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Preface

Risk Management in Neonatal-Perinatal Medicine

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Guest Editor

The Doctor's Dream

And thus I dreamt that round me stood
The victims of disease,
The patients I had failed to cure,
Though some had paid my fees.
One said, "It is a happy place,
My bliss is unalloyed;
Though your mistakes just ten years more
Of Heaven I have enjoyed." . . .
Another made this queer complaint;
"I'm prematurely sent;
The bungling doctors got me here
Before complete development." . . .
I got here shaky in my shoes,
And asked if they'd attack us,
And raise a rumpus in these courts,
With questions of malpractice.

—William Snowden Battles (1827–1895)

Risk management is defined by the Joint Commission on Accreditation of Health care Organizations as "clinical and administrative activities that [health care organizations] undertake to identify, evaluate, and reduce the risk of injury and loss to patients, personnel, visitors, and [the organization] itself." Risk manage-

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ment includes clinical, administrative, and legal strategies and tactics. These actions are both proactive in risk prevention and reactive in response to adverse events.

This issue of the *Clinics in Perinatology* reviews techniques of clinical risk reduction in neonatal–perinatal medicine. Many of our authors emphasize the importance of good doctor–patient communication as a means toward risk reduction. Specific clinical recommendations are offered to lessen the risks of birth asphyxia, traumatic birth injuries, medication errors, resuscitation pitfalls, intravascular catheter complications, and kernicterus. If even one reader adapts only one of our recommendations and prevents a single adverse outcome, this issue will have been a success.

Despite our best efforts, some adverse events and adverse clinical outcomes will occur. In theory there are many opportunities to review the quality of clinical care provided in these cases. State boards of medicine, health care insurers, hospital credentialing systems, and hospital quality assurance reviewers all have the opportunity to monitor a practitioner's patterns of care and evaluate cases with adverse outcomes. Yet it is unusual for these systems to impose any punitive action against a practitioner—even those with a disproportionate number of adverse outcomes and a history of repeated acts of negligence. Additionally, even if these systems were to reprimand an individual health care provider for an act of negligence, they do not compensate the injured patient. Therefore, the medical malpractice legal system remains the primary method of evaluating the quality of care of an individual case and to compensate injured patients if the injury was caused by an act of negligence.

This issue of the *Clinics in Perinatology* explores the medical malpractice system – how the system works, the problems inherent in the system today, and opportunities for improvement. The use of evidence-based expert testimony, caps on damages, state-sponsored reinsurance funds, and the use of alternative dispute resolution services are just a few of the options offered for readers' consideration. The medical malpractice system will remain a part of our profession—clinicians will benefit by learning how the system currently works and by becoming involved in efforts to improve its effectiveness. Again, if this issue contributes to any improvement—however slight—in the medical malpractice system, this effort will have been a success.

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