

## **Pediatric / Neonatal Liability**

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This chapter will focus on medical malpractice issues in pediatrics and in perinatal/neonatal medicine that can affect the daily professional lives of those who work with infants, children, and adolescents. Note that most of the neonatal issues are common issues and apply to pediatricians who care for newborns and attend deliveries as well as neonatologists. Practicing clinicians must understand their rights, duties, and liabilities as physicians.

### **Case Presentation**

In their pediatric malpractice lawsuit, Mr. and Mrs. Smith claimed that on July 27, 2005, Mrs. Smith called Dr. Case for advice regarding their 15-month old daughter Samantha. Samantha had been well until the 25<sup>th</sup>, when she developed a low-grade fever. At that time Mrs. Smith talked to Dr. Case's partner who recommended Acetaminophen. By the next day (the 26<sup>th</sup>), in addition to the fever Samantha had developed a significant cough. Dr. Case recommended Robitussin and also thought that she may be dehydrated and stated that Pedialyte should be given to see if she would produce a wet diaper by 2:00 pm, which she did. Mrs. Smith called back to inform Dr. Case of this, and also that Samantha seemed abnormally drowsy and sluggish and still had a fever despite the acetaminophen. Mrs. Smith also allegedly asked whether she should take Samantha to the Emergency Department but was told by Dr. Case that this was not necessary and that Samantha could be given ibuprofen and to see if she produced six wet diapers by that evening. Samantha produced five by that evening, so the Smith's thought everything was fine and went to bed.

The next morning on the 27<sup>th</sup> at about 9:00 a.m., Mrs. Smith had a hard time waking Samantha and called Dr. Case again about taking her to the Emergency Department, but he told her to "give it half an hour" to see if she improves. The Smith's were unsatisfied with this advice and took her to the ED at

the Main Street Hospital where they waited half an hour before being seen by the triage nurse. At that time she was immediately taken to a treatment room where a spinal tap was performed and she was diagnosed with bacterial meningitis. Antibiotics were started but by that time she was severely brain damaged.

When Dr. Case visited the family he told the family that antibiotics seemed unnecessary because their baby would be better off dead. He also argued with the family over whether he should have diagnosed the meningitis earlier, stating that “over the phone it sounded like dehydration.”

While not admitting to any negligence or responsibility, the suit was settled for \$9,000,000.

## **Issues**

### ***Introduction***

As the above case illustrates, pediatric malpractice claims can result in very large money damages. Pediatric patients are often treated with enormous sympathy by juries. Also, many of the most common errors in diagnosis, such as meningitis and brain-damaged infants, lead to severe and permanent injuries. Furthermore, children are at the beginning of their lives, so that the lifetime cost of care for a permanently injured child can easily run in the millions of dollars.

Due to the factors mentioned above, the average closed pediatric malpractice claim in 2004 was approximately \$468,000 according to the Physician Insurers Association of America (PIAA). This is 43% higher than the overall average for all physician specialties. Indeed, the PIAA ranks pediatrics fourth in highest average indemnity from 1985-2004, behind neurology, neurosurgery and obstetrics/gynecology.

The relatively high malpractice risks are due in part to the tremendous clinical and ethical challenges surrounding pediatric and neonatal medicine. In both fields, there are some unique challenges and issues which differ somewhat from adult medicine. First, parents or guardians have moral and legal responsibility to care for and protect their children and thus become an additional and essential party in the doctor-patient relationship. Second, infants and young children are unable to create or express their own preferences and thus the physician has their own legal and moral obligation to ensure that the parents are acting in the best interests of the child. Third, as children get older, they

generally can communicate their own preferences. Therefore, their assent to treatment becomes increasingly important.

Neonatologists, like pediatricians, face multiple challenges, especially surrounding the care of premature infants at the limits of viability. Does the physician have to honor whatever the parents' request? What if the parents do not want resuscitation and the medical team disagrees? What if there is conflict between the parents' wishes and hospital policy or national guidelines? These questions are not just academic. A recently overturned \$60,000,000 verdict (HCA, Inc. v. Miller ex rel. Miller) accentuates the importance of knowing the multitude of cases and legislation that affect clinical practice. These areas remain contentious and ill-defined in many states. Physicians are often caught in the middle with potential liability for either resuscitating or not resuscitating, although certainly good communication can minimize this risk.

## **Common Malpractice Suits In Pediatrics**

**Meningitis**

**Appendicitis**

**Specified nonteratogenic anomalies**

**Pneumonia**

**Brain-damaged infant**

**Telephone triage – failure to treat / delayed treatment**

The most prevalent causes of malpractice suits against pediatricians involve errors in diagnosis. Part of the reason for this lies with the nature of pediatrics; obtaining a history from a child is very different from that of an adult. Does the eight-year-old with abdominal pain have a surgical emergency such as appendicitis, or are they trying to avoid confronting the school bully on the playground? Additionally, the pediatrician is often trying to provide medical care and advice over the telephone, without the advantage of having the patient in front of them.

One theme that arises repeatedly in pediatric malpractice cases, however, is a failure of the physician to heed the concerns of the parent. In general, no one knows their child better than the parents, and their concerns should always be taken seriously. Furthermore, while parents may not be able to explain their exact concern, they are often able to correctly intuit that something is wrong. Much

of the advice in this book applies to pediatric patients. In the following paragraphs we will examine some specific issues in pediatrics.

### ***Meningitis***

As the case illustrates, pediatric meningitis malpractice cases lead to some of the highest average indemnities paid and also has among the highest pay-out ratios. Often these cases involve children too young to verbalize their symptoms, with the median age of patients being two-years-old in the PIAA Meningitis Claims Study undertaken in 2000. Many of these cases, almost 25% in the PIAA study, claim a delay in diagnosis, and, as in the case noted above, often the first contact is over the phone. Symptoms are often generalized and can include fever, nausea and vomiting, lethargy, change in mental status, and neck stiffness. Furthermore, it is important to maintain a low threshold to work up (including lumbar puncture) and treat possible meningitis, especially in infants and toddlers. Finally, a prudent physician will note if a parent states that a child is lethargic or not acting normal.

### ***Appendicitis***

Abdominal pain is an extremely common presenting complaint for pediatric patients. Approximately 15% of school-aged children are brought to a physician because of abdominal pain, of which the most common serious disorder is appendicitis. Misdiagnosing appendicitis for other causes of abdominal pain, such as constipation, gas pain, or gastroenteritis can lead to a lawsuit. In the PIAA Data Sharing System Report from 1985 to 2003, failure to diagnose appendicitis was the second most frequent patient condition missed. One important problem in many of these cases was poor documentation. If a child presents with symptoms that may represent a “surgical abdomen”, it would seem prudent for the pediatrician to document the presence or absence of pain in each quadrant, distension, guarding, rebound, tenderness, and bowel sounds. It is also important to recognize that the diagnosis of gastroenteritis is generally associated with vomiting and diarrhea. Finally, the parents need to be educated as to their most appropriate course of action should the child’s condition worsen. Parents should be instructed that prompt reevaluation may stave off a serious medical/surgical problem, and the physician’s instructions to the parents should be documented in the child’s chart.

## ***Telephone Triage***

Pediatricians regularly offer medical advice over the telephone. Indeed, it has been estimated that up to 30% of all ambulatory pediatric care is delivered via the phone. This care led to almost 100 malpractice claims and over \$11 million dollars to plaintiffs during the period 1985-2004. In the case presented at the beginning of the chapter, it is certainly possible that the outcome would have been different had Samantha been seen and examined in the office rather than over the phone. Thorough documentation is important, as is accessibility, when setting up a phone triage system. It is particularly important to recognize that the parent or caregiver that has made the call is not a trained health care professional and cannot be expected to know exactly what to look for and what to tell you. If the telephone triage personnel determine that the parents seem to be overly nervous or the parents are insisting that their child be evaluated in person, then the prudent practitioner will strongly consider accommodating the family or referring the family to an acute care center or emergency department. The American Academy of Pediatrics Section on Telephone Care has developed an comprehensive set of management guidelines. When followed appropriately, these guidelines can mitigate the considerable legal risk associated with telephone care.

## **Common Malpractice Suits In Neonatology**

**Delivery room management/resuscitation**

**Poor neurologic outcome- Cerebral Palsy / Hypoxic-Ischemic Encephalopathy**

**Line complications- thrombus and vascular accidents related to central lines**

**Delay in diagnoses/treatment- acidosis, hypotension, antibiotics, developmental dysplasia of the hip, congenital heart disease**

**Failure to adequately monitor / treat – hypoglycemia, hypoxia, hyperoxia, seizure**

In recent years, considerable advances have been made in the care of sick newborns. New ventilator techniques, surfactant replacement therapy, and antenatal steroids have provided vital tools in the armamentarium of the neonatologist. However, many sick newborns either die in the newborn intensive care unit (NICU) or ultimately emerge from the NICU with significant complications. Often,

when a newborn is handicapped, extremely premature, or has suffered from oxygen deprivation, the NICU can be a sad and troubling environment. When these clinical situations arise, it is not uncommon for legal action to be initiated. A small but growing body of law addresses care provided in the delivery room and during the neonatal period.

### ***Delivery room management/resuscitation***

Pediatricians and neonatologists are often called to attend deliveries when complications are present or anticipated. First and foremost, the clinician must insure that the facility is properly equipped to handle “this” delivery. Does this facility have a staff that is trained in newborn resuscitation? Is the resuscitation equipment present and functional? It is virtually a certainty that unanticipated events will arise. However, proper preparation of the resuscitation team and the presence of the appropriate equipment are the tantamount to a successful resuscitation.

Whether the resuscitation team is called because of a nonreassuring fetal monitoring strip, concern for placental abruption, extreme prematurity or other circumstances, the presence of the pediatrician or neonatologist in the delivery room is often an indication of some type of problem. A variety of interventions are often attempted in the delivery room. Depending on the needs of the newborn, the clinician may simply insure adequate thermal-regulation, evaluate the ABC’s, and check for anomalies. However, in other cases, the delivery room management may require the physician to perform endotracheal intubation, initiate cardiac compressions, secure vascular access, administer cardiac medications, give volume expansion or a variety of other emergency interventions.

Any time that procedures are being performed in an emergency setting, there is an increased possibility that complications will arise. Further complicating this picture is the fact that the resuscitation team often meets families for the first time in the delivery room setting. While the obstetrician may have known the family throughout the pregnancy (and perhaps through earlier pregnancies), the resuscitation team often does not have the luxury of establishing rapport with the family prior to initiation of care for the infant. This lack of rapport can contribute to malpractice litigation. Without a foundation of trust between the family and the resuscitation team, an untoward outcome may result in a family filing suit.

### ***Poor neurologic outcome- Cerebral Palsy / Hypoxic-Ischemic Encephalopathy***

As noted in the OBSTETRICAL CHAPTER of this textbook, evaluation of fetal monitoring strips is a common cause of malpractice cases for obstetricians. Under certain circumstances, an infant will be born in a depressed state following a non-reassuring fetal monitoring strip. Because it is often difficult to determine if a specific injury is due to in-utero complications or immediate post-natal events, plaintiffs will often sue the neonatologist as well.

Perhaps no area of legal medicine is more contentious than the “brain damaged newborn”. In fact, many plaintiff’s attorneys advertise that this area of law is one of their specialties. Fetal monitoring has become a staple of labor-delivery management. Despite the almost universal use of this technology, there is a paucity of evidence that fetal monitoring actually improves neonatal outcome. Additionally, there is evidence that neonatal brain injury is frequently present days to weeks prior to labor. Furthermore, data suggest an association between chorioamnionitis and cerebral palsy in the child. While there remains debate over the precise mechanism of cerebral cellular injury during a hypoxic/anoxic event, it is commonly accepted that a variety of events or insults suffered prior to labor, during labor, and following parturition can be associated with long-term neurologic impairment. A great deal has been written on the neurologic effects of fluctuating blood pressure, poor auto-regulation of cerebral blood flow, and perfusion-reperfusion injury. These physiologic mechanisms are beyond the scope of this chapter. However, the clinician is advised to be well-versed in the various theories of cerebral injury suffered in the antepartum period.

When expert witnesses review these types of malpractice cases, there is often significant importance placed on the interpretation of the fetal monitoring strip and umbilical cord pH. Experts will opine on the significance of severe, repetitive, late decelerations, or “overshoot”, or prolonged fetal bradycardia. If a non-reassuring fetal monitoring strip is accompanied by a low cord pH, a plaintiff’s attorney will attempt to demonstrate that a child’s neurologic impairment is a direct result of delayed intervention on the part of the obstetrician. If the neonatal resuscitation or post-resuscitation stabilization does not go smoothly, the neonatologist may also be named as a defendant in a malpractice action.

As mentioned in the Introduction to this chapter, obstetricians are one of the few specialists that have the unpleasant distinction of being sued more commonly than pediatricians. Many obstetricians have stopped delivering infants citing medical malpractice insurance premiums as the reason.

## *Hypoglycemia*

Pediatricians and neonatologists are commonly called by staff from the normal nursery and a serum glucose level is reported. There is disagreement among clinical experts as to the exact plasma glucose level that qualifies for a diagnosis of “hypoglycemia”. While threshold levels of 30 mg/dl or 40 mg/dl have been debated, it is generally accepted that severe or prolonged hypoglycemia can be associated with brain damage. It is often important to understand the etiology of the hypoglycemia. Is this an infant of a diabetic mother? Is this a premature infant with decreased glycogen stores? Does the infant have metabolic disease? Has the infant been cold-stressed? As in all other areas of medicine, the prudent physician will attempt to understand the etiology of the disease so that the appropriate therapy can be initiated.

Early initiation of feeds may be indicated for some infants, while intravenous boluses of glucose may be more appropriate for another infant. In rarer cases, glucagon or intravenous steroids will be required to treat severe, refractory hypoglycemia. Regardless of the treatment initiated, the prudent physician will follow serum glucose levels until it is clear that the danger of hypoglycemia has passed.

## *Newborn Sepsis*

Accurate diagnosis of neonatal bacteremia often starts with a high index of suspicion. Certain maternal risk factors place an infant at higher risk of sepsis. These factors include maternal Group B Strep cervical culture status, length of time that membranes have been ruptured, and presence of maternal fever. Has the clinician documented whether or not the above factors are present? If an infant is born to a woman whose membranes have been ruptured for greater than 18 hours, and the woman had a fever, and she was pretreated with antibiotics, a prudent physician will carefully monitor or screen that newborn. Clinicians should be familiar with current hematologic screening criteria, including immature white blood cell ratios, C-reactive protein values, and other blood tests. By practicing careful medicine and documenting one’s thinking, the neonatologist can minimize the chance that there is a delay in diagnosing a bacteremic infant. A delay in making this diagnosis can have profound implications for the infant, including death.

### ***Developmental Dysplasia of the Hip***

Part of the physical exam of any newborn includes an evaluation of the hips. Are “hip clicks” present when the hips are abducted and adducted? The hip click is detected if there is an abnormality in the acetabulum or femoral head. If this abnormality is promptly discovered, good orthopedic care can often lead to an excellent clinical outcome. On the other hand, if the femoral head remains outside of the joint for an extended period of time, good function may never be achieved. Because of this, documentation of a proper hip exam is vital to all pediatricians and neonatologists

### ***Congenital Heart Disease***

This clinical situation is somewhat similar to the above section on developmental dysplasia of the hip. A high index of suspicion and prompt referral can often mitigate substantial complications. Many types of congenital heart disease (CHD) do not necessarily present with significant hypoxemia in the immediate neonatal period. Ductal-dependent lesions may or may not be associated with a murmur in the newborn. A thorough cardiac exam of any newborn requires evaluation and documentation of the following: overall appearance of the infant, breath sounds, heart tones, murmurs, hepatomegaly, splenomegaly, femoral pulses, peripheral pulses, and perfusion.

Infants with CHD often present in the first two to six weeks of life. The presentation may include lethargy, poor feeding, failure to thrive, or a variety of other non-specific findings. It is common for the pediatrician or emergency room physician to confuse an infant with a ductal-dependent lesion with neonatal bacteremia. Because newborn sepsis is so much more common, these infants are often cultured and started on antibiotics. Often, there are long and costly delays in making the correct diagnosis that can lead to the infant’s death. The prudent pediatrician or emergency room physician must always maintain a high index of suspicion for congenital heart disease. In the appropriate situations, these clinicians will consider a chest x-ray, ekg, arterial blood gas, echocardiogram, or consultation with the neonatologist or pediatric cardiologist to assist in the diagnosis and management. The prompt initiation of certain therapies, such as PGE1 infusion, can be life-saving. Clearly, every infant with suspected sepsis does not require a pediatric cardiology consultation. However, the ability to promptly recognize and treat a case of congenital heart disease can potentially save a child’s life.

## ***Prematurity***

Managing premature infant requires comprehensive training and preparation of the healthcare team. Every decision, including the facility in which delivery will take place, can have life-long implications for a premature infant. A matter as simple as a malfunctioning radiant warmer can have catastrophic results. Because hypothermia has been associated with intraventricular hemorrhage, proper thermal-regulation is an integral part of care for the premature infant.

Premature infants, and especially extremely premature newborns, are often born in critical condition. There is little margin for error in these small, fragile patients.

Starting in the delivery room, all preparation must be comprehensive. Will the infant be intubated in the delivery room? Can the staff accomplish this? Will exogenous surfactant be administered? Should the infant be resuscitated with 100% oxygen even if the infant's oxygen saturation is reading 100%?

Are proper ventilators available and staff that know how to use them? If a complication such as a pneumothorax arises, will this be promptly recognized and treated. More importantly, could the complication have been prevented?

## ***Retinopathy Of Prematurity***

Retinopathy of prematurity (ROP), formerly referred to as retrolental fibroplasias, is a common cause of litigation for the neonatologist as well as the pediatric ophthalmologist. While controversy exists concerning ideal oxygen and ventilator management of the sick premature newborn, close follow-up for ROP is absolutely required for these patients. With various interventions, including laser surgery, the effects of ROP can, in some cases, be somewhat mitigated.

## ***Line Complications***

Deep venous lines and central or peripheral arterial lines are routinely placed in sick newborns. For a variety of reasons, including small vessels, high hematocrit, and fluctuating blood pressure, line complications are not a rare complication in neonatology.

Malpractice cases have been based on negligence theory related to placement and management of vascular access in sick newborns. The clinician should generally document the indications for the

vascular access. Why was central access required or preferred? Was the line heparinized? Was the fluid running through the line at an appropriate rate to insure line patency? Have the physicians and nurses documented good perfusion to the limb, hand, or other part of the infant's anatomy? Was an Allen's test documented prior to peripheral arterial line insertion? Was proper care offered after the injury was discovered? If a skin graft was ultimately required, was a plastic surgeon promptly consulted?

### ***Neonatal Transport***

As mentioned above, it is ideal to deliver an infant at a facility that can provide the care that the infant will require. It is generally preferable to arrange for a maternal transport as opposed to a neonatal transport. If the pregnant woman can tolerate a transport, then the transfer of a sick infant can be avoided. Unfortunately, it is common for an infant to be critically ill without an antecedent history that forewarns the obstetrical and pediatric teams that the newborn will be so sick. If a newborn is unstable after birth, then a neonatal transport may be required. The transport relocates the infant to a facility that can deliver a higher level of care.

There are a variety of risks associated with neonatal transport. The equipment, including ventilators, warmers, and infusion pumps, can fail. Ambulances can be involved in collisions. In rare cases, helicopter transport and airplane transports have ended in tragedy for the infant, the health care team, and the crew. If possible, informed consent should be obtained from the family prior to neonatal transport. If a parent is not available (such as a single mother with post-delivery complications) to give informed consent, then the referring and accepting physicians should both document the emergency nature of the transfer and the reasons for a lack of informed consent.

### ***Avoiding Malpractice Suits in the Delivery Room and NICU***

As in other areas of medicine, strong clinical practice, clear documentation, and good communication with the family are strategies to help avoid a malpractice action. Practicing good medicine helps avoid bad outcomes. Is the delivery room staff prepared for a sick newborn? Does the respiratory therapist have experience in the resuscitation of newborns? Does the equipment function? Are there spare batteries for the laryngoscope? Has the infant warmer been turned to the "on" position?

## Survival Strategies

Pediatricians are generally an optimistic group, and most of our patients do well. When there is a bad outcome, pediatricians often feel guilty and to blame and also fear a lawsuit. Furthermore, in addition to the mental anguish that one can experience as a result of being named as a defendant in a malpractice case, these proceedings are often time-consuming and expensive. There are, however, steps that one can take to minimize the chances of being named in a malpractice suit.

Maintaining competency is always crucial, not just to minimize malpractice risk, but also as a moral and ethical duty in and of itself. Pediatricians and neonatologists need to take the necessary steps in order to stay current in their discipline. In addition to conferences, journals and textbooks, the internet is a relatively new source of continuing education which may assist a physician in their clinical practice. Medical practices change rapidly. For example, dexamethasone was used routinely ten years ago to wean premature babies with chronic lung disease from ventilators. After studies revealed long-term neurologic concerns, however, steroids are now reserved for only the sickest of babies. Failing to keep up with the latest standards and practices could lead a neonatologist to continue administering a medication or offering a form of therapy well after its use has been widely abandoned or curtailed.

Pediatric sub-specialty and tertiary care services are generally organized in a regional system, often around free-standing children's hospitals. Through this system, small and large community pediatricians and neonatologists can maintain professional ties with one another and with larger medical centers. These ties allow an exchange of ideas and practices. As the American Board of Pediatrics has recently recognized, clinicians must consider their professional development as a continuous process.

If a clinician is faced with a rare or particularly challenging case, they should not hesitate to call a colleague. Maintaining contact with one's former attendings and mentors from residency and fellowship can provide great benefit for one's patients. Experienced neonatologists that work at other institutions can often assist with difficult cases. Most academic centers with training programs generally make it a point to regularly discuss the most difficult clinical cases at Management Conferences, Morning Report, Grand Rounds or other venues.

In addition to maintaining good communication with colleagues, it is essential that parents are kept updated and involved. This is a requirement for legal as well as ethical reasons, and it is an

essential component of informed consent. Maintaining good communication with parents is not always easy, but the consequences of poor communication may include a malpractice suit. Parents who feel uninformed and out of the loop will often become frustrated and angry. It is hard enough to deal with having a sick child. Feelings of mistrust can quickly lead to conflict. Furthermore, as the case demonstrates, a suboptimal relationship with the family of a sick child can be a harbinger of a pending malpractice suit.

While communication with the family is important, it is also essential to document appropriately. Indeed, of all the closed claims involving a problem with the medical record in 2004, the PIAA found that there was a payout in 62% of them. Chart entries need to be punctual, legible, and accurate. Time and date should be on every note, and “late entries” need to be documented as such. Important events, such as a significant complication with the patient or a comprehensive family conference, should be documented in the chart. Furthermore, a note documenting a family conference should include the content of what was discussed as well as a delineation of whom was present during the conference.

As discussed earlier, phone advice can be a source of liability and appropriate documentation is important. This can be accomplished with standard phone log forms although detailed documentation is required for complex calls. Referring doctors or parents do not always follow a physician’s advice. Proper documentation of the phone discussion can provide protection for the physician.

Finally, while many United States Supreme Court cases necessarily generate a significant amount of attention, it is important to realize that most government regulation of medical practice involves state law. These state regulations include issues ranging from basic medical malpractice standards to resuscitation of extremely premature infants to professional licensing. Thus, staying up to date on the state laws and regulations that affect their practice is important for every practicing pediatrician and neonatologist.

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