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Do the Claims Hold Up? A Study of Medical Negligence Claims Against Neurologists

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We performed an in-depth review of each of the 42 closed medical malpractice claims filed in the past 20 years against neurologist defendants covered by a common insurer. For each case, we determined whether the neurologist had rendered harmful, substandard care and noted the case outcome. In 23 of 42 claims (55 percent), there had been no harmful negligence, and payment on behalf of the neurologist occurred only once. The other 19 claims had negligent harm, but in 13 of them (68 percent) no payment was made on behalf of the negligent neurologist. In our series, the medical negligence system performed poorly, yielding a majority of inappropriate claims and no payment in a majority of appropriate claims.

Several studies have investigated whether medical negligence claims yield merited outcomes.[1–9] We sought to expand this body of knowledge by studying a series of claims against neurologists.

I. Methods

The data for the current study are identical to the data used in a previous report,[10] but the data are analyzed differently here. The previous report, emphasizing patient safety, assessed whether the neurologist committed

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harmful, preventable errors. This report, applying the standard of tort law, assesses whether the neurologist committed harmful, negligent errors.[1]

The data are drawn from all 42 closed claims (resolved by withdrawal, dismissal, settlement, or judgment) since 1986 that involved at least one staff or resident neurologist defendant covered by Controlled Risk Insurance Company (CRICO), the sole malpractice insurer for all Harvard-affiliated medical institutions and their staff, and its patient-safety and risk-management arm The Risk Management Foundation of the Harvard Medical Institutions (RMF).

Two of us who are neurologists (L.D.C., T.H.G.) reviewed the entire case files—including medical records, expert reports, and legal documents. For each case, the two of us agreed whether or not there had been substandard neurologic care that caused significant patient harm. We used the legal definition of substandard care—that is, care below the standard that would be expected of any neurologist under similar circumstances. (We made no formal assessment of the quality of care rendered by non-neurologist defendants.) We then looked at the outcome of the claims to see if payments were matched to harmful, substandard care.

Since it was only the neurologist's care that was being evaluated, we tabulated only whether payments were made on behalf of the neurologist defendants. In a case with co-defendants from other specialties, if payments to the plaintiff were made on behalf of the other specialist(s) but no payment was made on behalf of the neurologist defendant, the case was counted as a no-payment case. Conversely, if any fraction of the payment to the plaintiff was made on behalf of the neurologist defendant, the case was tallied as a payment case.

II. Results

Of the 42 claims, four were formal requests for compensation that did not evolve into lawsuits. The remaining 38 claims started as or became lawsuits. The non-lawsuit cases were comparable in character and outcome to the lawsuit cases.[2]

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[1]Also, upon further reflection by us, one case we had previously reported as having no significant patient harm has been reclassified and is reported here as having significant patient harm.

[2]No payment was made on behalf of the neurologist defendants in any of the four non-lawsuit cases. Of the three cases that were withdrawn by the plaintiff, the neurologist defendant met the

Table 1: Care Received from the Neurologist Defendant(s) Versus Outcome

	Payment N *(%)*	*No Payment* N *(%)*	*Totals* N *(%)*
Harmful substandard care	6 (32%)	13 (68%)	19 (100%)
No harmful substandard care	1 (4%)	22 (96%)	23 (100%)
Totals	7	35	42

NOTE: $p = 0.034$ (two-tailed Fisher's exact test).

Payments on behalf of neurologist defendants in seven cases (Table 1) ranged from low (less than $100,000) to high (more than $500,000). All payments occurred as part of a settlement agreement between the plaintiff and the defendant's insurer. No payment occurred as a result of a trial verdict, as all trial verdicts were in the defendants' favor. In the 35 cases without payment on behalf of a neurologist defendant, five received money from settlement with non-neurologist defendants, at which point the claim against the neurologist was dropped. The remaining 30 cases received no payment on behalf of any defendant and were comprised of 18 withdrawn by the plaintiff, nine with a jury verdict in favor of the defendant, two dismissed by a judge before trial, and one with a binding arbitration decision in favor of the defendant. Of the 18 withdrawn cases, harmful substandard care was present in five.

Nineteen cases had harmful substandard care by a neurologist and 23 did not. Of these 23, the patient suffered no harm in 10, harm because of the illness in four, harm because of unavoidable iatrogenic injury in three, and harmful error in six that might have been obviated by more proactive, dogged, and team-oriented care by the neurologist, whose care, nonetheless, was not substandard. In most of these six cases, the cardinal error had been made by a non-neurologist, as exemplified by Case 1.

Case 1. *While he was in the hospital under the care of an endocrinologist, a 65-year-old diabetes patient fell and may have struck his head. The patient appeared to recover quickly and seemed fine to the endocrinologist. The endocrinologist spoke on the phone with a neurologist, who reportedly said that no brain imaging (such as CT or MRI) was necessary unless the patient developed new symptoms or signs. The neurologist did not offer to see the patient, nor was he asked to. The patient was discharged from the hospital the next day, but*

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standard of care in two but not in one. In the fourth case, the neurologist defendants had not met the standard of care, but the claim against them was dropped after settlement with non-neurologist defendants.

two days later he became comatose. He was then admitted to a different hospital, where a large intracranial hemorrhage (subdural hematoma) was discovered. Despite surgery to remove the hematoma, the patient died.

Of the 19 cases with harmful substandard care, payment was made in six. These six cases included some with highly regrettable outcomes due to definite errors.

Case 2. *A 22-year-old woman developed sudden left-sided weakness and numbness that resolved after a matter of hours. A neurology resident in the emergency room did not consider the correct diagnosis of transient ischemic attack (a short-lived focal neurological deficit that is often a warning for an impending stroke) nor did the resident consult with a supervising neurologist. The patient was sent home. Three days later, the patient had a major stroke, and she was left with inability to use her left arm, a weak left leg, blindness in the left field of vision, cognitive deficits, a need to rely on others for routine daily activities, and prominent self-consciousness about her disfigurement. In her case, the stroke probably could have been prevented with proper treatment. The case was settled in the high range.*

Case 3. *A 26-year-old man had new-onset epileptic seizures. A head CT scan revealed a brain abnormality that the radiologist tentatively attributed to a brain tumor, and the radiologist advised obtaining an MRI. However, even though the patient then saw the neurologist five times over the course of nine months, no further imaging study of any sort was performed. By the time such study was performed, it revealed a malignant brain tumor that was much larger than it had been originally. At surgery it was impossible to remove all of the tumor. The case was settled in the high range.*

Of the 19 cases with harmful, substandard care, 13 (over two-thirds) did not result in payment even though many of them also had highly regrettable outcomes.

Case 4. *A 32-year-old woman was referred for neurology consultation when she developed leg numbness the day after hysterectomy surgery. A neurology resident documented that the patient had a number of signs (warm, tender, swollen leg; a positive "stretch sign") pointing to swelling in a muscular compartment of the leg, a condition requiring emergency surgery to prevent leg damage. However, the senior consulting neurologist ignored the resident's findings, gave an alternate diagnosis that proved to be erroneous, recommended no treatment, and failed to follow up on the patient in the ensuing three days—by which time the patient had permanent nerve damage and permanent loss of function in the leg. The plaintiff lost at trial.*

Case 5. *An 18-year-old man hit his head and perhaps suffered a concussion while playing rugby, and he then had headaches that persisted for weeks. He was seen by a neurologist, who did not order any imaging study, such as a head CT scan. However, the neurologist did recommend a follow-up appointment, which the patient did not keep. When a head CT scan was obtained about a week later by a different physician, a very large and life-threatening subdural hematoma was present. Surgery removed the hematoma, but because of its large size at that point, some brain damage was incurred. The patient was left with neurologic deficits, including a seizure disorder. The case was withdrawn before trial.*

Table 2: Medical Negligence Claims: Quality of Care Rendered and Outcome

	Brennan et al.[1]	*Taragin et al.*[2]	*Cheney et al.*[3]	*Farber et al.,*[4] *White*[5]	*Cranberg et al.*
Percentage of Claims with					
Negligence	20	25	47	35	45
Unclear		13	13	23	
No negligence	80	62	40	42	55
Percentage of Claims Resulting in Payment, by Claim Type					
Claims with					
Negligence	56	91	89[a]	66	32
Unclear		59		45	
No negligence	44	21	47[a]	16	4
Number of Claims	46	8,231	1,004	748	42

[a]Calculated by omitting cases for which the payment outcome was unknown.

SOURCE: Adapted from White.[5]

Patients given adequate care almost never received payment. Of the 23 patients whose neurologic care met the standard, only one received payment. Payments were made almost exclusively (six of seven payments) in cases of negligent harm.[3] This finding was statistically significant ($p = 0.034$).

III. DISCUSSION

Our study joins several others that have investigated the merits and outcomes of medical malpractice claims.[1–9] Table 2 summarizes those studies that have evaluated claims according to whether patient harm had been due to the tort requirement of negligence. Studies of malpractice claims evaluated by other criteria, such as whether the harmful care was "avoidable"[6] or

[3]The one case that resulted in payment on behalf of a non-negligent neurologist was that of a two-and-a-half-year-old child who was rendered blind after neurosurgeons failed to perform surgery to remove bilateral subdural hematomata that were causing increased intracranial pressure. The defendants were a pediatric neurology fellow and a staff neurosurgeon. The pediatric neurology fellow was rotating through the neurosurgery service at the time, was low man on the neurosurgical team, and did not have the authority to decide whether to operate. Since it was our judgment that he had abided by the standard of care for neurologists, we did not think payment should have been made on his behalf. However, in the ultimate settlement agreement, responsibility was ascribed at 20 percent for him and at 80 percent for the neurosurgeon. (As explained in Section I, we did not make a formal judgment about the quality of care rendered by the neurosurgeon.)

"defensible,"[7] or contained "error,"[8] are not included in the table. Also excluded from the table is one study[9] with insufficient numerical data.

Like Cheney et al.[3] and the study by Farber and White,[4,5] and unlike the other studies in Table 2, our assessment of whether a physician's care had been substandard was made by physicians whose specialty was the same as that of the defendant. We did not necessarily adopt the insurer's assessment of whether negligence was present but instead made our independent assessment after a review of records, including the neurologist expert witness reports for both the plaintiff and defendant.

Our focus on neurologists was a limitation of our study. We did not judge the care rendered by non-neurologist defendants or tally payments on their behalf, whereas the other studies in Table 2 gauged the care and outcome for all defendants.[4]

Because the number of cases in our series is small and because all our cases are drawn from one insurer and one specialty, the generalizability of our findings is uncertain. Nonetheless, our key findings are in line with previous studies. A significant proportion of claims filed (55 percent in our study; a range of 40 to 80 percent in the other studies) were in cases without negligence. The evidence suggests that the explanation for this phenomenon has less to do with cunning plaintiffs or lawyers hoping for an undeserved windfall than it does with the paucity of information available to plaintiffs and their attorneys before filing a claim.[8,11] Often, it is only during the discovery process of a lawsuit, when records are received and expert opinions rendered, that plaintiffs can learn the full story of what happened to them and recognize that perhaps some or all of the defendants named in a claim had, in fact, abided by the standard of care.[8,11]

Whereas defendants were negligent or not in roughly equal numbers, payments were incurred almost exclusively by the negligent defendants. In our series, a plaintiff was eight times more likely to receive payment if the defendant had rendered substandard care than if the defendant had not (32 percent vs. 4 percent).[5] In fact, in our series there was only one case in which

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[4]One possible exception is Cheney et al.,[3] a study of claims against anesthesiologists. It is not clear from their report whether they assessed the care or outcome for non-anesthesiologist co-defendants.

[5]In our series, the proportion of cases resulting in payment—whether they be negligent cases (0.32) or non-negligent ones (0.04)—is lower than those of the other series displayed in Table 2. Part of the explanation is that our figures do not include payments on behalf of

payment was made for non-negligent care.[6] The other studies displayed in Table 2 show a similar pattern of negligent cases yielding payment (56–91 percent of such cases) more often than non-negligent ones (16–47 percent), indicative of a system with some ability to sift negligent cases meriting payment from non-negligent ones.

Unfortunately, the sifting has been far from perfect, resulting in two types of mismatches: payment for non-negligent cases and no payment for negligent ones. The former mismatch—arising in 4 to 47 percent of cases (see Table 2)—understandably worries physicians. Non-culpable defendants on whose behalf payment is made often feel unjustly "convicted" and "fined," and they incur undeserved grief, besmirched reputation, and possible personal financial loss.

The other mismatch (no payment despite negligent harm) is also unjust. The medical tort system failed to pay 13 of 19 (68 percent) deserving plaintiffs in our series[7] and from 9 to 44 percent of deserving plaintiffs in the other series in Table 2. Five of the 13 unpaid but deserving cases in our series were withdrawn before trial. We have the impression that the financial and psychic expenses and serial legal successes required to prevail in a several-year-long malpractice lawsuit were overwhelming for many of the plaintiffs and/or their attorneys.

This study and others based on claims data undoubtedly understate the inadequacy of the medical tort system to compensate deserving patients since claims data necessarily do not include the unknown number of aggrieved patients who did not file a claim.

Money can rarely truly compensate for a plaintiff's loss,[8] which may include death or life-changing disability, but lack of financial compensation for unnecessary, negligent injury can be doubly embittering to plaintiffs and

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non-neurologist defendants. Another reason may be that CRICO refuses to settle any defensible case.

[6]See note 3.

[7]In five cases, the claim against the neurologist was dropped after settlement with non-neurologist defendants. In three of them the neurologist had rendered substandard care, and in two of them the neurologist had abided by the standard of care. Even if the designation of all five of these cases is changed to deserving cases with payment, still about 50 percent of deserving cases would not have received any payment.

[8]For one family's experience, see Gilbert, S. M. ([1995] 1997) *Wrongful Death: A Memoir*. New York: W.W. Norton & Company.

their families. After having been let down by the health-care system, they are let down by the legal system as well.

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