Risk Management

Risk Management in Obstetrical Care

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The personal, professional and dollar cost of perinatal injury remains high as families faced with the financial burden of long term care for an injured child or mother, the perception that something wrong occurred and information has been withheld, a desire to prevent an accident from recurring…or simply a wish to “get even” often lead people down the path of litigation. Our statistics indicate that the average cost of indemnity paid on obstetrical claims over the past five years is more than double that of the average indemnity paid on all non-obstetrical claims combined.

An unexpected outcome does not always mean that the quality of care was compromised and a bad outcome doesn’t necessarily signify malpractice; however, negligence does occur…often the result of oversight, accident, or poor judgment due to lack of training or skill, miscommunication, or failure to act.

Non-medical causes of injury, such as damaged doctor-patient relationships, and erroneous or incomplete documentation as well as other preventable causes of physical and emotional injuries are often the catalysts for malpractice litigation.

Communication

One prevalent trend in virtually all malpractice suits is that a series of events usually occur…the most common stemming from a breakdown in communication, either between the practitioner and patient or between care givers. In fact, the generation of lawsuits – in the presence of an adverse outcome – is more often than not, precipitated by poor communication.i

Communicating With Patients

Medical literature reports four types of communication problems cited in a majority of plaintiff depositions: deserting the patient, devaluing patients’ views, delivering information poorly and failing to understand patients’ perspectives. In a nutshell, healthcare practitioners must listen and talk to patients in a positive manner.

Communication experts stress the skills of engagement, empathy, education and enlistment to improve patient outcomes and patient compliance and to decrease the likelihood of malpractice suits.

Communication With Other Practitioners

Many lawsuits in obstetrics stem from allegations of failure to notify or delay in notification of the physician. Some important elements for establishing good intraprofessional communication practices include a readily available list of all practitioners and those with whom they rotate calls; call schedules of all practitioners; telephone numbers and an established method of reaching the physician immediately, which eliminates triage through office personnel in order to reach the physician directly.

When hospital nurses and other staff call physicians, they should have accurate and timely information readily available for the practitioner. They should state immediately the reason for the call, and whether the practitioner is needed.

Of particular importance, is a method to evaluate and promptly resolve problems with communication between hospital staff, physicians, and other practitioners. Chain of Command policies should also be established and followed, in which all staff, including physicians and residents, have a mechanism to immediately communicate upward, so that any concerns regarding patient care can be addressed.

Treat every member of the staff with professional courtesy and respect and deal with disagreements with other care providers outside of the medical record and earshot of patients.

Telephone Communications

Telephone conversations may be critical in a malpractice action. All prenatal telephone conversations with the patient, including those that take place outside the office setting should be documented in the prenatal record.

Be mindful of common pitfalls associated with telephone triaging including failure to accurately access maternal-fetal status, failure to advise the
patient to seek evaluation and treatment, failure to correctly communicate maternal-fetal status to the primary health care provider, and failure of the physician/nurse-midwife to come to the hospital to see the woman when requested to do so by the nurse.

When Something Goes Wrong

When something goes wrong, the impulse to deny a problem and avoid the family can be strong. Patients often file malpractice suits against physicians because they feel that information was deliberately withheld, or the physician refused to apologize for what happened or they do not believe that the facility will prevent the problem from happening to another patient.

Always keep in mind, when talking to patients, what you would want a physician to tell you if something went wrong with you or your child’s treatment. In order to decide on the best strategy, in these difficult cases, it is strongly suggested that physicians discuss the issue with a risk manager and medical leader before talking to the patient.

Documentation

Prenatal records should include the following:

• Notations regarding fetal surveillance, fetal well being and routine examinations, results of both normal and abnormal laboratory results, as well as results of radiological and ultrasound studies

• Your diagnostic rationale, especially for situations in which the medical record might suggest another course was overlooked.

• Consultation reports, prescribed medications as well as a prominent display of patient allergies to medications or contrast media

• Informed consent discussions or the patient’s refusal of care should be documented, including the risks, benefits and alternatives discussed

• Instructions to patients that include time and action-specific directives such as “if your temperature doesn’t return to normal by tomorrow, call me”

• Follow-up plans should be included, particularly if a serious finding or diagnosis is being ruled out

• Clinically pertinent telephone calls should include notations regarding the nature of the call, prescriptions or instructions regarding when to seek further medical care, the date and time of the call

• Describe patient behavior, including non-compliant behavior. Be objective and don’t label, i.e. chart “patient did not return for follow-up appointment,” rather than “patient is non-compliant”

Complete prenatal information should be available in order for you and hospital staff to know the facts that can impact on the management of your obstetrical patient. Once prenatal records are forwarded to the hospital, in anticipation of a delivery, a system should be in place to ensure that subsequent treatment services provided and additional documentation made on the prenatal record is either mailed or faxed per hospital policy as term approaches.

Labor and Delivery Documentation

• Documentation describing the course of a patient’s labor and delivery should include:

• Interactions with the patient as well as interventions, such as internal monitoring

• Fetal well-being, review of fetal heart rate tracing, and its reassuring or non-reassuring status

• Any discussions with consultants

• Decisions concerning the management of labor, such as artificial rupture of membranes, use of tocolytics, trial of labor, use of oxytocin

• Rationale for decisions

• Any abnormality, or change in management, e.g. pitocin intervention after second stage, or shoulder dystocia

• Date and time all entries as factually as possible.

Fetal Heart Rate Monitoring

Electronic fetal monitoring (EFM) interpretation, communication and documentation are often the focal point during a malpractice action. The fetal heart rate (FHR) strip is part of the medical record, therefore, a legal document and is typically used to correlate the fetal status with the progress notes and the testimony of the witnesses.

Documentation on the strip is never a substitute for progress notes; however, documenting directly on the strip is acceptable whenever the strips are reviewed, when there is a change in maternal position, when the monitor is adjusted or removed, or when there are changes in maternal or fetal status. When documenting directly on the strip, include initials and the time of the entry.

Interpretation of the strip becomes critical in many cases, so it is important that care be taken to document the interpretation of the strip concurrently and accurately, including:

• The patient’s name and the date on all strips

• The time the monitor was applied and the mode of monitoring used

• Baseline FHR, and whether it is reactive or nonreactive

• Clearly understood terms, such as “average” or “diminished” when estimating baseline variability

• Interpretation of fetal heart rate patterns, and patterns noted over time

• Uterine activity, contraction frequency, duration and intensity

• Whether the overall pattern is reassuring or nonreassuring

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Professional Standards, Guidelines and Recommendations

Topics that have been prevalent for the past two decades continue to be significant issues for risk exposure. These include the use of oxytocin, hyperstimulation of uterine activity, fetal heart rate pattern interpretation, timely emergency cesarean birth, fundal pressure, shoulder dystocia, operative vaginal birth, iatrogenic prematurity and multiple gestation and have lead to the development of standards, guidelines and recommendations from professional organizations and regulatory agencies. Other new trends in clinical care have lead to the development of even newer recommendations such as those for elective induction of labor, use of ripening agents, prevention of perinatal group B strep, second stage labor management and VBAC.

Professional organizations such as the American College of Obstetricians and Gynecologists (ACOG), the Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) and the American College of Nurse-Midwives (ACNM) offer guidelines based on current clinical evidence. While most publications about clinical practice from professional organizations include disclaimers that they are guidelines, rather than standards of care, it is these very guidelines that do in fact become standards of care for all practical purposes in legal proceedings as both plaintiff and defense frequently offer these publications to support their case. Allegations against physicians, nurse midwives, nurses, and institutions often based upon a lack of knowledge of or lack of commitment to practice based on current standards, guidelines, and clinical evidence.

While all published standards are important, analysis of professional liability claims does suggest that disregard for a few select standards of care published by ACOG and AWHONN is associated in a preponderance of liability claims. These relate to:

- Misoprostol (Cytotec) for cervical ripening/labor induction (indications, dosage and route of administration)
- Oxytocin for labor induction/augmentation (indications, administration beyond physiological dosage and timing regimen and avoidance of uterine hyperstimulation)
- Electronic fetal monitoring (EFM) interpretation and clinical response (use of common EFM language, training and competence)
- Management of shoulder dystocia (anticipation of, maneuver sequence and avoidance of fundal pressure)
- Second stage labor management (passive fetal descent vs. indiscriminate instrumentation and aggressive coached closed-glottis pushing; oxytocin maintained at rate which simulates physiologic second stage labor)
- Operative vaginal birth (absent true maternal-fetal indications, clinical privileges)
- VBACs (cautious trial of labor, non use of induction or labor augmentation aids, ability to perform immediate cesarean delivery in the face of uterine rupture, informed consent)

Systems Approach to Obstetrical Care

Injuries in obstetrics often involve system failures, such as delays in response times, lack of recognition of high-risk situations, inadequate transfer of information and understaffing, just to name a few. The multifaceted, technical environment of the hospital obstetrical unit requires a focus on reviewing systems for managing clinical risk and adverse events as well as building and sustaining a multidisciplinary team that learns, trains and communicates together to affect change and create a care model that will improve patient safety and quality of care.

One such model, The High Reliability Organization model*, draws heavily from the work of psychologists and industry and uses a systems approach to identify cause and assists the multidisciplinary obstetrical care team to identify gaps or holes in the complex systems of the hospital environment. Using the key values and principles of High Reliability Organization systems enables the patient care team to integrate evidence-based obstetrical practice with the six key principles below:

- Safety is everyone’s responsibility
- Operations are a team effort
- Communication is highly valued
- Hierarchy disappears in an emergency
- Emergencies are rehearsed and the unexpected is practiced
- There is a multidisciplinary review of near misses

A systems approach to obstetrical care recognizes patient safety as a fundamental principle. Achieving improved patient safety within the hospital environment requires substantive, sustained change within the clinical practice culture and care delivery systems.

In High Reliability Organizations, the patient care team relies on a practice model in which all disciplines work and learn together to create a practice community that is rich in knowledge and experience by breaking down traditional hierarchies and establishing an environment of respect, trust and continuous learning.

References:

i Karp, D., The Misdirected Search for Malpractice Solutions, *DCBA Brief (Journal of the DuPage County Bar Association – Online)*


iii *Risk Management Pearls For Obstetrics, AHSRM Publication, 2000*

iv ibid

v ibid

vi Sentinel Event Alert #30, Joint Commission on Accreditation of Healthcare Organizations

vii Insight Into Risk Factors and Management of Shoulder Dystocia, collaborative article by ECRI and RM & Patient Safety Institute, Summer 2003