

# PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

## **Medical Diagnoses Commonly Associated With Pediatric Malpractice Lawsuits in the United States**

Gary N. McAbee, Steven M. Donn, Robert A. Mendelson, William M. McDonnell,  
Jose L. Gonzalez and Julie Kersten Ake

*Pediatrics* 2008;122:e1282-e1286

DOI: 10.1542/peds.2008-1594

The online version of this article, along with updated information and services, is  
located on the World Wide Web at:

<http://www.pediatrics.org/cgi/content/full/122/6/e1282>

PEDIATRICS is the official journal of the American Academy of Pediatrics. A monthly publication, it has been published continuously since 1948. PEDIATRICS is owned, published, and trademarked by the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove Village, Illinois, 60007. Copyright © 2008 by the American Academy of Pediatrics. All rights reserved. Print ISSN: 0031-4005. Online ISSN: 1098-4275.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



# Medical Diagnoses Commonly Associated With Pediatric Malpractice Lawsuits in the United States

Gary N. McAbee, DO, JD<sup>a</sup>, Steven M. Donn, MD<sup>b</sup>, Robert A. Mendelson, MD<sup>c</sup>, William M. McDonnell, MD, JD<sup>d</sup>, Jose L. Gonzalez, MD, JD<sup>e</sup>, Julie Kersten Ake, BA<sup>f</sup>

<sup>a</sup>Division of Child Neurology, Department of Pediatrics, Robert Wood Johnson School of Medicine, Camden, New Jersey; <sup>b</sup>Division of Neonatal-Perinatal Medicine, Department of Pediatrics, University of Michigan Health System, Ann Arbor, Michigan; <sup>c</sup>Private Pediatric Practice, Portland, Oregon; <sup>d</sup>Division of Pediatric Emergency Medicine, Department of Pediatrics, University of Utah School of Medicine, Salt Lake City, Utah; <sup>e</sup>Divisions of Pediatric Endocrinology and Medical Education, Department of Pediatrics, University of Texas Medical Branch at Galveston, Galveston, Texas; <sup>f</sup>Division of Health Care Finance and Quality Improvement, American Academy of Pediatrics, Elk Grove Village, Illinois

The authors have indicated they have no financial relationships relevant to this article to disclose.

*Medicine is a calling. Medicine is a profession. Medicine is a business. People in business get sued.*

Gary N. McAbee, DO, JD

## ABSTRACT

In this article we discuss the medical diagnoses underlying the most common lawsuits involving pediatricians in the United States. Where applicable, specific and general risk-management techniques are noted as a means of increasing patient safety and reducing the risk of medical malpractice exposure. *Pediatrics* 2008;122:e1282–e1286

**M**EDICAL MALPRACTICE LITIGATION continues to be at a crisis level in 17 states.<sup>1</sup> This level has declined from a peak of 22 states designated to be in crisis by the American Medical Association and, in part, represents the effort of tort reform in some regions of the country. There must be continual efforts to find ways to reduce pediatricians' risks of medical malpractice litigation. Since 1989 the American Academy of Pediatrics Annual Survey of Fellows has consistently found that nearly one third of all pediatricians will be sued during their careers.<sup>2</sup> Pediatricians have a unique exposure to liability issues because of the severity of the indemnities paid in settlements and jury awards.

Two recent publications in *Pediatrics* addressed the malpractice situation as it relates to pediatricians. Kain and Caldwell-Andrews<sup>3</sup> reviewed data from the National Practitioner Data Bank and noted significant variability within the United States regarding the incidence of malpractice payments and the median payment amount. Carroll and Buddenbaum<sup>4</sup> reviewed data from the Physician Insurers Association of America (PIAA), a trade association of medical malpractice insurance companies in the United States. Their review noted, in part, that although only 28% of lawsuits resulted in an indemnity, the cost of defending these suits was alarmingly high: mean defense costs were \$28 779 for cases in which no indemnity was paid and \$67 502 for paid claims. Pediatricians was the fourth highest among 28 specialties in terms of mean defense expenses.

The specific medical diagnoses that underlie the most common lawsuits involving pediatricians have not yet been systematically analyzed. This is important to practitioners, because the law is based on precedent and successful legal claims may encourage similar claims in the future. Thus, if an attorney is aware that a drug-induced adverse effect resulted in a large monetary settlement or verdict, it is likely that a lawsuit will be filed on behalf of a future client who presents with the same drug-induced adverse effect. If pediatricians are knowledgeable about the medical conditions that have produced successful malpractice suits, they can institute risk-management techniques that can be effective for both improving patient safety and reducing risk of liability. An excellent example of this is the American Society of Anesthesiologists (ASA). More than 20 years ago the ASA created its closed claims-analysis project. By instituting risk-management techniques to improve patient safety, anesthesiologists decreased their liability risk as a group from one of the most frequently sued specialties to a current rank of 20th of the 28 medical specialties listed.<sup>5</sup>

In this article we analyze data from the data-sharing project of the PIAA from the years 1985–2006.<sup>6</sup> The medical conditions commonly associated with lawsuits against pediatricians were identified (see Table 1). The focus of this analysis relates to allegations of diagnostic errors, because this is the most common cause of action underlying the major medical misadventure in pediatric malpractice closed claims (see Table 2).<sup>4</sup> Some risk-management techniques

[www.pediatrics.org/cgi/doi/10.1542/peds.2008-1594](http://www.pediatrics.org/cgi/doi/10.1542/peds.2008-1594)

doi:10.1542/peds.2008-1594

The authors are members of the 2007–2008 American Academy of Pediatrics Committee on Medical Liability and Risk Management. The views expressed herein are those of the authors, and no official endorsement of the American Academy of Pediatrics is intended or inferred.

### Key Words

malpractice, pediatricians, medical diagnoses

### Abbreviations

PIAA—Physician Insurers Association of America  
DDH—developmental dysplasia of the hip  
CAP—community-acquired pneumonia

Accepted for publication Aug 11, 2008

Address correspondence to Gary N. McAbee, DO, JD, Children's Regional Hospital at Cooper University Hospital, Department of Pediatrics, 3 Cooper Plaza, Suite 309, Camden, NJ 08103. E-mail: [mcabee-gary@cooperhealth.edu](mailto:mcabee-gary@cooperhealth.edu)

PEDIATRICS (ISSN Numbers: Print, 0031-4005; Online, 1098-4275). Copyright © 2008 by the American Academy of Pediatrics

**TABLE 1 Most Prevalent Conditions Resulting in Malpractice Lawsuits (in Order of Frequency)**

Condition	Average Indemnity (for All Claims), \$
1. Brain-damaged infant	440 379
2. Meningitis	437 423
3. Routine infant or child health check	155 039
4. Respiratory problems in newborns	270 607
5. Appendicitis	116 285
6. Pneumonia	239 531
7. Specified nonteratogenic anomalies	186 708
8. Premature birth	250 031
9. Birth	286 407
10. Asthma	193 414

**TABLE 2 Most Prevalent Conditions in Pediatric Malpractice Claims Caused by Error in Diagnosis (1985–2006)**

Condition	Average Indemnity (for Diagnostic Errors), \$
1. Meningitis	433 464
2. Appendicitis	131 842
3. Specified nonteratogenic anomalies	197 707
4. Pneumonia	396 318
5. Brain-damaged infant	335 804

that may reduce the potential risk of misdiagnosis and liability risk associated with these conditions will be discussed. It should be noted that although an insurance database relating to medical malpractice may contain a wealth of claims data, it is also likely to be incomplete and even fragmented. Thus, analyzing every question related to clinical care and subsequent malpractice action may not be possible. Nevertheless, the information provided should be invaluable to the practitioner.

## MENINGITIS

Meningitis continues to be a major issue among pediatric malpractice allegations, resulting in one of the most expensive medical conditions in regard to average indemnity costs and average costs to defend. From a malpractice perspective, the PIAA Meningitis Claims Study noted that meningitis lawsuits are predominately a pediatric problem.<sup>7</sup> The median age of the patient with a meningitis claim was 2 years, indicating the large number of infants and toddlers involved. Sixty percent of claims involved patients <2 years of age. In 82.6% of meningitis claims that involved patient death, the patient was <1 year of age. The highest average indemnity (\$433 464) was paid on behalf of pediatricians who were the most frequently sued physician group for this diagnosis.<sup>6</sup> The high expense of these claims relates to the long life expectancy of a child with neurologic sequelae as well as the higher rate of mortality. Generally, any pediatric malpractice case that involves a death has both a higher incidence and amount of a payout. The most common cause of action in meningitis cases was delay in diagnosis. Relevant to the progression of symptoms is

**TABLE 3 Initial Diagnoses in Cases of Meningitis**

Condition	Percentage
Viral infection/influenza	35.6
Other	24.9
Meningitis	12.3
Ear infection	12.3
Gastroenteritis	4.1
Urinary tract infection	2.7
Postoperative infection	2.7
Migraine	2.7
Febrile seizure	2.7

**TABLE 4 Presenting Symptoms in Cases of Meningitis**

Symptom	Percentage
Fever	74
Nausea/vomiting	49
Lethargy	32
Headache	27
Influenza symptoms	25
Change in mental status	12
Poor appetite	11
Neck stiffness	10
Surgery	6
Photosensitivity	3

that the time between first examination and diagnosis was 3 to 24 hours in 43.8%; treatment was sought within 24 hours of symptom onset in 57.5%; and antibiotics were given within 24 hours of contact in 49.3% of the cases. The initial contact varied (office, 35.6%; emergency department, 30.1%; telephone, 17.8%; hospital, 9.6%; urgent care/home visit, 5.5%). The average payout was twice as high when initial contact was with a nurse (12.3% of claims). Also, payout for claims resulting from telephone-based care was one third higher than for those resulting from non-telephone-based care. Sixty percent of claims resulting from telephone-based care involved children <2 years of age. Initial diagnoses for meningitis cases are listed in Table 3, and presenting symptoms and their frequency are listed in Table 4. An important statistic for the practitioner is that 25% of children did not present with fever, and the majority of them lacked change in mental status, headache, lethargy, and neck stiffness. The absence of stiff neck is likely from the lack of meningeal signs associated with the younger age of these patients. Lumbar punctures were not performed in nearly 30% of cases resulting in claims, which probably reflects the lack of suspicion of meningitis, especially in infants and toddlers. Yet, of the claims regarding cases in which a spinal tap was not performed in a timely fashion, the average age of the patient was 7 years.

Because typical central nervous system signs and symptoms are frequently absent at presentation, risk management is challenging. There is no such thing as too high of an index of suspicion for meningitis, especially for infants and young toddlers during “flu” season. Because of the increased space that exists between the brain and the inner calvarium in an infant, a great deal of pathology can occur before the onset of neurologic

**TABLE 5 Misdiagnoses of Appendicitis**

Common	Gastroenteritis; upper respiratory illness; otitis; sinusitis; pelvic inflammatory disease
Less common	Pneumonia; sepsis; urinary tract infection; encephalitis/meningitis/encephalopathy; febrile seizure; blunt abdominal trauma

Adapted from Becker T, Kharbanda A, Bachur R. *Acad Emerg Med.* 2007;14(2):124–129 and Reynolds SL. *Pediatr Emerg Care.* 1993;9(1):1–3.

symptoms and signs. To assist with this high index of suspicion, use acceptable pediatric telephone triage and advice protocols when physicians are not providing telephone triage. Periodically, monitor triage and advise staff to ensure that they are adhering to your protocols and that documentation is adequate. Be sure that non-clinical staff is not providing clinical advice to parents. Be aware of “red flags” such as “a strange look” or “walking funny” or the development of progressive symptoms.

Twelve percent of the PIAA meningitis claims involved problems with the medical chart. These problems included failure to document standards of practice, failure to record pertinent negative findings relevant to the diagnosis, failure to record interactions with the patient, and failure to record referrals to other physicians. Alterations in the chart were also noted.

Communication issues were also cited as an associated problem that allegedly contributed to the delay in diagnosis because of poor communication between providers, failure to inform of critical test results, failure to provide the consultant with a complete account of medical findings to date, and failure to provide the patient with clear follow-up instructions.

### APPENDICITIS

From a medicolegal perspective, appendicitis presents a particularly difficult diagnostic problem, especially in young children. The perforation rate is inversely related to the age of the patient, making diagnosis in the younger patient critical.<sup>8</sup> Missed diagnoses have been reported in up to 27% of cases.<sup>9–12</sup> Atypical symptoms and signs are not uncommon and often underlie the misdiagnosis.<sup>9–12</sup> Atypical positive symptoms include diarrhea, vomiting before pain, upper respiratory symptoms, minimal right lower quadrant pain, and constipation. Atypical negative symptoms include lack of fever, absence of rebound or guarding, normal appetite, and normal (or increased) bowel sounds. Some patients are seen twice before the correct diagnosis is made.<sup>10,11</sup> Female adolescents are frequently misdiagnosed, with symptoms attributed to pelvic inflammatory disease or urinary tract infections.<sup>11</sup>

Common misdiagnoses are listed in Table 5. PIAA claims with failure to diagnose as the cause of action paid out 36.7% of the time for an average indemnity payment of \$131 842.<sup>6</sup>

### NONTERATOGENIC ANOMALIES/CONGENITAL ANOMALIES OF THE GENITAL ORGANS

Overall, the average indemnity payout for specified non-teratogenic anomalies was \$197 707. Claims for nonter-

**TABLE 6 Conditions Associated With Nonteratogenic Anomalies**

Condition	Median Indemnity, \$
Craniofacial	102 000
Spine (eg, spina bifida occulta)	80 000
Foot deformities	1000–300 000
Metatarsus varus/valgus/bowing/genu recurvatum	45 000–400 000

**TABLE 7 Conditions Associated With Genital Anomalies**

Condition	Median Indemnity, \$
Undescended/retractile testicle (60%)	95 000–250 000
Hypospadias/epispadias (20%)	63 000
Anomalies of uterus/other female organs	120 000

atogenic anomalies are usually a result of a failure to diagnose (>50% of claims) rather than failure to refer (3% of claims). Nevertheless, subspecialty referral may be indicated, because these conditions may be a component of an underlying genetic syndrome.

Developmental dysplasia of the hip (DDH) previously represented nearly three quarters of the claims in the PIAA database.<sup>6</sup> However, this frequency has been decreasing over the years, presumably because of better awareness of the condition with earlier and better diagnosis, particularly since the advent of ultrasound technology. DDH is an example of a condition for which identification of certain risk factors can translate into effective risk management. Risk factors for DDH are present in up to 25% of cases and may include female gender, breech presentation, cesarean section, oligohydramnios, family history of DDH, being firstborn, heredity (eg, Italian, Native American, Japanese), associated neuromuscular conditions such as torticollis and metatarsus adductus, and possibly swaddling.<sup>13,14</sup> However, absence of risk factors should not reassure a practitioner that DDH is not present.<sup>15</sup> The average indemnity paid for a misdiagnosis of unilateral and bilateral DDH was \$100 000 and \$200 000, respectively.<sup>6</sup>

Other common causes of action for nonteratogenic anomalies and congenital anomalies of the genital organs and median indemnity amounts are listed in Tables 6 and 7.

### PNEUMONIA

Compared with other diagnoses, fewer closed claims resulted in a payout for failure to diagnose pneumonia. Nevertheless, this diagnosis resulted in the second highest average indemnity paid out since 2001.<sup>6</sup> There are few specific data that permit specific recommendations for risk management for this condition. Pneumonia is typically divided into 2 clinical types: community-acquired pneumonia (CAP) and nosocomial pneumonia. Although there are several clinical guidelines for managing CAP in adults, guidelines for CAP in children have not been universally accepted. Thus, there are variations relating to diagnosis of children with this condition. The average indemnity for errors in diagnosis relating to pneumonia was \$396 318.

## BRAIN-DAMAGED INFANTS

Virtually any medical scenario in which an infant or child has sustained brain damage is highly likely to result in a lawsuit. These claims tend to relate to newborns. Examples include head injury from a fall after an abrupt vaginal delivery,<sup>16</sup> profound developmental delay from inadequate hydration of a dehydrated newborn,<sup>17</sup> and developmental delay and cerebral palsy secondary to failure to timely diagnose and treat hypoglycemia.<sup>18</sup> Typical reasons for initiating a lawsuit for a neonatal brain-injury claim have been reported to include concerns for a medical “cover-up,” the parents’ need for medical information about their infant, the need for financial support to help care for the infant over a lifetime for a child whose parents do not recognize a future, dissatisfaction about communication between physicians and parents, and desire for revenge.<sup>19</sup> In 70% of cases, the parent expressed dissatisfaction that caretakers did not warn him or her about the possibility of long-term neurodevelopmental problems.<sup>19</sup> The latter point suggests that parents do not like “surprises” when they are told later that their child is developmentally delayed because of events during the newborn period.

Average indemnity payments for a brain-damaged infant are among the highest for pediatric claims (average indemnity: \$440 379 [for all claims] and \$335 804 [for claims relating to diagnostic error]).

## MEDICATION ERRORS

Issues related to medication are relevant to all medical diagnoses and account for >5% of malpractice cases involving children.<sup>6</sup> A review of the PIAA data reveals valuable information about malpractice claims relating to medications.

In pediatrics, it is not surprising that allergy and respiratory medications, 2 of the more commonly prescribed classes of drugs, are frequently the basis for malpractice actions. The average indemnity paid for these classes of drugs was \$325 676 for asthma medications and \$180 140 for bronchitis medications. However, a third class of drugs commonly associated with malpractice claims involves the anticonvulsant drugs, with an average indemnity paid of \$97 500. Studies have raised concerns about pediatricians’ knowledge about the pharmacokinetics of some anticonvulsant medications.<sup>20</sup>

Errors arise in 1 of 4 ways: ordering (56% of errors); administration (ie, wrong dose, drug, timing, or technique) (34% of errors); transcription (6% of errors); and dispensing (4% of errors).<sup>21</sup>

PIAA data show that 14% of medication claims are allergy related. These claims fall under 3 categories: failed to ask about drug allergy; asked about and previously documented drug allergies but failed to read the medical chart; and failed to re-ask about recent development of drug allergy. Physician-related mistakes occurred in 69%, nurse-related mistakes in 13%, and pharmacy-related mistakes in 8% of the claims. Thirty-seven percent of cases involved an incorrect dosage, an inappropriate drug, or failure to monitor adverse effects.

Practitioners should inquire about drug allergies every time a prescription is written. Practitioners should

also consider prescribing anticonvulsant drugs in close consultation with the appropriate specialists. For pediatric inpatients, computerized prescriber order entry systems have been effective in reducing the incidence of adverse drug events.<sup>22</sup>

## PEDIATRICIANS PRACTICING IN EMERGENCY SETTINGS

Pediatricians practicing in emergency settings must be especially cognizant of the common causes of malpractice suits. An analysis of the PIAA database regarding pediatric lawsuits arising in an emergency department setting from 1985 to 2000 noted that common causes of malpractice suits involved meningitis, neurologically impaired newborns, and pneumonia in suits involving children <2 years old; fracture, meningitis, and appendicitis in lawsuits involving children from 3 to 11 years old; and fractures, appendicitis, and testicular torsion in lawsuits involving children from 12 to 17 years old.<sup>23</sup> Cases in which death occurred often related to meningitis and pneumonia.

## GENERAL RISK-MANAGEMENT TECHNIQUES

Some generalized risk-management techniques are useful regardless of the medical diagnosis. These techniques include:

1. Document all pertinent positive and negative clinical findings. For example, meningeal signs may be lacking in a patient with meningitis, and the proper diagnosis may be missed. However, the physician who has documented the absence of meningeal signs has provided some evidence that he or she considered the possibility of this condition and has properly evaluated the child.
2. Document carefully. The medical chart should contain the information that the physician would want present if a claim were to be made in the future. Entries should be clear, complete, and free of flippancy, critical, or other inappropriate comments. Whenever writing on a medical chart, assume that “Dear Mr/Ms Attorney” is written at the top. One day this is who may be reading it.
3. Although there are differences of opinion about how much to write in a medical chart, quality is always preferred over quantity.
4. When appropriate, do not underestimate the importance of referring to specialists.
5. If a patient has identified risk factors for a specific condition, visibly and clearly “red flag” the front of the chart as a reminder to check for the condition at each visit. This is especially important for conditions such as DDH, for which the age of onset and diagnosis varies widely.
6. Communication and use of terminology is critical. Numerous studies have demonstrated that poor communication between physicians and parents/patients is the catalyst for most medical malpractice lawsuits. Good communication involves the use of layman’s terms and the avoidance of medical jargon.

7. Avoid language that blames (eg, unintentionally, inadvertently) or embellishes (eg, profound, excessive) unless it is relevant to medical care.
8. Correctly label conditions such as DDH as “developmental” rather than “congenital” so that it does not lead a parent to believe that the condition should have been diagnosed soon after birth.
9. Medications should be written as mg/kg per time period. Ask about drug allergies every time a prescription is written.
10. Similar to the 3 rules of real estate (location, location, location), the 3 rules of medical malpractice are damages, damages, damages. Careful and extensive documentation is critical with patients likely to sustain long-term sequelae.
11. The Institute of Medicine has noted that half of Americans, even among the well educated, do not understand basic health information.<sup>24</sup> Furthermore, many Americans lack good reading skills. Verbal instructions should be simple, clear, and concise. Written material provided to patients should be written at an eighth-grade level.

## REFERENCES

1. Doctors for Medical Liability Reform. Protect Patients Now! action center. Available at: [www.protectpatientsnow.org/site/c.8oIDJLNnHIE/b.1090567/k.C061/State\\_Information.htm](http://www.protectpatientsnow.org/site/c.8oIDJLNnHIE/b.1090567/k.C061/State_Information.htm). Accessed September 30, 2008
2. American Academy of Pediatrics. *AAP Periodic Survey of Fellows, #69*. Elk Grove Village, IL: American Academy of Pediatrics; 2008
3. Kain ZN, Caldwell-Andrews AA. What pediatricians should know about child-related malpractice payments in the United States. *Pediatrics*. 2006;118(2):464–468
4. Carroll AE, Buddenbaum JL. Malpractice claims involving pediatricians: epidemiology and etiology [published correction appears in *Pediatrics*. 2007;120(4):935]. *Pediatrics*. 2007;120(1):10–17
5. Pierce EC. Looking back on the anesthesia critical incident studies and their role in catalyzing patient safety. *Qual Saf Health Care*. 2002;11(3):282–283
6. Physicians Insurers Association of America. *Data-Sharing Project: 1985–2006*. Rockville, MD
7. Physicians Insurers Association of America. *Meningitis Claims Study 2000*. Rockville, MD
8. Rodriguez DP, Vargas S, Callahan MJ, Zurakowski D, Taylor GA. Appendicitis in young children: imaging experience and clinical outcomes. *AJR Am J Roentgenol*. 2006;186(4):1158–1164
9. Becker T, Kharbanda A, Bachur R. Atypical clinical features of pediatric appendicitis. *Acad Emerg Med*. 2007;14(2):124–129
10. Reynolds SL. Missed appendicitis in a pediatric emergency department. *Pediatr Emerg Care*. 1993;9(1):1–3
11. Rothrock SG, Pagane J. Acute appendicitis in children: emergency department diagnosis and management. *Ann Emerg Med*. 2000;36(1):39–51
12. Sallin K, Rothrock SG. Diagnosis of acute appendicitis: increasing accuracy, improving outcome, and decreasing liability. *J Fla Med Assoc*. 1997;84(9):543–548
13. American Academy of Pediatrics, Committee on Quality Improvement, Subcommittee on Developmental Dysplasia of the Hip. Clinical practice guidelines: early detection of DDH. *Pediatrics*. 2000;105(4 pt 1):896–905
14. Mahan ST, Kasser JR. Does swaddling influence developmental dysplasia of the hip? *Pediatrics*. 2008;121(1):177–178
15. Schwend RM, Schoenecker P, Richards BS, Flynn JM, Vitale M; Pediatric Orthopaedic Society of North America. Screening the newborn for DDH: now what do we do? *J Pediatr Orthop*. 2007;27(6):607–610
16. Laska L. *Med Malpract Verdicts Settl Experts*. 2006;22:3. Available at: [www.verdictslaska.com](http://www.verdictslaska.com). Accessed October 2, 2008
17. Jackson County (Missouri) Circuit Court, Case 00CV204766 (2006)
18. St Clair County (Illinois) Circuit Court, Case 00L-373 (2006)
19. Hickson GB, Clayton EW, Githens PB, Sloan FA. Factors that prompted families to file medical malpractice claims following perinatal injuries. *JAMA*. 1992;267(10):1359–1363
20. McAbee G, Atluru V, Carrachio T. Phenytoin (Dilantin) prescribing practices among Long Island, NY pediatricians. *Pediatrics*. 1991;87:266–267
21. Pediatric Patient Safety. In: Berger JE, Deitschel CH, eds. *Medical Liability for Pediatricians*. 6th ed. Elk Grove Village, IL: American Academy of Pediatrics; 2004:213
22. Holdsworth MT, Fichtl RE, Raisch DW, et al. Impact of computerized prescriber order entry on the incidence of adverse drug events in pediatric inpatients. *Pediatrics*. 2007;120(5):1058–1065
23. Selbst SM, Friedman MJ, Singh SB. Epidemiology and etiology of malpractice lawsuits involving children in US emergency departments and urgent care centers. *Pediatr Emerg Care*. 2005;21(3):165–169
24. Institute of Medicine, Committee on Health Literacy. *Health Literacy: A Prescription to End Confusion*. Washington, DC: National Academies Press; 2004

## Medical Diagnoses Commonly Associated With Pediatric Malpractice Lawsuits in the United States

Gary N. McAbee, Steven M. Donn, Robert A. Mendelson, William M. McDonnell,  
Jose L. Gonzalez and Julie Kersten Ake

*Pediatrics* 2008;122:e1282-e1286

DOI: 10.1542/peds.2008-1594

<b>Updated Information &amp; Services</b>	including high-resolution figures, can be found at: <a href="http://www.pediatrics.org/cgi/content/full/122/6/e1282">http://www.pediatrics.org/cgi/content/full/122/6/e1282</a>
<b>References</b>	This article cites 16 articles, 9 of which you can access for free at: <a href="http://www.pediatrics.org/cgi/content/full/122/6/e1282#BIBL">http://www.pediatrics.org/cgi/content/full/122/6/e1282#BIBL</a>
<b>Subspecialty Collections</b>	This article, along with others on similar topics, appears in the following collection(s): <b>Office Practice</b> <a href="http://www.pediatrics.org/cgi/collection/office_practice">http://www.pediatrics.org/cgi/collection/office_practice</a>
<b>Permissions &amp; Licensing</b>	Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at: <a href="http://www.pediatrics.org/misc/Permissions.shtml">http://www.pediatrics.org/misc/Permissions.shtml</a>
<b>Reprints</b>	Information about ordering reprints can be found online: <a href="http://www.pediatrics.org/misc/reprints.shtml">http://www.pediatrics.org/misc/reprints.shtml</a>

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

