Malpractice Insurance: Who Needs It?

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This issue of Pediatric Annals is devoted to gender-nonconforming youth and is guest edited by Robert Garofalo, MD, MPH, a true expert in this increasingly important field for the general pediatrician. Practical reviews of topics in this field are not easily identified, and the reviews included here will be valuable resources when we encounter children with these complex medical issues.

CAUTIONARY TALE ABOUT MALPRACTICE COVERAGE

If you believe that you generally provide excellent care and have never been sued for malpractice, have you wondered if you really need malpractice coverage? Here is a cautionary tale.

I recently became aware of a patient encounter for which a board-certified pediatrician was sued for allegedly not complying with the standard of care. An 18-month-old child was seen in January with complaints of fever, nausea, vomiting, a blanching pink rash, cough, and rhinorrhea. The child was in daycare and had not been vaccinated against influenza. The patient was moderately febrile (close to 102°F), breathing comfortably and not rapidly or with retractions, and positive examination findings were limited to mild rhinorrhea, faint rash, and slight pharyngeal erythema. After a flu test came back as negative, the child was discharged home with instructions for acetaminophen and to return if symptoms worsened. The diagnosis was a viral syndrome.

Approximately 1.5 days later, the child awoke with a purpura fulminans rash, gasping respirations, and could not be resuscitated during and after transport to a nearby children’s hospital. Autopsy showed overwhelming group A streptococcal sepsis and hemorrhagic adrenals (as seen in meningococcemia), without a specific anatomic focus of infection, such as pneumonia. The pediatrician was sued for failing to suspect a serious bacterial illness and failing to perform additional lab tests. This case recently went to trial, and after 2 weeks of testimony and deliberation, the jury in a split decision concluded that the pediatrician had in fact complied with the standard of care.

I believe this was a just and proper outcome, as the child’s symptoms were classic for a viral illness, and the exam did not reveal worrisome features. Of course, a primary care pediatrician is likely to see numerous similar patients weekly during the winter months. Tragically for this child, an essentially undiagnosable fulminant group A streptococcal infection supervened, an exceptionally rare occurrence.

The defense of a case like this is not always so successful, but it is always very expensive, requiring many defense attorney hours of work, and a number of expert witnesses. This is particularly why we need malpractice insurance, to cover the expense required to defend competent practitioners when a negative outcome occurs, even if the medical care was excellent and the outcome completely unanticipated and unpredictable. In our litigious society, a negative outcome very often leads to allegations of malpractice, sometimes supported by expert witnesses who testify outside their true area of expertise and who, for example, do not themselves treat children.

In the United Kingdom there is more of a tradition that the court, rather than each party involved, appoints an expert witness, or that experts hired by each party write a joint report for the court outlining areas of agreement and disagreement. In the U.S. system, each side hires experts who often present very different opinions that can confuse a jury of lay persons.

In any case, do not let your insurance coverage lapse, no matter how competent and thorough you believe you are! In addition, do not use words such as “lethargy” in clinical notes when you...
really are describing a listless but not truly lethargic (impaired consciousness) child. “Lethargy” to lay persons like most parents generally means tired, listless, or lassitudinous but does not really connote neurologically abnormal behavior, as it does in medical jargon.

**THIS MONTH’S STAMPS**

The three stamps accompanying this column are highly varied. The 4¢ U.S. stamp was issued in 1959 to honor Dr. Ephraim McDowell (1771-1830) on the 150th anniversary of a remarkable operation. The young McDowell was apprenticed in Virginia to a graduate of the University of Edinburgh, and then he attended lectures in Edinburgh before setting up surgical practice in Danville, Kentucky. In 1809, without anesthesia, antisepsis, or (of course) antibiotics, he removed a 10-kg ovarian tumor in a 25-minute operation. The patient, who had insisted on surgery despite the risks, lived for 32 years after this unprecedented abdominal surgery. In 1817, McDowell published a report of his by then three successful such cases. His home, office, and apothecary shop (all part of a National Historic Landmark) can be visited today in Danville.

The multicolored 2013 stamp from Vatican City celebrates the 60th annual World Leprosy Day and the 110th birthday of Raoul Follereau (1903-1977). This French writer, journalist, and lawyer first encountered leprosy patients in 1935 and was so impressed by their ill health, poverty, and ostracism that he became a global spokesman and advocate for them. He is shown on this stamp meeting with a group of patients. Follereau established a large number of foundations to aid leprosy patients, and many of those are still active. Leprosy continues to be a threat in a number of countries, especially India, Brazil, and Myanmar, and approximately 200,000 new cases occur globally each year.

The 2010 stamp from Burkino Faso (formerly Upper Volta) in French West Africa highlights the fight against malaria, specifically the use of bed nets. Shown here are a mother and child under a bed net with dead mosquitoes scattered on the floor. In Burkino Faso, 40,000 children die from malaria annually, and a national bed net distribution program was launched in 2010, funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria. The most effective kind of net is the long-lasting insecticidal net (LLIN), which is impregnated with deltamethrin or similar insecticide to repel, disable, or kill mosquitoes for up to 4 years. Child mortality in those younger than age 5 years has been reduced by 20% by use of the LLINs, with up to 50% lower mortality in pregnant women. In Africa, a child dies of malaria an average of one per minute, day and night.