payment to the plaintiff as an outcome of the lawsuit.

Coping with Involvement in Litigation

No matter what the outcome, involvement in litigation is stressful.21-23 Defendants may experience a wide range of distressing emotions and increased stress, affecting their work and personal lives.21,24 Common responses to involvement in litigation include feelings of shock, outrage, denial, anxiety, guilt, and physiologic signs of critical incident stress, which is a studied phenomenon that occurs after a sentinel event and includes a myriad of psychological, behavioral, emotional, or physiologic symptoms.25 The legal advice traditionally given to clinicians involved in an adverse outcome that could result in litigation (eg, do not speak to anyone about the case) can lead to isolation and increased stress.21

In addition to one’s representative attorney, the most appropriate people with whom a midwife can discuss or process both the details of a case and any emotional response to litigation are with a counselor, spiritual advisor, or in the confines of a formal morbidity and mortality committee meeting at one’s place of employment or site of delivering care. While laws regarding admissible evidence in litigation cases vary from state to state, generally all 4 of these areas of discussion are considered situations in which particulars discussed about the case in question are considered nondiscoverable, meaning they are not admissible as evidence for or against a midwife in court or in settlement of a lawsuit. However, in the survey reported here, aside from discussions with one’s attorney, other opportunities for safe processing, discussion, or support were not cited as being frequently used by midwives who had been sued. Most midwives involved in litigation identified their main sources of coping as support from practice partners, colleagues, their attorneys, family, and friends.

Effects of Actual or Feared Litigation on Midwifery Practice

Of those respondents who had been named in a lawsuit, very few reported that this affected their ability to subsequently obtain malpractice insurance. Indeed, a higher proportion of midwives reported making changes in their clinical practice due to fear of litigation than did those who were actually involved in litigation. Interestingly, being named in a lawsuit also had little impact on a midwife’s working status. Less than 1% of the respondents named in a lawsuit stopped practicing clinically. While being named in a lawsuit can have a dramatic emotional and personal effect on the individual,21-23 it appears that the effect on professional practice is much less severe.
**Strengths and Limitations**

Strengths of the survey include that it is a national survey whose respondents reflected the general membership of ACNM. Age distribution and regions were appropriately represented. The return rate was typical of Web-based surveys and greater than that of the 2005 survey. Limitations of the survey include wording of questions and answer choices that restricted the potential analyses. For example, it was difficult to ascertain risk by practice setting, as neither the ACNM membership data nor the choices in this survey were mutually exclusive for practice setting. Respondents were asked how they received support when involved in litigation, but their knowledge of what support systems were available to them was not assessed. Greater clarity in analysis of the data could be reached in the future by separating out the responses of those who had been involved in a lawsuit versus those who had not for all questions. Although the majority of midwives who had been named in a lawsuit reported no change in employment, there is no way of knowing whether some who had been involved in litigation have left practice and ACNM membership and therefore were left out of the sample. Additionally, it is unclear whether those who have been named in a lawsuit are more inclined to answer the survey because of their experience or less inclined to answer the survey because it may be difficult subject matter for them to revisit.

**CONCLUSION**

This survey offers valuable insight into the demographics, effects, practices, and coping strategies of midwives who have experienced malpractice litigation. Almost as valuable was learning what midwives do not know about litigation. A large number of CNMs/CMs did not know what type of malpractice insurance they carried. In the current era of health care practice, fully understanding the type and limits of one’s malpractice insurance should be included in any employment negotiation by a midwife. Also, the underuse of counseling as a means of coping with litigation suggested that midwives may be unaware of the resources and safe havens available to them if they are ever named in a lawsuit.

Malpractice litigation receives a great deal of attention in discussions of health care reform, including malpractice insurance coverage; alterations in professional clinical practice; and additional health care professional, policy, and personal matters. Indeed, one-third of the surveyed midwives reported having been involved in litigation at least once. However, it appears that some fears about malpractice and litigation are not supported by the findings of this survey. Despite the current litigious climate in the United States and the reported number of midwives who have been sued, lawsuits or the threat of litigation did not change clinical practice or the ability to obtain malpractice insurance for most midwives.

The subject of midwives and litigation, seldom discussed within the profession until recent years, increasingly has been incorporated into presentations at the ACNM annual meetings to educate CNMs/CMs regarding these matters. It is important for practicing midwives to engage in continuing education regarding litigation, because the median number of years in practice when adverse outcomes leading to lawsuits occurred for the respondents to this survey was 6 years.

The authors encourage midwifery program educators to include content on midwives and litigation in curricula to educate students and normalize litigation as a part of midwifery careers.

Much can be learned from ongoing data collection regarding midwives and liability. It is important for ACNM to continue to gather data on a cyclic basis, much as ACOG and other health care organizations have done, to empower midwives with accurate information about litigation, to normalize the experience, and to encourage the development of risk-management strategies.

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**CONFLICT OF INTEREST**

The authors have no conflicts of interest to disclose.

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Malpractice Liability Burden in Midwifery: A Survey of Michigan Certified Nurse-Midwives
Xiao Xu, PhD, Jody R. Lori, CNM, MS, Kristine A. Siefert, MPH, PhD, Peter D. Jacobson, JD, MPH, and Scott B. Ransom, DO, MPH, MBA

A statewide survey was conducted among 282 nurse-midwives in Michigan to examine the extent of their current medical liability burden. Two hundred ten responses were received for an adjusted response rate of 76.9%. Data from 145 certified nurse-midwives (CNMs) who were currently engaged in clinical practice in Michigan were used for this analysis. Sixty-nine percent of CNMs reported that liability concerns had a negative impact on their clinical decision making. Most CNMs (88.1%) acquired malpractice insurance coverage through an employer, whereas 4.9% were practicing “bare” due to difficulty in obtaining coverage. Thirty-five percent of the respondents had been named in a malpractice claim at least once in their career, and 15.5% had at least one malpractice payment of $30,000 or more made on their behalf. CNMs who purchased malpractice insurance coverage themselves or were going bare were significantly less likely to include obstetrics in their practice than their counterparts covered through an employer (70.6% versus 87.2%; P = .04). These findings among Michigan CNMs call for further investigation into the consequences of the current malpractice situation surrounding nurse-midwifery practice and its influence on obstetric care, particularly among women from disadvantaged populations. J Midwifery Womens Health 2008;53:19–27

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keywords: certified nurse-midwives, malpractice, midwifery, obstetrics

BACKGROUND

The current climate of medical liability has sparked extensive discussion regarding its influence on patient care. As one of the areas most affected by malpractice issues, obstetric care has attracted attention in scientific publications as well as in the media at large. However, most data available have focused on obstetricians/gynecologists or family physicians providing obstetric care. Less is known about medical liability pressure facing nurse-midwives in the current practice environment.

Although historically CNMs have not felt the same threat of litigation as their physician colleagues, the profession of nurse-midwifery is not immune to the legal risks associated with obstetric practice. The Journal of Midwifery & Women’s Health featured a special continuing education issue on liability and risk management in midwifery practice in the November/December 2005 issue to assist its members in identifying risks in clinical practice as well as strategies to limit malpractice liability. Jevitt et al. reported that between September 1, 1990, and March 31, 2005, 484 nurse-midwifery malpractice payments were registered in the National Practitioner Data Bank (NPDB). Of these reports, 375 were identified with obstetric criteria for patient management, and more frequent consultation, declining services to high-risk patients, adoption of more rigid risk criteria for patient management, and more frequent consultation with collaborating physicians, all with significant quality and cost implications. Evidence of defensive practice has been documented among obstetricians. However, whether such practices are present in midwifery care remains unclear.
Objectives
Data on nurse-midwives and their medical liability burden in the current malpractice crisis have been sparse, limiting the ability to assess its influence on midwifery care. Discussions surrounding malpractice are often based on anecdotal experience. To help address this issue, this study sought to assess the experience of nurse-midwives practicing in Michigan and to examine the extent of malpractice pressure they face in the current practice environment, including availability of liability insurance, malpractice claims history, affordability of malpractice insurance premiums, defensive practice, and career satisfaction.

METHODS
Data Sources
Data for this study came from a statewide survey conducted in Michigan assessing the influence of medical liability issues on obstetric care. CNMs have been practicing in Michigan since 1980. There are currently about 260 midwives in Michigan practicing at 60 sites throughout the state, including birth centers, community hospitals, and academic health centers. In 2004, CNMs attended 6,900 births in Michigan, ranking the state 14th in the number of midwife-attended births. Michigan is home to two of the 43 midwifery education programs accredited by the American College of Nurse-Midwives (ACNM) Division of Accreditation. The University of Michigan and Wayne State University programs graduated 10 midwifery students in 2006. Compared with other states, CNM practice in Michigan has received a medium level of support on regulatory and reimbursement issues. Currently, nurse-midwifery in Michigan is regulated by the Board of Nursing, and CNMs in Michigan have prescriptive privileges.

In February 2006, 282 nurse-midwives with mailing addresses in Michigan were surveyed as part of a larger survey project on obstetric providers in Michigan. Contact information was obtained from the ACNM mailing list and the University of Michigan Nurse-Midwifery Program. This served as our sampling frame. All nurse-midwives with an address in Michigan who were on the ACNM mailing list and all senior nurse-midwifery students enrolled in the Nurse-Midwifery Program at the University of Michigan were included (due to the recent opening of the Wayne State University education program, no students were ranked at senior level at the time of the survey). In a cover letter accompanying the survey questionnaire, potential risks and benefits of participation in the study were explained, and contact information for the research group was provided to help address any questions. A reminder and two follow-up contacts were made to improve the response rate. The study was approved by the University of Michigan Medical School Institutional Review Board, and a waiver of documentation of informed consent was obtained (i.e., informed consent was established by potential respondents’ completing and returning the survey questionnaire).

The primary focus of this paper is medical malpractice insurance coverage and claim experience among practicing CNMs in Michigan. Data on Michigan obstetricians/gynecologists and family physicians, as well as other variables on nurse-midwives, are reported elsewhere. Two hundred ten nurse-midwives responded to the survey, resulting in an adjusted response rate of 76.9% (nine surveys were returned as undeliverable mail). There were no significant differences between respondents and non-respondents in terms of gender and geographic location (metropolitan versus nonmetropolitan counties)—the only two characteristics that were deducible from the mailing list. Of the 210 respondents, 46 were not currently engaged in clinical practice (e.g., retired or in academic positions), 11 were practicing outside Michigan, seven were currently nurse-midwifery students, and one provided insufficient data. For the purposes of this paper, the analysis was limited to the remaining 145 CNM respondents who were actively practicing in Michigan at the time of the survey (including those on short leave, e.g., sabbatical or maternity leave).

Statistical Analysis
Descriptive statistics were computed to determine the demographic and practice characteristics of the respondents, including the type of primary practice, practice location, provision of obstetric care, and patient population. Details regarding their source of insurance coverage, amount of insurance premium, difficulty in obtaining coverage, previous malpractice claims, payments made for malpractice claims, and the overall influence of malpractice concerns on their clinical decision making were assessed. Chi-square tests were used to compare the provision of obstetric care between CNMs with different levels of medical liability burden. Specifically, compar-
isons were made between 1) CNMs with employer-provided malpractice insurance coverage and those who purchased the coverage themselves or were without coverage, 2) CNMs who had malpractice claims filed against them and those without such claims, and 3) CNMs who had malpractice payments made on their behalf and those who had not.

In addition, the survey inquired about each respondent’s overall career satisfaction and his/her perception of the degree of defensive medicine practiced in nurse-midwifery. Based on comments received during the pilot test of an early version of the survey instrument, questions on defensive practice were phrased as follows: “How often do you think an average provider in your specialty would have performed the following activities due to malpractice concerns?” This was to reduce the sensitivity of the questions and hence increase the response rate. The list of clinical activities included using more diagnostic tests than might be medically necessary, performing more treatment procedures than might be medically necessary, introducing interventions earlier than might be medically necessary, referring patients to specialists earlier than might be medically necessary, prescribing more medications than might be medically necessary, and requesting more follow-up visits than might be medically necessary. For each of these activities, the respondents could answer “never,” “sometimes (about 25% of the time),” “usually (about 75% of the time),” or “always (about 100% of the time).”

Due to the voluntary nature of the survey, nonresponse adjustments were made to reduce potential bias in survey estimates. Weights were constructed for this purpose and routinely applied to the analyses. P values <.05 were

| Table 1. Practice Characteristics of Michigan Certified Nurse-Midwives (N=145)* |
|-----------------------------------------------|---|---|
| **Characteristics** | **n** | **Weighted† %** |
| Location of primary office‡ | | |
| Metropolitan counties | 124 | 85.5 |
| Nonmetropolitan urban counties | 19 | 13.1 |
| Rural counties | 2 | 1.4 |
| Type of primary practice | | |
| Solo/two-person practice | 19 | 13.1 |
| Group practice (≥3 providers) | 40 | 27.6 |
| Group/staff model HMO | 9 | 6.2 |
| Hospital affiliated (teaching/academic or community hospital) | 46 | 31.7 |
| Public clinic/federally qualified health center | 21 | 14.5 |
| Other | 10 | 6.9 |
| Provision of obstetric care | | |
| Currently practicing obstetrics | 121 | 85.2 |
| Practiced obstetrics before | 16 | 11.3 |
| Never practiced obstetrics | 5 | 3.5 |
| No. of years practicing obstetrics (mean ± SD, range)§ | 12.8 ± 8.6 (1.0–36.0) |
| No. of babies delivered in the past year (mean ± SD, range)§ | 74.7 ± 54.3 (0–225) |
| Approximate percentage of obstetric patients with high-risk pregnancy§ | | |
| 0% | 14 | 12.0 |
| 1%–10% | 65 | 55.6 |
| 11%–25% | 22 | 18.8 |
| 26%–50% | 9 | 7.7 |
| >50% | 6 | 5.1 |
| Don’t know | 1 | 0.9 |
| Approximate percentage of obstetric patients covered under Medicaid§ | | |
| 0% | 4 | 3.4 |
| 1%–10% | 10 | 8.5 |
| 11%–25% | 15 | 12.8 |
| 26%–50% | 29 | 24.8 |
| >50% | 57 | 48.7 |
| Don’t know | 2 | 1.7 |

HMO = Health maintenance organization.

*Respondents with missing data on the variable were not included in these descriptive statistics. For any one of the variables, the proportion with missing data did not exceed 5.0%. Percentages may not add up to exactly 100% due to rounding.

†Weights were applied in data analysis to reduce nonresponse bias.

‡Categorized based on respondent self-reported county name/zip code of primary office and the 2003 version of the Rural-Urban Continuum Code scheme from the Department of Agriculture Economic Research Service.

§Among those who were currently practicing obstetrics (n = 121, unweighted).
considered statistically significant. All data analyses were conducted using SAS 9.1 (SAS Institute Inc., Cary, NC).

RESULTS

Sample Characteristics

The 145 respondents who were currently engaged in clinical practice in Michigan were all female and were certified as nurse-midwives. The majority (93.8%) were non-Hispanic white. Very few (1.4%) had graduated from a nurse-midwifery program from another country, whereas 30.3% had graduated from a nurse-midwifery program in Michigan. The remaining 68.3% were from a nurse-midwifery program in another state within the US. On average, the respondents had practiced in Michigan for 11.4 years (standard deviation [SD] = 7.6; range, 0.2–33.8). Fifty-five percent stated that they spend at least 40 hours per week in direct patient care (mean = 37.3 hours per week; SD = 17.6; range, 2–90).

Respondents’ primary offices were located in 28 of the 83 counties in Michigan, mostly in metropolitan counties. Only 1.4% had a primary office in a completely rural area or a county with less than 2500 urban population.

Table 2. Burden of Medical Liability Insurance and Malpractice Litigation (N=145)*

<table>
<thead>
<tr>
<th>Medical Liability Burden</th>
<th>n</th>
<th>Weighted†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have medical liability insurance coverage for your current practice?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, self-purchased</td>
<td>10</td>
<td>7.0</td>
</tr>
<tr>
<td>Yes, covered through an employer</td>
<td>126</td>
<td>88.1</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>4.9</td>
</tr>
<tr>
<td>Ever had a malpractice claim filed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>50</td>
<td>35.2</td>
</tr>
<tr>
<td>When the claim was filed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malpractice claim in the past 5 years</td>
<td>32</td>
<td>22.5</td>
</tr>
<tr>
<td>Malpractice claim more than 5 years ago</td>
<td>17</td>
<td>12.0</td>
</tr>
<tr>
<td>Malpractice claim both in the past 5 years and more than 5 years ago</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Malpractice payment‡</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest amount paid for a malpractice claim was $30,000</td>
<td>22</td>
<td>15.5</td>
</tr>
<tr>
<td>Highest amount paid for a malpractice claim was &lt;$30,000</td>
<td>3</td>
<td>2.1</td>
</tr>
<tr>
<td>No payment made for malpractice claims, but had claims pending</td>
<td>5</td>
<td>3.5</td>
</tr>
<tr>
<td>Never made payments for malpractice claims</td>
<td>18</td>
<td>12.7</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td>No</td>
<td>92</td>
<td>64.8</td>
</tr>
</tbody>
</table>

Overall, how much have medical liability concerns influenced your clinical decision making?

A great deal of positive impact | 5 | 3.6 |
Moderate positive impact | 11 | 8.0 |
Slight positive impact | 9 | 6.6 |
No impact at all | 17 | 12.4 |
Slight negative impact | 55 | 40.1 |
Moderate negative impact | 29 | 21.2 |
A great deal of negative impact | 11 | 8.0 |

*Respondents with missing data on the variable were not included in these descriptive statistics. No more than 5.5% of the respondents had missing data on each of the variables. Percentages may not add up to exactly 100% due to rounding.
†Weights were applied in data analysis to reduce nonresponse bias.
‡Including jury verdicts, settlements, or arbitration awards either paid by themselves or by someone else on their behalf.
training program. Of the remaining seven respondents who said they usually attend births in other settings, five were in freestanding birth centers and/or at home. This is consistent with national data, indicating that the majority of CNM-attended births occur in hospitals (97% in 2003).3

Medical Liability Burden
When asked about their professional liability insurance, seven CNMs (4.9%) reported going bare, or without coverage (Table 2). Five of them said that it was extremely difficult to obtain coverage, and the other two reported it was somewhat difficult. In addition, four of them were in solo or two-provider practice. Most CNMs were covered through an employer—only 7.0% had to purchase liability insurance themselves. The average premium rate for self-purchased coverage was $11,131 (95% confidence interval, $4,114–$18,149). With regard to claims experience, 35.2% reported having a malpractice claim filed against them at least once in their career. Most of these claims (66.0%) had been within the last five years. A total of 17.6% had made some payments for malpractice claims, including jury verdicts, settlements, or arbitration awards either paid by themselves or by someone else on their behalf. Another 3.5% had no malpractice payments made previously but currently had claims pending. Among the listed activities, fewest respondents reported defensive practice related to medication prescribing.

<table>
<thead>
<tr>
<th>Medical Liability Burden</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical malpractice insurance coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-purchased or not covered</td>
<td>n=12, Weighted=70.6%</td>
<td>n=5, Weighted=29.4%</td>
</tr>
<tr>
<td>Covered through an employer</td>
<td>n=109, Weighted=87.2%</td>
<td>n=16, Weighted=12.8%</td>
</tr>
<tr>
<td>Ever had a malpractice claim filed?</td>
<td>n=42, Weighted=85.7%</td>
<td>n=7, Weighted=14.3%</td>
</tr>
<tr>
<td>Yes</td>
<td>n=36, Weighted=84.4%</td>
<td>n=14, Weighted=15.6%</td>
</tr>
<tr>
<td>No</td>
<td>n=19, Weighted=78.2%</td>
<td>n=5, Weighted=20.8%</td>
</tr>
<tr>
<td>Ever made payments for malpractice claims?</td>
<td>n=98, Weighted=86.7%</td>
<td>n=15, Weighted=13.3%</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Medical Liability Burden and Practice of Obstetric Care (N = 145)*

*Of the 145 respondents, 121 included obstetrics in their practice at the time of survey. Respondents with missing data on the variable were not included in the statistics. No more than 5.5% of the respondents had missing data on each of the variables. Percentages in each row may not add up to exactly 100% due to rounding.

†Weights were applied in data analysis to reduce nonresponse bias.

‡Including jury verdicts, settlements, or arbitration awards either paid by themselves or by someone else on their behalf.

§Including certified nurse-midwives who had never paid for a malpractice claim, as well as those who had not yet paid for any malpractice claim but currently had claims pending.

Defensive Practice
In terms of defensive practice, 11.4% of the respondents felt that the average nurse-midwife would always use more diagnostic tests than might be medically indicated due to malpractice concerns, and 38.6% said that the average nurse-midwife would usually do so (Figure 1). Likewise, 10.8% of the respondents felt that an average CNM would always introduce interventions earlier than might be medically necessary and 31.7% indicated “usually.” This was followed by early referral to specialists, performance of more treatment procedures, and request for more follow-up visits, which were reported by 40.0%, 35.7%, and 34.2% of respondents, respectively, as being usually or always practiced. Among the listed activities, fewest respondents reported defensive practice related to medication prescribing.
Clinical Implications

As one of the “caution states” (i.e., states that are showing signs of developing a liability crisis) declared by the American Medical Association with regard to its medical liability climate, there is legitimate reason to be concerned about the current malpractice burden among Michigan nurse-midwives and the potential impact on their practice. In contrast to national data reported in 1982 showing only 5% of nurse-midwives had ever been sued, the present study indicates that 35.2% of practicing Michigan CNMs had been named as a defendants in medical malpractice claims by 2006, and 15.5% had made malpractice payments of $30,000 or higher. Although a small proportion, some CNMs (4.9%) were practicing bare due to difficulties in obtaining liability insurance coverage. Nearly 70% of CNMs in this survey reported liability concerns as having a negative impact on their clinical decision making.

These findings are consistent with the limited evidence available. Benedetti et al. found that in the state of Washington, the average liability insurance premiums for CNMs increased from $5,948 in 2002 to $10,952 in 2004, up by 84%. A mail survey of obstetrician-gynecologist practices in southern New Jersey also reported that some CNMs had annual premiums as high as $13,000 in 2003, compared with $25,000 to $40,000 in earlier years. Many of the recent birth center closures in the Washington-Baltimore area have cited rising malpractice insurance premiums as one of the driving factors. In addition, data from the NPDB showed that since September 1990, there had been 349 medical malpractice payment reports on nurse-midwives as of December 2002. This number increased to 516 by December 2005. The median claim payment made on behalf of nurse-midwives between 1990 and 2005 was $225,000.

Experience from previous malpractice crises suggests that excessive medical professional liability insurance problems could have a significant impact on nurse-midwives. At the peak of the last crisis in the 1980s, malpractice policies were either unavailable to nurse-midwives or prohibitively expensive—with premiums as high as $15,000 to $30,000 compared with their average annual income of about $25,000 at that time. During this crisis, many midwives had to increase the number of patients they saw to increase practice revenue. This undermined the tradition of midwifery care in terms of time spent with patients and triggered practice of a more defensive posture. A 1987 telephone survey of CNMs in rural Arizona found that 10% of CNMs were going bare because of the prohibitively expensive premiums, and another 10% said that they had been prevented from practicing in rural areas due to the malpractice insurance problem. These prior experiences shed light on the potential influence of the current malpractice crisis on midwifery care in the US.

In addition, a recent review article on midwifery care showed that midwives serve a high proportion of disadvantaged populations, including adolescents, racial/ethnic minorities, Medicaid beneficiaries, and women who are less educated, unmarried, or residing in rural areas or health professional shortage areas. A large proportion of payments (44%) for CNM care is from Medicaid, which
tends to have lower reimbursement rates. Compared with other obstetric providers (obstetricians/gynecologists and family physicians), CNMs are paid a lower salary and are unable to offset lower insurance reimbursement with higher paying procedures such as surgery, limiting their ability to absorb large increases in malpractice premiums. Moreover, as reported elsewhere, 22% and 15% of CNM respondents to the current survey study reported risk of malpractice litigation and difficulty in affordability/availability of liability insurance, respectively, as high impact factors for their decision of whether to include obstetric care in their practice. If there are indeed excessive medical malpractice burdens for nurse-midwifery care, it may exert a worrisome influence on patient care, especially for vulnerable populations.

Rising malpractice premiums also add more complexities to midwifery practice, driving up the cost of midwifery care and potentially undermining collaborative working relationships with physicians and hospitals. Some professional liability insurance companies impose premium surcharges on physicians working with nurse-midwives, which could also impact collaborative partnerships. In addition, when the malpractice climate is aggravated, many hospitals require nurse-midwives to obtain a large amount of insurance coverage before granting practice privileges. However, data from the 2006 American College of Obstetricians and Gynecologists found that nurse-midwives were named in only 3.8% of malpractice claims against obstetricians/gynecologists. There is also evidence suggesting that a lower number of medical malpractice claims are brought against physicians who work with CNMs compared with those who do not.

Another important finding of this study is the substantial amount of defensive practice reported by CNMs. Each unnecessary test or procedure may pose added risk for the patient (e.g., complications and side effects of treatment resulting from false-positive diagnostic tests). Fear of malpractice lawsuits could also deter timely reporting of medical errors, putting patients at further risk. The potential adverse effects of defensive practice may be even greater in obstetric and midwifery care than in other clinical areas, because there are patient safety implications applicable to both the mother and the infant.

Several limitations of the study should be acknowledged. First, because the data for this study were collected as part of a survey, the results may not be generalizable to all CNMs. Second, the sample size may be too small to detect differences in practice patterns across different regions or types of practices. Third, the survey questions may not capture all aspects of CNM practice, such as the use of technology or the effectiveness of team-based care. Despite these limitations, the findings of this study highlight the importance of addressing the financial and legal challenges facing CNMs and suggest potential strategies for improving the practice and safety of midwifery care.

Table 4. Career Satisfaction (N = 145)*

<table>
<thead>
<tr>
<th>Career Satisfaction</th>
<th>n</th>
<th>Weighted†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thinking very generally about your satisfaction with your overall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>career in health care, would you say that you are currently</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very satisfied</td>
<td>60</td>
<td>42.0</td>
</tr>
<tr>
<td>Somewhat satisfied</td>
<td>70</td>
<td>49.0</td>
</tr>
<tr>
<td>Neither satisfied nor dissatisfied</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Somewhat dissatisfied</td>
<td>12</td>
<td>8.4</td>
</tr>
<tr>
<td>Very dissatisfied</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Compared with your career satisfaction 5 years ago, would you say</td>
<td></td>
<td></td>
</tr>
<tr>
<td>you are now</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A lot more satisfied</td>
<td>28</td>
<td>19.6</td>
</tr>
<tr>
<td>Somewhat more satisfied</td>
<td>47</td>
<td>32.9</td>
</tr>
<tr>
<td>About the same</td>
<td>32</td>
<td>22.4</td>
</tr>
<tr>
<td>Somewhat more dissatisfied</td>
<td>27</td>
<td>18.9</td>
</tr>
<tr>
<td>A lot more dissatisfied</td>
<td>7</td>
<td>4.9</td>
</tr>
<tr>
<td>Not applicable‡</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td>Compared with your interest in obstetric care (including intrapartum care) when you first practiced obstetrics, would you say that you are now</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A lot more interested in obstetric care</td>
<td>11</td>
<td>7.7</td>
</tr>
<tr>
<td>Somewhat more interested in obstetric care</td>
<td>13</td>
<td>9.2</td>
</tr>
<tr>
<td>About the same</td>
<td>69</td>
<td>48.6</td>
</tr>
<tr>
<td>Somewhat less interested in obstetric care</td>
<td>26</td>
<td>18.3</td>
</tr>
<tr>
<td>A lot less interested in obstetric care</td>
<td>18</td>
<td>12.7</td>
</tr>
<tr>
<td>Not applicable§</td>
<td>5</td>
<td>3.5</td>
</tr>
</tbody>
</table>

*Respondents with missing data on the variable were not included in the statistics. No more than 2.1% of the respondents had missing data on each of the variables. Percentages may not add up to exactly 100% due to rounding.
†Weights were applied in data analysis to reduce nonresponse bias.
‡For instance, some nurse-midwives may not have been in practice for 5 years.
§Five providers who said that they were not currently practicing obstetrics indicated not applicable on this question.
of a larger project to assess the influence of medical liability issues on obstetric care, focus of analysis was placed on the obstetric care component of nurse-midwifery practice. How other aspects of nurse-midwifery care may be influenced by malpractice pressure was not addressed. Second, it is difficult to accurately measure the practice of defensive medicine. In many clinical situations, there is no definitive answer regarding the optimal amount of care that should be provided. Data reported here were based on providers’ own perceptions of what might be medically necessary. Third, the survey targeted providers’ experience with medical malpractice issues. The effect of the malpractice climate on patient access to care and patient safety, especially among disadvantaged populations, was not directly assessable. Fourth, findings from this study were based on data from Michigan, and conditions in other parts of the country may differ. Finally, the cross-sectional design of this study precludes inferences regarding changes in the malpractice climate for nurse-midwives in Michigan (e.g., increasing or decreasing burden). Instead, the study provides good baseline data for future research in this area.

CONCLUSION
Nurse-midwifery plays an important role in the care of pregnant women, especially in disadvantaged populations. However, it tends to be overlooked in the current discussion surrounding the medical legal system and its impact on patient care. Findings from the present study provide some evidence for the challenges faced by Michigan CNMs associated with malpractice insurance costs and litigation risk. It is one of the few studies that have directly evaluated medical malpractice burden among CNMs. Further research using other approaches or data sources in examining liability burden in midwifery care and assessing the extent of liability burden in other parts of the country will provide additional information to help fully understand the ramifications of the current malpractice crisis for midwifery practice.

This study was funded by grant 1060.II from the Blue Cross Blue Shield of Michigan Foundation. Some preliminary work for this study was supported by the National Institutes of Health Roadmap Initiative grant 1 P20 RR020682-01. Findings from this study were presented at the American Public Health Association’s 134th Annual Meeting in Boston, MA, November 4-8, 2006. We thank the Wayne County Medical Society of Southeast Michigan and the Southeastern Michigan ACOA Chapter for assistance in implementing the survey, Dr. Katherine Gold, Dr. Alastair MacLennan, and Dr. Ariel Smits for help with development of the survey instrument, and Ken Guire for advice on data analysis.

REFERENCES


Closed Claims Analysis of 65 Medical Malpractice Cases Involving Nurse-Midwives

Diane J. Angelini, CNM, EdD, and Linda Greenwald, RN, MS

The threat of litigation in clinical midwifery is evident in daily practice. Although midwives have not had the same risk of claims and suits as obstetricians, all obstetric providers are potentially subject to claims of malpractice. Closed claims analysis has been used in the past to review risk patterns and to heighten awareness of certain risks. It is a methodology that can suggest corrective or preventive action for future practice and thereby minimize the risk of future errors. An analysis of nurse-midwifery closed claims can help to evaluate past risk and proactively modify future liability. J Midwifery Womens Health 2005;50: 454–460 © 2005 by the American College of Nurse-Midwives.

keywords: closed claims analysis, risk assessment, liability, litigation, malpractice

INTRODUCTION

Among the many forces weighing heavily on midwives in practice today is the threat of litigation. Certified nurse-midwives have traditionally not shared the same risk of involvement in claim and suit as some of their physician colleagues, partially a result of the emphasis midwifery places on education, communication, and relationship with clients.

However, according to a 1999 survey performed by the American College of Obstetricians and Gynecologists (ACOG), certified nurse-midwives were named as codefendants in 2.2% of the claims opened and closed between 1996 and 1998.1 As increasing numbers of midwives deliver health care to women, particularly in the high-risk area of obstetrics, this number is likely to increase.2

A malpractice suit is not an indictment of one’s professional competence, nor is it a condemnation of one's personal integrity. Many cases are likely a reflection of unmet parental expectations, miscommunication, or a woman’s perceived need for more information or explanation than she received.3 Although malpractice cases involving midwives are not numerous, many are costly, in terms of both indemnity dollars and human lives.

The purpose of this article is to present the results of a retrospective closed claims analysis of 65 cases involving midwives in 22 states and to identify practice patterns in midwifery that have led to past litigation. This analysis suggests steps that may help practicing midwives decrease their risk of involvement in claims and loss, and ultimately, to mitigate the human and financial losses of malpractice litigation in the future.

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Review of Literature

Malpractice claims reflect the actions of a small percentage of people. Of the 10% hospitalized patients who suffer significant injuries, only 2% file a malpractice claim.4 On the other hand, a number of suits are filed by persons who are found to have suffered no preventable harm or injury. Almost all malpractice suits allege negligence and/or malfeasance. In fact, however, many are expressions of anger at and dissatisfaction with a perceived lack of openness and honesty on the part of the practitioner after an adverse outcome.5

Closed malpractice claims (i.e., those that have been resolved by settlement, jury verdict, or dismissal) are more readily quantifiable than open claims, the outcome of which is unknown. However, all claims are invariably only a portion of the total picture because malpractice cases represent neither all outcomes nor all adverse outcomes. Thus, such studies are, at best, pictures, not of injury, but of liability.5

Despite their admitted limitations, analyses of closed malpractice claims can serve several important functions. They can identify negative clinical practice patterns that represent a real or potential threat to patient safety. They can also raise practitioners’ awareness of certain risks that are specific to their own practice or to their specialty and address or suggest corrective action that may be indicated. Finally, they can minimize the risk of future claim and loss while increasing patient safety and practitioner satisfaction.

Using the past to inform the present and the future is an accepted practice in the medical malpractice insurance industry, with insurers repeatedly analyzing closed claims to determine the patterns and assess the risks specific to a group, institution, specialty, or region. For example, one malpractice insurance carrier’s 2002 study of closed claims in internal medicine revealed that for the first time, the number of colorectal cancer claims closed within a 3-year
period exceeded the number of breast cancer claims. That led the company to undertake a study of the colorectal cancer claims in all affected specialties to determine at what point in the diagnosis-treatment spectrum claims were occurring and what education the company needed to offer its insured health care practitioners to stem the incidence of new claims.

Insurers are not alone in their use of closed claims as a means to understanding practice issues. In the 1980s, when anesthesiology, like obstetrics, represented a significant malpractice insurance risk, anesthesiologists became concerned that although they represented 3% of all insured physicians, the indemnity payments required to close their claims represented 11% of all dollars paid out in patient injury cases. In 1984, the American Society of Anesthesiologists (ASA) began The Closed Claims Project, a study of closed claims in anesthesiology, which continues today. An analysis of the Project’s first 900 claims led the researchers to the realization that many of their most serious and costly claims could be traced to events involving the respiratory system. Patient outcomes improved, largely as a result of the study, when intraoperative and postoperative pulse oximetry and the use of capnography (a continuous record of the carbon dioxide content of expired air to verify endotracheal intubation) became the standard of care. Anesthesia cases involving respiratory-related events dropped from 36% to 15%, and anesthesiology became a moderate-risk specialty.

Similar in-depth studies of midwifery cases are difficult to find, although the physician-editor of the Professional Liability Newsletter asserted in 1999 that in the previous 2 years, he had seen an increase in cases alleging either a failure on the part of midwives to advocate for pregnant women or a failure to summon medical assistance in a timely fashion. In 1997, a researcher identified three key issues in the midwifery claims in one health region in Britain: 1) failure to identify a shift from normal to abnormal labor, 2) failure to advocate for the birthing woman when the midwife had concerns about medical management, and 3) “shortcomings” in the interpretation of electronic fetal monitor tracings.

Far more common are studies of the overall specialty of obstetrics and gynecology. By almost all measures, obstetrician/gynecologists are the medical practitioners at highest risk for claim and suit. In a Physician Insurers Association of America (PIAA) study of malpractice claims that closed between 1985 and 2000, obstetrics and gynecology was the medical specialty with the greatest number of claims (22,980), the highest percent that closed with payment (36%), and, with the exception of neurology, the highest average indemnity payment ($235,000). There are several probable reasons. Parents often expect a perfect baby, and yet there is no way of definitively establishing the etiology of neurological injury, including cerebral palsy. In addition, the appearance in a courtroom of a brain-damaged child exerts a strong emotional impact on a jury, and the medical cost of providing lifelong care for a physically impaired or neurologically impaired individual is substantial.

Given the above, it is no surprise that the allegations made against providers of obstetric care focus almost entirely on the perceived mismanagement of labor and delivery. In 1998, MMI Companies, a malpractice insurance carrier no longer in operation, published a 12-year study of perinatal injuries, which resulted in claims. Data were collected from 263 US hospitals. The study revealed that those allegations fell into 1 of 5 categories: 1) failure to recognize or respond to fetal distress, 2) failure to perform a timely cesarean delivery, 3) failure to perform appropriate neonatal resuscitation, 4) inappropriate use of oxytocin, 5) inappropriate use of forceps or vacuum.

Four years later, a retrospective study of 271 obstetric/gynecology claims conducted by ProMutual Group, the largest medical liability carrier in New England, revealed two additional repetitive clinical practices that contributed to the high costs of obstetric-related litigation: misinterpretation of fetal heart rate tracings and mismanagement of shoulder dystocia.

Risk Management Tools: MMI Triad

The data from closed claim studies are not simply informational. They also have the potential to diminish risk and improve clinical outcomes. Their ability to realize this goal, however, is dependent on three basic risk management tools, which are known as the MMI Triad. Postulated by the MMI Companies at the conclusion of their study, the Triad consists of 1) education, the sharing of data with other members of the perinatal team, and familiarization with risk items particular to their specialty, practice, or institution; 2) consultation, the creation of strategies such as educational seminars or the development of multidisciplinary guidelines to mitigate those risks; and 3) information, monitoring the ongoing success or failure of any interventions.

The MMI Triad is a systems approach to risk reduction. It acknowledges that most errors result not from one person’s failure, but rather, from the failure of all or parts of a system. An analysis of closed claims is an effective means of identifying systemic weaknesses; the corrective action suggested by the Triad is a useful method for responding to those weaknesses. In asking “what” and

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“why,” rather than “who,” it represents a significant departure from the blame culture\(^{15}\) that has long pervaded American health care and denied many practitioners the opportunity to learn from their own mistakes and profit from those of their colleagues.

An analysis of nurse-midwifery claims can identify trends in claims and pinpoint where liability is greatest. Careful review of trending data can impact practice and thereby modify risk.

**Methodology**

Seventy-seven closed midwifery claims were reviewed. The distribution and sources of all cases include the following: 50 cases were obtained from the Medical Malpractice Jury Verdict Reporting Service, a national publication that reports medical malpractice verdicts and settlements as well as case information (primarily supplied by plaintiff attorneys). It also provides a search service (for a fee) of its database by provider and, in this case, the database was searched for all existing nurse-midwifery cases. Fourteen cases were from a large medical malpractice insurance carrier in the Northeast, five cases were from various national legal reporting newsletters such as the Regan Report, five cases came from the files of the Neurological Injury Compensation Fund in Florida, and three were closed cases supplied by private practice midwives.

Only 65 closed claims cases were usable for full analysis. Fifty-three cases involved intrapartum events, 12 were non-intrapartum-related events. Of the 12 unusable cases, 7 had incomplete databases, 2 cases did not have the consent of the private midwives involved in the case, and 3 cases were noted to be duplicates. All cases were further reviewed to ensure no duplication.

To determine the primary focus involved in each claim, all cases were independently reviewed by both authors, and the findings were compared with regard to 1) the key topic in the case and 2) critical subissues. Both reviewers had access to the same data set for all cases. The percentage of initial agreement based on case content and identification of the key topic was 80% (n = 52 cases). The remaining 20% of the cases (n = 13 cases) were further reviewed and discussed in detail by both reviewers to identify critical subissues. Subanalysis continued until consensus was reached by both reviewers on all cases. Midwives were the provider of care in all cases, with physicians serving as consultants.

**RESULTS**

Analysis was performed by using the closed malpractice claims, where the midwife (midwives) was a primary defendant in each case. The initial analysis involved reviewing cases by year of occurrence. The range of years for all cases was from 1982 to 2001, a total of 19 years. Fifty-three cases were from the 1990s, 7 were from 1980s, and 5 cases occurred after 2000, as noted in Figure 1. There is no way to tell if this sample is representative of all midwifery claims for this time period.

The cases were derived from 22 states. The insurance carrier providing the largest single number of cases is based in the Northeast, and the majority of cases supplied to the jury verdict reporter publication were from Massachusetts. The regional distribution of cases is listed in Figure 2.

A financial analysis of the outcomes showed that 12 cases were either dismissed, dropped, or ended in defense verdicts. Nineteen cases were settled or had plaintiff verdicts of less than one million dollars (in three of these cases,
the midwife was found to have no indemnity, but physician codefendants still had settlements or verdicts to pay out). Twenty-one cases involved greater than 1 million dollars but less than 5 million dollars in settlements or plaintiff verdicts. Another 5 were resolved for greater than 5 million dollars but less than 9 million dollars. Two claims were settled (or settled postverdict) for more than 9 million dollars. Three claims were decided by mediation or arbitration, ranging from $194,000 to 3 million dollars. Two cases had confidential settlements, and 1 case was settled by the Neurological Injury Compensation Fund in Florida for an undisclosed amount.

Major Categories of Liability Risk

Seven major categories of liability risk were revealed when all usable cases were fully analyzed, as noted in Figure 3. These 7 categories, which represent the primary problem on which the malpractice case was based, represent 57 of the 65 cases (87.6% of total cases). They involve the following, in descending order based on greatest percentage of cases: 1) fetal assessment and fetal heart rate (FHR) monitoring interpretation, 2) shoulder dystocia, 3) resuscitation efforts, 4) diagnostic errors, 5) vaginal birth after cesarean (VBAC), 6) testing measures, and 7) laceration repair and healing.

Fetal Assessment/Interpretation of FHR Monitoring

The category of FHR monitoring interpretation and management was larger than any other single claims group, with 22 cases (33.8%). The major contributing factors in this category are listed in Table 1.

Meconium was noted in nine of the 22 FHR monitoring cases. The question of meconium being an etiology of subsequent neonatal respiratory compromise versus damage occurring in utero secondary to fetal gasping/chronic asphyxia was noted in the description of these selected cases. Other issues in this category not related to direct midwifery care were consultants responding late to the clinical crisis or not being on-site, and surgeons not being on-site to perform a cesarean delivery, which were noted in six cases within this category.

Fetal scalp stimulation was another item that appeared frequently in the cases involving FHR monitoring interpretation. In some cases, it was difficult to determine whether fetal scalp stimulation was performed, unless it was specifically documented.

In other cases, there were notations that fetal heart rate could not be found for critical moments, or a fetus not monitored, or, in two cases, the fetal heart tracings were inadequate, and thus, uninterpretable to experts. One case noted that fetal assessment in second stage was not performed according to ACOG guidelines and, therefore, did not meet the standard of care.

In selected cases, it appeared that the midwife could have benefited from using the chain of command/communication or seeking improved consultation when the consultant was negligent, or when given inadequate advice or when care was abandoned altogether by the consultant. In one case involving a nonreassuring fetal heart rate, the midwife was asked to exceed the scope of practice for midwifery in that particular setting by using a vacuum extractor at delivery.

Shoulder Dystocia

Eighteen cases (27.6%) involved shoulder dystocia. Of the 18 cases, three were defense verdicts and two were settled on behalf of the plaintiff but with no indemnity payment for the midwife. The 13 remaining cases in this category were settled on behalf of the plaintiff. In two of the shoulder dystocia cases, a student nurse-midwife was involved with the birth. The biggest issue, noted in four cases, was not securing consultation in a timely manner. In one case, involving the birth of a macrosomic infant, a vacuum extractor was used by a nurse-midwife. Documentation was brief or lacking in three cases.

Fundal pressure was noted in one case, and excessive traction was noted in three cases. In two cases involving women with a known history of macrosomia, no ultrasound...
was performed to assess estimated fetal weight in the current pregnancy or to decide if a cesarean birth should be offered.

Resuscitative difficulties (i.e., lack of adequate resuscitation equipment and personnel) appeared to result in further anoxia in two shoulder dystocia cases. One of the shoulder dystocia case decisions resulted in corporate liability for the hospital. In that case, it was noted that hospitals are responsible to see that care is properly provided, even when the provider is not an employee of the hospital (i.e., the hospital is liable for negligence of a nonemployee).

Factors that appeared to favor positive outcomes for midwives in shoulder dystocia cases included 1) having the consultant in the room or close by when or if shoulder dystocia was anticipated; 2) discussing shoulder dystocia or having a “big baby” talk with a woman during pregnancy, including explanation of potential complications during shoulder dystocia; 3) implementing all maneuvers to free the anterior shoulder; and 4) documenting each step thoroughly.

**Resuscitation Efforts**

There were four cases (6.2%) in which the acuity of the resuscitation efforts overshadowed all other available facts of the case. Meconium was involved in two of the four resuscitation cases. The primary issue in all the resuscitation cases was not initiating active resuscitation until 10 to 15 minutes after delivery. Difficulty accessing proper staff to perform appropriate resuscitation was involved in all four cases. In three cases, the infant was not resuscitated adequately. In one case, resuscitation equipment was not in the room and had to be brought in by the resuscitation team.

**Diagnostic Errors**

There were four cases (6.2%) involving diagnostic errors (i.e., incorrect or missed diagnoses). Three cases involved preeclampsia. They included 1) missing the symptoms of preeclampsia, 2) abruption, and 3) worsening HELLP syndrome (incorrectly diagnosed as gestational thrombocytopenia). Another case in this category involved misdiagnosis of breast cancer.

**Vaginal Birth After Cesarean (VBAC)**

There were three cases that involved women attempting VBAC (4.6%). In two cases, an oxytocin infusion was administered to a patient while the consulting physician was not in hospital. It is difficult to address hospital policies regarding the administration of oxytocin to a woman who is considering VBAC because the data were somewhat limited on these cases and hospital policies were not noted. In one case, the midwife was thought to exceed the scope of practice, because VBACs were not considered appropriate for independent management in that setting. In another case, the consultant did not come in when the midwife reported that the woman was bleeding, and yet both clinicians thought they had fully communicated with each other. A key legal point that evolved from one of the VBAC cases was that a physician providing coverage for a colleague who has a collaborative agreement with a midwife or midwifery group must be familiar with that agreement and the midwifery scope of practice.

**Testing Measures**

Two of the three cases (4.6%) involved inadequate follow-up of laboratory testing measures. Not informing women of test result status, assuming a test was performed, and then assuming that the result was negative were problematic issues in this category. One case involved a delay in follow-up of fetal testing measures and then a delay in following through to cesarean delivery.

**Laceration Repair and Healing**

All three cases (4.6%) in this category were managed well by midwives, and all cases were either dropped or resulted in verdicts for the defense. In the first case, which involved rectal laceration with resulting incontinence, the plaintiff questioned the type of sutures used by the consultant for the repair. The second case involved delivery by a midwife and a second-degree laceration was sustained. This was repaired and there was dehiscence, which healed by secondary intention. The defendant had persistent dyspareunia, and the repair was eventually redone. The last case involved a rectovaginal fistula and incontinence. The plaintiff alleged the midwife performed an improper delivery and that the woman never consented to delivery by a midwife. The favorable defendant outcomes of these claims were attributed to meticulous documentation, quick referral to a consultant, an agreed upon plan by both midwife and consultant, and an absence of significant long-term sequelae.

**DISCUSSION**

Of the total cases reviewed, 61.4% involved fetal assessment/FHR monitoring (33.8%) or shoulder dystocia (27.6%). These results support the findings of ProMutual’s retrospective study of obstetrician/gynecologist claims, which showed misinterpretation of FHR tracings and mismanagement of shoulder dystocia as two of the most prevalent malpractice categories. Likewise, the 1998 MMI Companies 12-year study of perinatal injuries in 263 US hospitals had similar findings. Managing nonreassuring FHR tracings, the ability to perform timely cesarean deliveries, and performing appropriate neonatal resuscitation were three of the five major categories in obstetric malpractice allegations.4,11

Limitations of this study include the fact that the sample represents only selected cases in 22 of 50 states in the United States. There is a bias by region that favors the Northeast because the large medical malpractice insurer...
that submitted cases for review represents cases predominately in the Northeast. In addition, more lawyers in the Northeast submitted cases to the jury verdict reporting service than those from other geographic regions in the United States. Many other insurance companies were reluctant to disclose cases, because most were not stratified by clinician. Plaintiff attorneys supplied most of the cases to the jury verdict reporting service.

On the basis of findings from this closed claims review, the following recommendations, proposed for consideration by the authors to limit liability exposure with fetal assessment and FHR monitoring interpretation, are noted in Table 2.16–18

Shoulder dystocia, the second most common reason for litigation, presents its own considerations. Attention needs to be focused on measures to recognize antepartum risk factors and to improve overall intrapartum performance when shoulder dystocia occurs. Risk management strategies for mitigating adverse consequences of shoulder dystocia are proposed in Table 3.19–22

Additional recommendations to limit liability as noted in this series of cases include the following:

- Eliminate delays in resuscitative efforts; a delay of 10 to 15 minutes while awaiting the resuscitative team can be too long. All equipment and personnel should be available and ready to perform resuscitation.
- Consider preeclampsia and its related sequelae in pregnant women after 20 weeks' gestation, especially women who complain of nausea, vomiting, and dizziness with borderline hypertension.
- Consider having consultants in hospital during VBAC attempts, especially if oxytocin is used for induction or augmentation. Midwives without immediate consultant availability may consider declining to manage labor for women who are attempting a VBAC and who require oxytocin augmentation. It is advisable to have a protocol that specifies the agreed upon time the consultant be present if a fetal bradycardia occurs when caring for a woman attempting a VBAC.23

### Table 2. Strategies to Limit Liability Exposure With Fetal Assessment and FHR Monitoring Interpretation

- Call consultant in a timely manner.
- Establish a mutually agreed upon set of criteria for consultation, specifically, consultant presence at the bedside and transfer of care.16
- Establish guidelines for assigning risk to specific FHR patterns and what management recommendations are agreed upon for variant patterns.16
- Consider decreasing oxytocin or turning it off and instituting intraterine resuscitative measures when a nonreassuring FHR tracing is noted. Documentation should include all intraterine resuscitation measures.17
- Consider regular meetings with consultants for the purpose of improving communication in patient encounters that require collaborative practice.
- Know how to access the chain of command/communication at individual institutions and settings.18
- Monitor the fetal heart rate in second-stage labor frequently (meet fetal assessment standards for second-stage labor.13)
- Establish agreed upon time frames for consultant response.16

### Table 3. Strategies for Mitigating the Adverse Consequences of Shoulder Dystocia

- Consider ultrasound for women near term who appear to have large fetuses, size greater than dates, history of macrosomic infants, or prior shoulder dystocia. If ultrasound findings indicate the fetus is macrosomic, refer to a physician with surgical skills for discussion of possible elective cesarean delivery. The American College of Obstetricians and Gynecologists addresses managing infants with an estimated fetal weight of 4500 g for diabetics and 5000 g for nondiabetics and states that cesarean birth will be offered.19 ACOG also recommends that with an estimated fetal weight > 4500 g and a prolonged second stage of labor or arrest of descent in second stage, a cesarean delivery is indicated.19 ACOG also recommends counseling when a history of previous shoulder dystocia has occurred.20
- Consider discussing potential shoulder dystocia with the woman if it appears an appropriate precaution.
- Arrange for a consultant to be quickly available or on-site if shoulder dystocia is anticipated.
- Alert the resuscitative team and have them in hospital. Homebirth practitioners must have a viable backup plan that can be implemented in a timely fashion. Hospitals have corporate liability and need to address neonatal resuscitation as a priority response.
- Do not place a vacuum extractor on a potentially large infant after a prolonged second stage. A vacuum extractor can allow for an increased capacity to deliver larger infants. Shoulder dystocia could potentially ensue.21
- Eliminate use of excessive traction.
- Eliminate use of fundal pressure.17
- Use the term “gentle pressure” for documentation.
- Document thoroughly all maneuvers performed and the time interval that occurred between each maneuver.22 Ensure that the nurse-midwife, obstetric consultant, pediatrician, and nursing staff do not document conflicting accounts.

### CONCLUSION

Closed case review is a useful mechanism from which to garner information that can be used proactively to address clinical midwifery practice and liability concerns. Midwives have fewer claims than obstetricians, yet no profession is claims-free. Reviewing what others have done correctly in the past and what can be done to enhance performance in the future is key to improving both clinical performance and patient safety. Midwives are held both to the applicable standard of care of a reasonably prudent midwife and to obstetric standards of care that have evidence-based proof. Familiarity with and adherence to these standards, either through the American College of Nurse-Midwives or through the American College of Obstetricians and Gynecologists, are basic to minimizing liability risks in clinical midwifery.

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Personal Protection: Vicarious Liability as Applied to the Various Business Structures
Brian Winrow, JD, MBA, and Amanda R. Winrow, SNM, BSN

Within the field of midwifery, the issue of vicarious liability has become an emerging issue. The doctrine of respondeat superior imputes liability to an employer without direct negligence. While the issue of vicarious liability has been explored in the past, those studies were focused on the vicarious liability of certified nurse-midwives/certified midwives (CNMs/CMs) for the negligence of their employees. This article explores the issue of vicarious liability under the doctrine of respondeat superior as applied within a practice consisting of two or more co-owners. This issue is of heightened importance, because CNMs/CMs increasingly enter into ventures with other CNMs/CMs in order to pool their resources. Many CNMs/CMs unsuspectingly assume the risks for the malpractice of their colleagues. This increased risk can be minimized by forming their practice as a limited liability entity, thus avoiding personal liability for the malpractice of their co-owner(s). J Midwifery Womens Health 2008;53:146–149 © 2008 by the American College of Nurse-Midwives.

keywords: certified nurse-midwife, limited liability, respondeat superior, vicarious liability

Two 60-year-old certified nurse-midwives (CNMs), Ann and Betty, have been actively practicing together for the past 20 years. During that time, both CNMs have invested their profits and anticipate retiring in the near future. Ann is involved in an adverse outcome. It is determined that she negligently performed her duties, and that this negligence was a contributing factor in the death of a newborn and her mother. In the subsequent lawsuit, the patient’s husband sues both Ann and the practice for malpractice, based upon the theory of respondeat superior. The jury finds in favor of the plaintiff and awards the plaintiff $1 million in damages. Ann and Betty had a combined insurance policy for $500,000 per claim. The question arises whether both are personally liable for the additional $500,000. If so, the plaintiff would be permitted to attach their individual savings to satisfy the judgment. The answer lies in a decision made by both CNMs about the form of organization they selected long before the malpractice occurred.

INTRODUCTION

The scenario above illustrates the issue of vicarious liability when operating a business in conjunction with another person. In today’s increasingly litigious society, midwives must take adequate precautions to avoid personal liability stemming from the alleged malpractice or malfeasance of their colleagues within the same practice. A recent article published in the Journal of Midwifery & Women’s Health described how midwives can incur personal liability based upon the theory of respondeat superior. This article builds upon that foundational framework and focuses on the issue of vicarious liability as it relates to liability for colleagues within the same practice. The basic concept of respondeat superior and how a midwife can incur personal liability for the malpractice of another midwife is described, and the various forms of entity and the protections each entity affords midwives are summarized.

RESPONDEAT SUPERIOR

The concept of respondeat superior is the attribution of responsibility to an employer (who is referred to as the “principal”) for the action of her employee (who is referred to as the “agent”). 2 Under this concept, the plaintiff imputes liability to the principal for the acts of the agent. 3 A principal is the party that permits a person to act on their behalf, while the agent is the person who has authority to act on behalf of the principal. 4 In its simplest form, the concept of respondeat superior refers to the employee/employer relationship. The employee serves as the agent while the employer serves as the principal. As long as the employee agent has authority to act on behalf of the employer principal, an agency relationship is created.

The purpose of respondeat superior is to provide recourse for an injured party by allowing the plaintiff to sue parties with sufficient resources to adequately redress the wrongdoing. 5 It is also used to prevent the employer from escaping liability by neglecting to adequately supervise subordinates, or to delegate work to avoid personal liability. 6 Moreover, it addresses the policy issues of encouraging sufficient training and providing adequate recourse for the injured patient's. 7

Once it is determined that an agency relationship exists, vicarious liability is the means by which personal liability is imputed to the principal. Vicarious liability entails liability without fault for the wrongful conduct of another party. 8 A tort is a civil wrongdoing, such as an...
act of malpractice, for which the law provides a remedy. An employer is vicariously liable for the torts of the employees that she directly supervises. When the employer is an organization as opposed to an individual, the issue is more complex. For example, when two or more midwives enter into a practice, it is possible for them to incur personal liability for the malpractice of their partner(s), even if they were uninvolved in the care of the injured patient. Whether or not this can occur depends on the form of business organization selected when the midwives started their practice.

**FICTITIOUS ENTITIES**

Some business structures, such as the corporation, are considered fictitious entities, meaning they have a separate existence from the actual owners. This concept permits the owners of a business to transfer their ownership interest to others without sacrificing the actual existence of the business. To illustrate, an investor in a corporation owns a share of stock, providing the investor with certain rights in the business. When the investor sells the stock, the corporation continues to exist. Because these forms of organization have a perpetual existence, they are granted certain constitutional rights, such as the right to purchase and sell property and to sue or be sued. Because these types of business structures are fictitious, the organization must hire employees, who serve as agents, to transact business on its behalf. As a result, the practice or corporation, acting in the capacity of the principal, is vicariously liable for the malpractice of its employees.

For purposes of illustration, consider the previous example of Ann and Betty. If they are working in conjunction with one another, with the intent to earn a profit, the practice will be vicariously liable for Ann’s malpractice, assuming that Ann had authority to act on behalf of the practice. In addition, Ann would be liable for her own malpractice. The extent of Betty’s liability is determined by the actual business structure under which they are operating.

**General Partnership**

The general partnership is the most rudimentary form of organization involving two or more individuals, and is defined as two or more people working together to make a profit. While each state reserves the right to regulate general partnerships, most have adopted the Revised Uniform Partnership Act (RUPA), which is the uniform act for the governance of business partnerships amongst the states. The RUPA provides a list of factors that are used to determine whether a partnership exists. As a general rule, a partnership is established if two or more co-owners share the profits from the practice. The owners of the partnership are referred to as partners. According to the RUPA, the partnership is considered to be a separate entity from the partners, making the partners agents of the partnership.

One of the disadvantages associated with the general partnership is that it does not possess the attribute of limited liability. According to the RUPA, the partners are jointly and severally liable for all the debts of the partnership. The concept of joint and several liability means that each partner is individually and collectively liable for all the debts of the partnership. To illustrate, assume that Ann commits an act of malpractice. The injured party will be able to directly sue Ann for malpractice, and can sue the partnership under the concept of vicarious liability. The issue of vicarious liability will only extend to the partnership, because the partnership, not the partners, serves as the principal in the agency relationship. In a general partnership, however, Betty is jointly and severally liable for all the debts of the partnership. If the partnership has $500,000 worth of assets, Ann and Betty will both be liable for the remaining $500,000. In order to satisfy the debt, the injured party can attach the personal assets of both Ann and Betty up to the collective amount of the remaining $500,000.

While the peril of unlimited liability is a significant disadvantage, there are advantages to forming a general partnership. First, the ease of formation associated with the general partnership is an attractive attribute. Midwives are not required to formally file any documents to create the partnership. If two or more people engage in the venture to make a profit without selecting an organizational entity, the general partnership serves as the default. While it is advisable to create a partnership agreement detailing the rights and responsibilities of the partners, it is not mandatory, as the RUPA would serve as the rules governing the internal operations of the practice. In addition, while some business structures are required to hold annual meetings and maintain minutes from those meetings, the partnership is immune from such stringent requirements, permitting the partners to focus on their practice as opposed to rigid formalities.

Another advantage is the method of taxation associated with the partnership. When midwives enter into a partnership, they are taxed at their individual tax rate, circumventing any corporate or business income tax. This favorable treatment is known as flow-through taxation, as the profits flow from the practice directly to the partners. In contrast, some business structures, such as the corporation, pay income tax on the profits earned.

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second level of tax is then imposed on the owners when dividends are distributed to them.

**Limited Liability Partnership**

The second feasible form of entity available to midwives is the limited liability partnership (LLP). The LLP possesses a combination of general partnership and corporate attributes. In some states, the LLP is reserved for professional organizations, with the qualified professions enumerated within the state statute. The LLP is analogous to the partnership in that it receives the favorable flow-through taxation.

The LLP is distinguished from the general partnership because it possesses the favorable limited liability attribute traditionally found within the corporate form of organization. Limited liability is a concept whereby the owner’s scope of financial responsibility is limited to the amount invested in the practice. The limited liability protection does not, however, protect the personal assets of a negligent midwife. In returning to the case above, Ann is still directly and personally liable for her own malpractice. In addition, the LLP is vicariously liable based upon the concept of respondeat superior. As a result, all of the assets within the LLP can be attached by the injured party. Betty’s personal assets, however, are protected from the injured party. The limited liability protection protects her personal assets from being used to satisfy the remaining $500,000.

**Limited Liability Company**

In many states, the third viable form of entity available to midwives is the limited liability company (LLC). The owners of the LLC are referred to as members. The LLC is a hybrid form of organization, combining partnership and corporate characteristics. One of the corporate attributes is the LLC’s classification as an entity separate from its owners. The LLC is a creature of statute. It is a legal entity and possesses many of the same rights and privileges enjoyed by a US citizen. A LLC has the ability to own property, sue or be sued, and is entitled to due process under the Fourteenth Amendment.

The LLC affords its members the same liability protection the LLP affords to its partners. As a result, the liability consequences mirror those of the LLP. In addition to limited liability, the members of the LLC are permitted to elect the method of taxation. If midwives want to avoid double taxation, they have the option of being taxed as a partnership, enjoying the attribute of flow-through taxation. If, however, midwives anticipate retaining earnings, they can elect to be taxed as a corporation. When a business retains earnings, it keeps the earning within the practice as opposed to distributing the profits to the members. This allows the organization to reinvest the profits and to expand the practice.

**Corporation/Professional Corporation**

The final form of entity available to a midwife is the corporation. The corporation offers the same limited liability attribute previously discussed with the LLC, because the corporation is similarly considered a separate entity from the shareholders. This permits midwives the ability to work collectively, while protecting their personal assets against the malpractice of another shareholder.

When forming a corporation, a midwife can select either an S corporation or a C corporation. The distinction between the two types of corporations relates only to the method of taxation. The C corporation is subjected to double taxation. The corporation incurs income tax on the profits earned from the operations. If the corporation distributes the profits to the shareholders, the shareholders incur tax liability on the distributions, resulting in the second level of taxation. In contrast, the S corporation is taxed similarly to the partnership. The earnings from the S corporation flow through the organization directly to the shareholders, thus avoiding the corporate level of tax. In order to qualify for the S corporation election, the practice may not contain more than 100 shareholders, and must comply with additional restrictions regarding who may own an S corporation.

The corporation has its limitations in that midwives must comply with rigid formalities. The corporation must draft bylaws, hold annual shareholder and board of director meetings, and maintain minutes from those meetings. These requirements can be burdensome and time-consuming. However, the failure to comply with the formalities can contribute to the forfeiture of the limited liability protection in a lawsuit. When a court disregards the limited liability protection and imposes personal liability to the shareholders, it is commonly referred to as “piercing the corporate veil.” When this occurs, the coveted protection is disregarded, exposing midwives to personal liability for those debts.

**CONCLUSION**

Vicarious liability can be an impediment for a midwife. It extends the scope of malpractice to include not only the negligence of a midwife but also the negligence of her colleagues if she is practicing in a general partnership. This result can impute negligence to an innocent party who has never attended to the injured party, merely by serving as a partner within the general partnership. Seeking the protection of a limited liability entity can
minimize this risk. While a midwife still risks the assets within her practice, she preserves her own personal wealth.

As for Ann and Betty, there is a high probability that they would lose a significant portion of their personal assets, because they formed the practice 20 years ago. Traditionally, the business structures available to practitioners were limited to either a general partnership or a corporation. Because of the formalities associated with the corporation, it would be likely that the midwives formed a general partnership, thus exposing their personal assets to satisfy the judgment against the partnership. However, as described above, a significant trend has emerged whereby a midwife can capitalize upon the flexibility of the partnership with the corporate attribute of limited liability. Moreover, a midwife is permitted to reorganize their current business structure to take advantage of the newer hybrid forms of organization.

The respective business structures possess unique characteristics and filing requirements exceeding the scope of this article. Moreover, the forms of organization available to midwives, and the requirements of those entities, vary from state to state. It is strongly recommended that midwives consult with an experienced business law attorney before selecting a business structure, or to determine whether the current business structure should be reorganized.

REFERENCES
10. Uniform Partnership Act §306 (c) (NCCUSL 1997).
Today’s litigious society and the fact that adverse outcomes are an inevitable and unfortunate component of healthcare demand midwives adequately protect themselves against liability claims. As further proof, results of a recent survey revealed that one-third of ACNM members reported being named in a claim. Midwives must be knowledgeable of the types of insurance policies that can safeguard their assets and partake in the right plan to provide maximum coverage to avoid severe financial loss. This resource packet will help by covering topics such as:

- Sources of professional liability coverage
- Types of insurance policies
- Advantages and disadvantages of different types of policies
- Limits of professional liability

Although insurance provides protection, it doesn’t prevent claims from being made against you. It’s helpful to know what to expect and do if you’re named in a lawsuit. Once again, this resource will help with coverage on topics such as disclosure, communication tips, and information and strategies for dealing with the litigation process.

A glossary and four previously published Journal articles on liability and medical malpractice cases are also included for your benefit to round out this collection. It’s all here for you, and, it’s free for ACNM members!