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Perinatal Risks

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Risk Management Foundation
101 Main Street
Cambridge, MA 02142
www.rmhf.harvard.edu

E-mail:
Forum@RMF.Harvard.edu

Fax: 617-495-9711

Editor
Priscilla S. Dasse

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Issue Editors
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Understanding CRICO's Perinatal Claims

By Heidi Groff, RN., N.P., M.P.H.

Heidi Groff is a Loss Prevention Specialist for Risk Management Foundation

High liability risk for obstetricians/gynecologists is neither a myth nor a mystery. Over the past 10 years, the claim rate for ob/gyn specialists was nearly four times higher than the average for all CRICO-insured physicians.¹⁻² Since 1990, about one out of every 1,000 births involving CRICO-insured clinicians has led to a malpractice claim or lawsuit.

Obstetrics-related cases are more expensive to defend and more likely to result in indemnity payment than cases involving other specialties. In many of these cases, including those resulting in payments, the recording and communication of labor and delivery events were as much an issue as the quality of the care provided.

Clearly, the care of pregnant women and delivery of babies exposes practitioners to extraordinary expectations and emotions. When the outcome of a pregnancy is sub-optimal or unforeseen, assigning blame to and seeking restitution from the involved caregivers is a potential reaction, even when the care meets acceptable standards. And, as the number of deliveries at CRICO-insured institutions increases (*Figure 1*), so too does the likelihood of malpractice cases related to perinatal care.

CRICO Data

From 1990-99, ob/gyns constituted five percent of CRICO's insured physicians, but a much higher percent of the defendants named in malpractice cases (*Figure 2*). This relatively higher frequency for ob/gyn defendants—along with the higher-than-average costs³ associated with defending ob/gyn cases—has prompted Risk Management Foundation to target and further evaluate the factors that lead to birth-related malpractice cases.

Not surprisingly, the majority (86 percent) of the ob/gyn cases directly stem from care provided in the perinatal period (21 weeks of pregnancy to 28 days of life). This edition of *Forum* addresses issues identified in 149 cases arising from care provided in that perinatal time period.

The Most Frequent Allegation

The most frequent allegation in CRICO's perinatal cases—delay in diagnosis of fetal distress (*Figure 3*), and the top risk management issue—insufficient documentation, often go hand-in-hand. Likewise, they often dictate the defensibility of the case independent of the appropriateness of the care provided.

Figure 1
While the number of births at CRICO-insured institutions increased, the claims rate was level.

Year	All MA Births ^a	CRICO births	Claims	Rate ^b
1990	92,461	10,087	16	1.6
1991	88,176	11,502	12	1.0
1992	87,202	12,918	18	1.4
1993	84,627	14,333	24	1.7
1994	83,758	16,816	16	1.0
1995	81,562	16,963	12	0.6
1996	80,164	18,070	16	0.9
1997	80,321	19,064	17	0.9
1998	81,406	20,268	11	0.5
1999	80,866	24,542	5	0.2

The claims per birth in the CRICO institutions remains stable and, given the increase number of births, may even reflect a slight decrease. However, the average lag time from the triggering event to the assertion of a perinatal claim is 35 months, and thus affects claims numbers from 1998 forward.

^a Massachusetts Births 1999, Bureau of Health Statistics, Research and Evaluation, Bureau of Family and Community Health, Massachusetts Department of Public Health.

^b Perinatal claims per 1000 live births.

Figure 2
Obstetrics-related cases are more expensive to defend and more likely to result in indemnity payment

- 5% of CRICO-insured MDs are Ob/Gyn specialists
- 18% of CRICO defendants are Ob/Gyn specialists
- 15% of CRICO incurred losses stem from Ob/Gyn claims
- 86% of Ob/Gyn claims involve perinatal care

	All CRICO	Ob/Gyn	Perinatal
Cases	1,910	174	149
Defendants	3,667	262	227
Closed with payment	36%	48%	49%
Average indemnity	\$265,000	\$310,000	\$678,000
Average expense	\$48,000	\$67,000	\$68,000

The prominence of the allegation of delay in diagnosis of fetal distress mirrors national malpractice experience. A study published in 1998 noted that fetal distress was a factor in 88 percent of malpractice cases related to neurologically impaired newborns, up from 41 percent 10 years earlier.⁴ That increase could be related in part to the increased use of electronic fetal monitoring (EFM). Documentation of each provider involved was often incomplete and/or contradicted information recorded by other providers. Another study found that inability to recognize and appropriately respond to both antepartum and intrapartum fetal distress accounts for the majority of potential and actual malpractice cases reviewed for attorneys on behalf of professional liability insurers.⁵

Diagnosis of fetal distress is multi-factorial; it frequently has at its root clinical judgment, imperfect data, teamwork, staffing, and supervision issues. One can perhaps understand the evolution of a professional liability claim when these diagnostic processes are insufficiently documented. Regardless of the etiology, plaintiffs—and, subsequently, jurors—measure diagnostics and treatment processes by what was or was not documented.

Case Example

A 32-year-old pregnant woman, presenting for the first time, was seen in the physician's office and determined to be 39 5/7 weeks. The physician instructed her, through a translator, to return in one week; however, the appointment was scheduled for almost three weeks later. One week prior to that appointment, the patient presented to the labor triage area where deep decelerations were noted on the EFM strip. Based on the non-reassuring fetal monitor pattern, she was transferred to the labor and delivery area. Minimal beat-to-beat variability was noted by the L&D nurse, who attributed this to the baby sleeping.

A second L & D nurse took over the care during the first nurse's break. During the next 2.5 hours, no care plan was documented. When the physician was notified of a non-reassuring pattern, he attempted to perform a biophysical profile. The baby's heart rate dropped into the 70s and remained there for two minutes. One hour later, a decision was made to perform a cesarean section and the baby was delivered within 30 minutes.

Figure 3

CRICO Perinatal Claims 1990-1999 ^a (N=149)	
Defendants N=227	
Staff MDs	107 (47%)
Residents	27
Fellows	6
Nurses	27
Institution	60
Risk Management Issues (Top 5) N = 426 ^b	
Insufficient/lack of documentation with clinical rationale (often missing electronic fetal monitor strips)	71 (17%)
Selection and management of therapy in labor and delivery	61
Selection and management of therapy on pregnancy	15
Technical problems	13
Failure/delay on ordering diagnostic tests	12
Allegations (Top Five) N = 149	
Delayed diagnosis of fetal distress	32 (21%)
Improper labor management	17
Improper choice of delivery method	14
Improper perf. of treatment/procedure	9
Improper management of pregnancy	9
Injuries (Top Five) N = 149	
Birth injury ^c	46 (31%)
Cerebral palsy	37
Death	25
Mobility dysfunction	12
Nerve damage	11
Final Diagnosis (Top Five) N = 149	
Severe birth asphyxia	18 (12%)
Brachial plexus injury	16
Placental separation/hemorrhage	6
Fetal distress during labor	6
Massive aspiration syndrome	6
Disposition N = 149	
Total Open	52
Total Closed	97
With payment	48 (49%)
Without payment	49
<p>^a Claims and suits stemming from events that occurred between 1990 and 1999.</p> <p>^b CRICO malpractice cases often have more than one contributing risk management issue.</p> <p>^c Includes severe neurologic impairment and cognitive delays (including mental retardation).</p>	

The baby, who had a nuchal cord and Apgars of 0,0, and 1 (with an arterial blood gas of 6.9), was resuscitated for eight minutes and survived. He is severely retarded. A malpractice claim against the institution and the nurses led to mediation awarding compensation to the plaintiff in the high range.⁶

The contributors to the inadequate identification and response to fetal distress included: communication among providers; inadequate care plans, initially and throughout labor; failure of coordination of care; communication/language barrier with the patient; and inadequate documentation of care.

The Problem of "Birth Asphyxia"

"Birth asphyxia" was listed as the final diagnosis in 19 of the 149 perinatal cases reviewed, followed by brachial plexus injuries (11 cases), and placental separation (8).

Listing "birth asphyxia" as a final diagnosis points to a problematic issue in claims management. The term may be written in the medical record for various reasons and yet not meet the clinical criteria (*see Page 4*). Despite the fact that "asphyxia" may not accurately reflect the clinical process that occurred, it may persist as the presumed cause of perinatal morbidity associated with outcomes like cerebral palsy and other neurological impairments.

Case Example #2

A 32-year-old woman with cerclage in place had spontaneous rupture of membranes at 5 p.m. At 8:30 p.m., the cerclage was removed. The patient's temperature was 99°F, and she was given IV gentamicin for possible chorioamnionitis. Pitocin was also begun. The fetus developed tachycardia with variable decelerations. At 12:10 a.m., the nurse documented "EFM applied, patient pushing, deep variable decelerations down to 70s followed by terminal bradycardia to 50s." At 12:23 a.m., a 1710 gram baby was born with Apgars of 4 and 6. The baby was intubated and placed on antibiotics. The child was admitted to the NICU with the admission note reading "fetal distress for 45 minutes with heart rate of 50 without recovery." The neurologists note read "likely hypoxic-ischemic event at delivery." The child has cerebral palsy.

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A suit against two attending obstetricians, alleging failure to recognize fetal distress with asphyxia, was dismissed. The non-reassuring EFM pattern and fetal bradycardia indicated probable neonatal depression and a worrisome outcome for the fetus. However, without known (documented) concurrent acidosis, it is not clear that this baby had asphyxia at birth.

What Can You Do?

The accompanying articles in this issue address many opportunities for the improvement of perinatal care and the reduction of malpractice claims against ob/gyns. As in any field of medicine, the best defense against malpractice is good care. But, as has been noted, a certain level of malpractice litigation is inevitable. Providing (and defending) appropriate care for pregnant women and their fetuses can be enhanced by the following measures:

- Strive to document contemporaneously. “Remembered” medical record notations are less credible.
- Pursue teamwork initiatives in labor and delivery (and also with neonatologists if required) to improve communication and coordination of care.
- Document comprehensive care plans in labor and delivery—especially with prolonged second stage and arrest of labor—and communicate the plan to all obstetrical team members.
- Attend to the appropriate clinical definitions of asphyxia. Stay abreast of future identifiers of hypoxic risk. Evidence is emerging that may link selected genetic factors that affect the fetal response to hypoxia and resultant apoptosis.⁷
- Address “non-reassuring” fetal heart tracings. First attempt to determine the etiology of the pattern, then attempt to correct the primary problem, or institute general measures aimed at improving fetal oxygenation and placental perfusion. If unsuccessful, perform fetal scalp blood pH or oximetry to determine whether operative intervention is needed.

- Obtain an umbilical artery blood gas analysis if indicated. At worst, it will substantiate the obvious: that the neonate was in poor condition at birth. This is valuable information for those caring for the neonate. At best, and most often, it will show that the fetus was born in a good metabolic state and that intrapartum care was appropriate.⁸
- Understand the current reality. Despite improvement in perinatal care, the prevalence of cerebral palsy has not decreased in France, Sweden, Australia, or the United States. The prevention of cerebral palsy must be undertaken very early, in pregnancy. In fact, premature birth is the strongest predictor of cerebral palsy and is difficult to predict, despite minimization of risk factors.⁹

More than a century ago, Sigmund Freud wrote: “One has to consider that the anomaly of the birth process, rather than being the causal etiologic factor, may be the consequence of the real prenatal etiology.”¹⁰ Today, with technical advances Freud could have only dreamed of, the mysteries of many newborn injuries remain unsolved.

The practice of obstetrics is still daunting. It involves a complex web of systems and professionals with varying roles and responsibilities. Despite the best intentions, injuries still occur. We must look at issues at a systemic level and question if and how we can do things in a safer manner. ■

Notes & References

- 1 Controlled Risk Insurance Company, Inc. (CRICO) provides professional liability insurance for Harvard-affiliated physicians, health care institutions, and their employees.
- 2 The rate for all CRICO physicians from 1990-99 was 3.2 claims per 100 physicians insured; for obstetrician/gynecologists, the rate was 12.1.
- 3 Defense costs include fees for attorneys, expert witnesses, and demonstrable evidence.
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Preventable versus Non-preventable Birth Injuries

By James A. Greenberg, M.D., and Jeffrey L. Ecker, M.D.

Dr. Greenberg is Chief of the Division of Gynecology at Faulkner Hospital (Boston) and Vice Chairman of the Department of Obstetrics and Gynecology at Boston's Brigham & Women's Hospital. Dr. Ecker practices in the Department of Ob/Gyn at Massachusetts General Hospital.

“**B**irth asphyxia” is a nightmare for patients *and* practitioners. Babies who survive are often profoundly affected with devastating and lifelong handicaps. The parents' lives are changed forever by both the heartache of the injury to their child as well as the burden of caring for a permanently physically and mentally impaired family member. Obstetricians, midwives, and nurses are often similarly devastated, and provider distress may be aggravated by speculation on the part of colleagues, supervisors, or parents that somehow the injuries might have been prevented by appropriate intervention.

From a malpractice liability perspective, providers are wise to take steps to reduce the likelihood of a successful lawsuit when no interventions could have altered the outcome. To this end, practitioners can collect important data which may identify cases in which the injury either occurred before admission or was demonstrably not the result of intrapartum asphyxia.

Misuse of the Term “Birth Asphyxia”

In spite of the physical and emotional burdens related to asphyxia and the payouts they generate, increasingly researchers recognize that not all cases labeled “birth asphyxia” are preventable. Many of these represent hypoxic-ischemic neurologic injuries that occurred prior to hospital admissions, and others result from non-hypoxic neurologic injuries. For example, both prematurity and infection absent asphyxia have been linked to cerebral palsy.¹

In recognition of the more limited role that intrapartum events may play in neonatal neurologic morbidity, in 1997 the Academy of Pediatrics and The American College of Obstetricians revised their definition of birth asphyxia.² To be labeled birth asphyxia any individual case must meet the following criteria:

- 1 Prolonged metabolic or mixed acidemia (pH<7.00) on an umbilical cord arterial blood sample;
- 2 Persistence of Apgar score of 0 to 3 for > 5 minutes;
- 3 Clinical neurologic sequelae in the immediate neonatal period (including seizures, hypotonia, coma or hypoxic-ischemic encephalopathy); and
- 4 Evidence of multi-organ system dysfunction in the immediate neonatal period (e.g., pulmonary failure, pulmonary hypertension, oliguria or renal failure, shock, hepatic dysfunction).

These criteria were not arrived at arbitrarily. Rather, they were derived from an understanding of physiologic changes that occur in-utero when primates are exposed to reduced

Practitioners need to identify, document and act on any concerns about fetal well-being on admission.

oxygen concentrations and/or reduced cerebral blood flow. In these animal models, as cerebral oxygenation falls below the threshold for normal cerebral function, lactic acid builds up, leading to an acidosis that disrupts both neuronal transmitters and energy production.³ If the hypoxia and resulting acidemia are severe or prolonged, these disruptions can result in irreversible neuronal damage.⁴ An important implication of this causal pathway is that without concurrent acidosis, even infants who are depressed at birth and demonstrate neurologic injuries cannot have true “birth asphyxia.”

Recognizing Antepartum Injuries

Antenatal insult, whether from a complication of pregnancy, maternal medical complications, or intrinsic fetal abnormalities, can result in fetal injury prior to labor and delivery. In evaluating neonatal health and timing of injury, an often overlooked issue is the neurologic status of the fetus upon admission to labor and delivery.

While the utility of electronic fetal monitoring in predicting fetal well-being has been widely debated, even the most ardent critics of such monitoring would agree that a reactive non-stress test is physiologically incompatible with a profound, global hypoxic-ischemic encephalopathy.⁵ Tracings with absent beat-to-beat variability (0 beats/minute, the so called “pencil line tracing”) are of great concern especially if continued observation demonstrates that the episode of absent variability is not transient.

In such patients, practitioners should not be reassured by the absence of decelerations, for the profoundly injured fetus may not have the reflex pathways needed to generate such changes in long term variability. While a fetal heart rate tracing with absent beat-to-beat variability is not always predictive of poor outcome, it should raise concern that the fetus has suffered an injury prior to admission. These observations may not affect intrapartum management—fetuses with such concerning testing are likely to be delivered by cesarean section even if care providers suspect an antepartum insult—but they may highlight fetuses that will still be compromised in spite of such intervention.

Practitioners need to identify, document and act on any concerns about fetal well-being on admission. In this regard, if the responsible practitioner is reassured by other testing or findings, these need to be documented in the medical record.

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Using Cord Blood Gasses

As argued above, the absence of fetal acidemia is incompatible with a recent significant rise in utero hypoxia. (Fetuses with more temporally remote insults may, however, have normal cord pHs at birth, a finding which further emphasizes the need to examine and document the state of fetal well-being at admission.) Collecting cord blood gasses can therefore help pediatricians accurately diagnose and treat a severely depressed newborn and help protect practitioners from claims of asphyxial birth injury.

To collect a sample, the cord is doubly clamped in two places about 25 cm apart. The cord is cut between each set of clamps, and blood is aspirated from the umbilical artery and vein using heparinized syringes. The bloods are then analyzed for pH, carbon dioxide, and oxygen tension in a blood gas machine. Because arterial blood more accurately reflects the fetal state (in the fetal circulation the umbilical artery carries blood from the fetal circulation to the placenta for oxygenation), arterial pH is especially important.

Once the cord is clamped, the time at which the samples are drawn from the cord and the interval preceding analysis in the laboratory appear to be much less critical. Nor is it important that either the cord or filled syringes remain on ice. Studies suggest that after the cord is clamped, specimens may be drawn and analyzed at the clinician's and laboratory's convenience. There is no evidence that normal pHs vary by gestational age and therefore should not be significantly affected in cases of prematurity.

In collecting cord gasses, the "normal" range of values is important to understand. While an arterial pH > 7.0 strongly argues against asphyxia, a pH < 7.0 is poorly predictive of neonatal outcome and the majority of newborns with low pHs will prove to be normal.

Summarizing their review of the available literature, Nelson and Emery concluded that "[t]he relationship of pH to neurologic symptomatology in the neonatal period is...weak. The association of pH with long-term neurologic outcome is even weaker...only extreme and rare values [predict] even short-term ...outcomes."⁶ Indeed, some investigators have argued that a cutoff of pH=6.80 is more appropriate for making clinical decisions.⁷ In cases in which a newborn is depressed and the cord pH suggests acidemia, those caring for the baby should be attentive to the other criteria needed to define birth asphyxia and should avoid using such terms until the definition is met.

Collecting cord blood gasses can therefore help pediatricians accurately diagnose and treat a severely depressed newborn and help protect practitioners from claims of asphyxial birth injury.

In recognition of the above findings, selective rather than universal cord blood sampling at birth is recommended. Set a segment of cord aside in those infants who are not immediately vigorous at birth. If such infants remain depressed at five minutes (Apgar < 5) or demonstrate other signs of injury (e.g., seizure), cord gases from the reserved segment should be obtained. Only those involved in research will want or need to obtain umbilical cord gases from every newborn.

Conclusion

In summary, while eliminating *all* cases of intrapartum asphyxial injuries would be ideal, that may not be possible at this time. That notwithstanding, we may be able to reduce the number of inappropriate "birth asphyxia" malpractice cases if practitioners diligently adhere to the following policies:

1. Collection of umbilical artery blood gas analyses in non-vigorous infants with five-minute Apgars < 5.
2. Careful *documentation* of fetal status on admission as demonstrated on the admission electronic fetal heart tracing.
3. Timely intervention in cases where fetal well-being is not reassuring on the electronic fetal heart tracings. ■

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Improving Obstetric/Pediatric Teamwork and Coordination of Shifting Care

by Steven Ringer, M.D., Ph.D.

Dr. Ringer is Director of Newborn Medicine at Brigham and Women's Hospital in Boston.

The shifting focus of perinatal care—from the mother's health alone, to the mother *and* fetus, and then the special concerns surrounding labor and delivery—can pose problems and concerns for new parents. Under stressful conditions, they must develop a relationship with, and trust in the new pediatric caregiver while still maintaining their bond with the obstetric provider.

When the birth involves unusual complications—or when potential problems arise—a lack of teamwork or coordination may exacerbate worries for both the parents and the clinicians. Poor team coordination can cast the appearance of inadequate or negligent care, even when the technical aspects of care are of impeccable quality.

Improving Care Team Communication

The likelihood of such problems can be minimized if every institution and group of caregivers creates a local system to ensure that care is delivered in a competent and coordinated manner. Communication with patients and among caregivers is central to success. In particular, obstetricians should:

- discuss pediatric care with the mother-to-be and, if none has been chosen, personally recommend a pediatrician;
- note what pediatric services are available during delivery; and
- explain the common clinical occurrences when the presence of a pediatrician might be desirable at the time of birth.

Parents are likely to be reassured knowing that special care is available if needed and, most often, is for minor issues.

This communication needs to continue during labor. If at any time the status of the fetus is a concern, or a potential problem, the obstetrician should invite the pediatrician to meet the parents—prior to delivery if possible. Demonstration of a collegial relationship between competent caregivers who share responsibility for care reassures parents that every effort is being made to anticipate and confront potential problems.

Some obstetricians are concerned that requesting pediatric consultation at delivery will worry parents, or give the impression that something has been done wrong. Extensive clinical experience has shown that the opposite is much more likely to be true. Parents are impressed that close attention is being paid to the condition of the baby, and that a caring, vigilant obstetrician is doing everything possible to ensure that the best care will be delivered to the baby through labor, delivery, and the immediate postpartum period.

Improving Pediatrician/Parent Communication

Communication and anticipation are not solely the province of the obstetrician. The pediatrician also bears a special responsibility to reassure the parents that those possessing the expertise to care for the baby are present, without overemphasizing or accentuating concerns. Anticipation should be highlighted as the best way to ensure good care, while at the same time giving an honest assessment of how likely it is that special care will be required. Confidence can be destroyed if the magnitude of potential problems is minimized, and then—for example—parents observe a major resuscitative effort.

Achieving the right balance in discussing concerns without causing undue worry is best done when the clinicians have a good understanding of the parents' personalities and general views of life. During a preliminary discussion between caregivers, the obstetrician may be able to offer the pediatrician important insight in these areas.

When the care of the baby is transferred to the pediatrician or pediatric caregiver, the situation, again, poses special challenges. Even the smoothest and most problem-free birth and neonatal transition can be unfamiliar and scary to parents. Reactions and perceptions are likely to be colored by the high emotions of birth. Even the emergence of a normal baby—who is wet, transiently cyanotic, and covered with blood streaks and amniotic fluid—is contrary to the reinforced mental image of a smiling pink baby like the ones on baby food jars. This can be a frightening or confusing several minutes.

Improving Crisis Communication

When birth complications do arise, clear communication among care team members is paramount. Personal anxiety or emotions of the caregivers must not be allowed to disrupt information transfer. Failure to heed this caveat can create the appearance of problems that *don't* exist, and can only hamper good care.

Vital signs must be accurately conveyed, and uncertainty, if present, must be recognized. For example, indicating that one is having some difficulty accurately assessing the umbilical pulse of a wet, slippery baby is perceived quite differently than a loud, anxious pronouncement that “there is no pulse.” Of course, the converse example is equally important: the entire team must be aware of a low or absent pulse rate if it in fact is present. The point is not to obscure problems, but to avoid inaccurate statements or actions.

If the baby requires resuscitation or additional care at delivery, caregivers must remain cognizant of the fact that parents are viewing the scene and will hear all comments

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and discussions. A discussion about “what’s happening to their baby” should be held with parent as soon as circumstances allow.

If additional care after birth is needed, a full explanation to parents must include a review of the care provided in the delivery room. When possible, including the obstetrician in the discussion will ensure that consistent information is given to parents, and that their questions and concerns are addressed to the fullest extent possible. If the baby must be transferred to another facility, both the pediatrician and obstetrician should explain the issues around levels of care and a commitment to optimizing the baby’s care. Explaining why the transfer is necessary (e.g., resource issues, not caregiver competence) is an important element of honest, coordinated communication.

One of the more common and most damaging lapses in team communication occurs in documentation. Inaccuracies will increase the chance that one member of the team will misunderstand or incorrectly explain some aspect of care to the parents. The result may be a perception of confusion within the care team or the suspicion that someone possesses inadequate knowledge, which may irrevocably disrupt patient trust in caregivers or an institution.

The more information shared between obstetrician and pediatrician before delivery, the greater the likelihood that an accurate recording of maternal and fetal issues will appear in the medical records. If the indications for a delivery or intrapartum events are not clearly specified, the risk for vague and potentially misleading phrases like “fetal distress” or “prolonged period of...” being entered in the record increases. Without adequate information, the tendency for pediatricians—however incorrect—is to assume that all depression at birth is secondary to acute hypoxemia or acute hypoxic-ischemic injury.

Communicating an Accurate Diagnosis

While such injuries do occur, many other known or theoretical causes of neonatal depression should be considered and ruled out before any diagnosis is made. Unless all available data and information about the antepartum period are known, the pediatrician is at risk of reaching an incorrect or incomplete conclusion. This type of error

Poor team coordination can cast the appearance of inadequate or negligent care, even when the technical aspects of care are of impeccable quality.

is then commonly compounded by another, even more dangerous one. Although clinicians would hope to avoid it, diagnoses tend to be carried forward in the record without review, and to become “facts” merely by virtue of repetition.

Case Sample

An infant was born at full term after a labor complicated by only a few variable decelerations in the fetal heart rate. The infant was mildly depressed at birth, but cord blood pH was normal at 7.36. The infant had some respiratory distress but continued to have a normal pH while in the nursery. Seizures occurred at 4-5 hours of life, with no evidence of metabolic derangement or infection. Due to limited facilities at the birth hospital, the infant was transferred to a Level III NICU for neuro-imaging. The discharge and admitting diagnoses around transfer were “Seizures, unknown etiology,” but a note written soon after transfer included the diagnosis “Seizures, r/o Hypoxic-ischemic encephalopathy.” The workup revealed no information consistent with this diagnosis.

The care team changed on the fourth hospital day and the initial note by the new pediatric resident included “Hypoxic-ischemic encephalopathy.” This diagnosis later appeared in the discharge summary and then subsequently in notes written during long term follow-up.

A completely incorrect and unsubstantiated diagnosis had, through repetition, become a “fact.” When issues of negligence were raised concerning the obstetric care rendered around the time of birth, this “fact” was extremely difficult to debunk. Such a sequence of events could have been prevented, if a coordinated team approach to care and communication had been in practice.

The conduct of perinatal care requires a system of coordination to ensure that information is communicated effectively among caregivers, and between caregivers and patients. The large number of handoff or transfer points increase the chance that a failure of communication will occur, and all members of the care team must help work to prevent this. The risk that a patient may have an inaccurate or incomplete perception of how care was delivered is accentuated by the fact that most people have limited knowledge about or familiarity with perinatal care, and their personal experience is colored by the normal powerful emotions that arise during the birth of a child. Anticipation, communication and teamwork will maximize the quality of care delivered, while reducing the potential for errors or misunderstanding. ■

The Perinatal Nurse's Communication Responsibilities

Patricia M. Connors, N.P.

Patricia Connors is a Perinatal Clinical Nurse Specialist at Massachusetts General Hospital and Certified Legal Nurse Consultant.

The perinatal nurse often has first contact with the expectant patient, during which time assessments are made and a care plan is formulated. By identifying risk factors (or evident risks) and notifying the appropriate provider, the perinatal nurse can help reduce preventable errors. Without this stage and level of assessment—and communication among subsequent caregivers—the obstetrical team's work could be placed in jeopardy.

To assure patient safety, the perinatal nurse needs to convey to the provider the patient's physiological status (vital signs, contractions, physical examination findings) and the well-being of the fetus as evidenced by fetal heart auscultation or monitoring in clear language. This entails both oral and written communication.

Oral communication is most effective when the following techniques are used:¹

- The provider is asked to see the patient immediately if the mother and/or fetus are at risk;
- Speech is clear, tone is congenial;
- All relevant facts, including concerns and abnormal findings, are communicated;
- Facts are presented in a methodical/chronological style;
- Clarification of orders is requested at the time the nurse has the physician or midwife's full attention;
- Reasons for any disagreement with the treatment plan are conveyed clearly at the time of the encounter; and
- The provider is informed if the "chain of command" process is to be enforced.

Written communication of patient information is most successful when it:³

- Accurately and legibly records:
 - ◆ reason for care
 - ◆ care plan
 - ◆ care given (and the results)
 - ◆ only interactions between the nurse and other providers related to patient care
- Is as time specific as possible, and
- Uses only approved hospital abbreviations.

Documentation should always be viewed as an essential element in the care of the patient and venue for maintaining cohesiveness among the health team members. An example would be the labor progress record of maternal/fetal data being of importance to the neonatologist should the infant show signs of sepsis. Maternal risk factors, change in vital signs, medication administration (such as antibiotics) and fetal intolerance to uterine contractions during the course of labor would be significant and helpful information for the implementation of care.

Mutual Ethical Concern

When differences of opinion arise, feelings of fear or intimidation should not inhibit nurse-physician communication. The American Medical Association's *Code of Medical Ethics*, states:

The primary bond between the practices of medicine is mutual ethical concern for patients. One of the duties in providing reasonable care is fulfilled by a nurse who carries out the order of the attending physician. Where orders appear to the nurse to be in error or contrary to customary medical and nursing practice, *the physician has an ethical obligation to hear the nurse's concern and explain those orders to the nurse involved*. The ethical physician should neither expect nor insist that nurses follow orders contrary to standards of good medical and nursing practice. In emergencies, when prompt action is necessary and the physician is not immediately available, a nurse may be justified in acting contrary to the physician's standing orders for the safety of the patient.³

Importance of Education

Staff should be oriented to the responsibilities of individual roles and communication principles. Nursing education should include the principles of leadership, management, delegation, and supervision. Where entry level education leaves off, health care organizations must invest in preparing the professional nurse for the care delivery in that organization.⁴

Breakdowns in communication channels need to be addressed without delay and the nursing staff kept aware of any changes in hospital policies or procedures. Sentinel events require immediate investigation, a plan of corrective action, and follow-up so that all team members are made aware of any changes to be implemented.

Nurses need to maintain effective communication skills and seek the guidance of the institution if problems are encountered. Inservice education should be readily available by accessing the clinical nurse specialist most suited to the topic. In some cases, conflict resolution may be necessary and that can be addressed by such an expert. Mutual respect for each member of the team by acknowledging his or her expertise, knowledge and significant contribution to patient care should be germane to all providers. ■

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Proactive Risk Management for Obstetrical Teams

By Daniel Risser, Ph.D.; Ronald Marcus, M.D.; and Heidi Groff, R.N., N.P., M.P.H.

Dan Risser is a Senior Scientist in the Crew Performance Group at Dynamics Research Corporation; Dr. Marcus is Medical Director for Obstetrical Services at Boston's Beth Israel Deaconess Medical Center; Heidi Groff is a Loss Prevention Consultant for Risk Management Foundation.

A review of CRICO's (closed) obstetrics-related malpractice claims is currently underway as part of a project to refine the teamwork system and focus the training of teamwork skills at Boston's Beth Israel Deaconess Medical Center (BIDMC) labor and delivery unit. In its preliminary assessment, the group has concluded that the decision to litigate was often driven by the following factors:

- clinical task performance,
- documentation quality,
- clinical outcome,
- clinician bedside manner, and
- patient involvement in decisions.

The review is also providing insights into the emerging risk management consequences of thinking of clinical errors as stemming from the design weaknesses of a complex care delivery system—rather than simply attributing clinical error to individual clinician negligence or incompetence.

Clinical Work Team Development

Rapid, face-to-face coordination is essential to high quality labor and delivery care. To that end, BIDMC is adapting the MedTeams system—currently used to organize and train clinical work teams in emergency departments (ED) across the country—in its labor and delivery unit.¹⁻³

Under this system, based on principles originally developed for aviation flight crews, each work team is responsible for a specific set of patients. Most commonly, a physician serves as the team leader. Work team size is small to permit efficient, reliable clinician coordination and communication. The physician retains the primary responsibility for the patient and clinical care decisions. The team contributes to care decisions, oversees care delivery, and serves as a safety net to help avoid errors. The five team dimensions associated with the operational employment of a team are:

- maintain team structure and climate,
- plan and problem solve,
- communicate with the team,
- manage workload, and
- improve team performance.

The MedTeams research project⁴ involves: 1) reviewing closed claims, 2) adjusting the teamwork training system to the labor and delivery environment, and 3) conducting a large-scale experimental validation via hospitals across the country. BIDMC is one of several participating hospitals.⁵

A Systemic Perspective in Health Care

The Institute of Medicine's "To Err Is Human" report spoke strongly for a move away from the ineffective "blame and punish" model of clinical error management to a more realistic "complex system redesign" model.⁶ The latter model recognizes that errors and patient risks stem primarily from the poor design of complex care systems. It also acknowledges that, too often, a failure to understand human limitations and the inherent fallibility of human performance when designing the system is a major contributor to clinical error.

This shift in the conceptualization of the origin of error is having a profound effect on both the health care system and risk management. While compensation for clinical error-induced injuries will still be addressed, much more risk management energy will be focused on understanding the system breakdowns that occurred and ways that the system weaknesses can be corrected.⁷ And, while risk management will clearly continue its *reactive* litigation duties, it will move toward *proactive* initiatives. Individual clinician performance will no longer be seen as the sole contributor to error occurrence.

Current RM/QI Approach

The basic quality improvement approach currently employed by risk management is a three-step process used to find patterns and provide general insights for clinical leaders and risk managers.

- 1 Capture essential facts surrounding each claim event.
- 2 Analyze set of claims for systemic problems.
- 3 Take practical actions to correct problems.

The approach works well for broadly categorizing claim events and systemic problems, but tends to break down at Step 3 where the insights gained are often difficult to convert to practical actions. Also, the facts traditionally collected are almost completely focused on the individual blame-related issues associated with legal defense of the case. The focus is on "winning a litigation" rather than understanding and refining the care delivery system so that future errors and litigation can be avoided.

While clinicians have a right and obligation to defend themselves against such claims, the legal process seldom effects restructuring of the system to avoid future errors. Even a root cause analysis on a sentinel event must be viewed with caution as a diagnostic tool for system problem correction since what one can learn about systemic problems from a single case is inherently limited. The bottom line is that this near-term "litigation fight" focus limits the opportunity for proactive management of risk.

Updating the RM/QI Approach

Leaders must learn to think of clinical errors as stemming from breakdowns in a complex delivery system.⁶ Figure 1 shows the adjustments to the current RM/QI system that we believe are necessary to generate practical, proactive care system improvements.

Caregivers and risk managers must develop a basic understanding of system factors that directly and indirectly influence patient safety and litigation. This enables them to create or select analysis tools that are sufficiently diagnostic in their structure so that practical recommendations can emerge from the analysis. Before use, however, each tool must be tested to see if sufficient data exists in the case files to support its use. Where sufficient data of sufficient quality exists for use of the tool, the analysis proceeds.

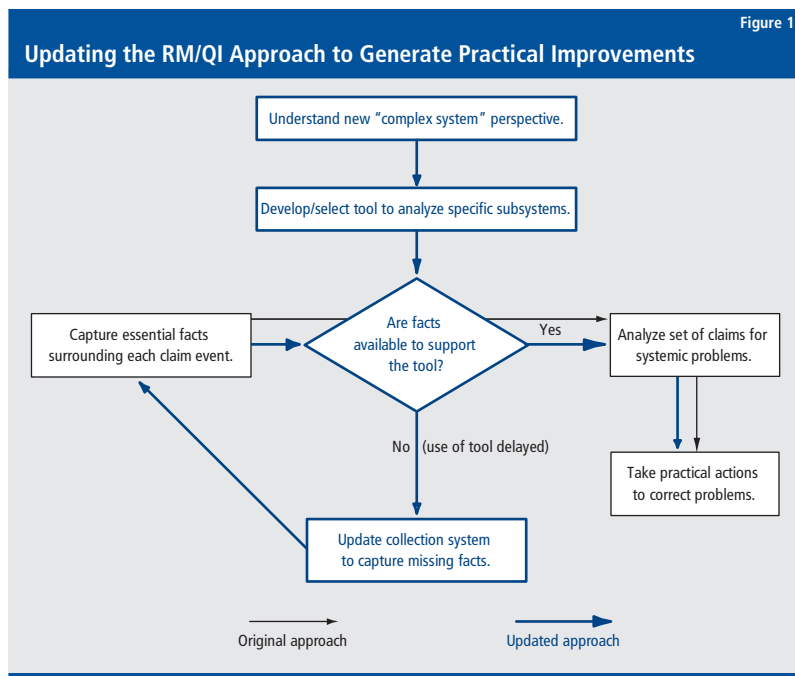
Where important data are missing, the collection process is revised to gather the relevant facts in future cases. These missing facts are probably best collected when the event first surfaces as a risk case, i.e., before it becomes a lawsuit. Collecting the information through interviews immediately following the event has several merits:

- the physical evidence associated with event actions is still fresh and available,
- the parties involved can still recall the details of the event and the decisions made, and
- collecting facts not specifically related to a suit is too risky once a lawsuit is filed; new information might trigger new avenues of litigation.

Note that data must, typically, be collected for a significant number of risk cases (at least 10-15) before useful analysis can be conducted. Additionally, the questions asked of the clinicians and others involved must be appropriately constructed to elicit the desired information. And the interview process must be sensitive to the anxieties of the individuals involved. Risk case data collection is a relatively slow process, requiring tactful interactions. Collecting the facts requires patience and sensitivity.

Closed Claims Review

As part of MedTeams review of CRICO claims, the review team—two attending obstetricians and two experienced nurses—identified factors they believe influence errors and the plaintiffs' decisions to litigate.



Top on the list, was *clinical task performance*, which was further viewed as being a function of two subfactors: individual *clinical skills*—ensured by the professional credentialing process—and the quality of the *clinical teamwork*. *Care documentation quality*, *clinical outcome*, and *bedside manner* were also listed.

The final factor that seemed to be triggering decisions to sue was *patient involvement in decisions* (including informed consent). This joint clinician-patient decision activity is becoming an increasingly critical facet of health care in a world where patients are demanding more involvement in their own treatment plans.

What was discovered regarding the availability of facts in the claim files is precisely what one would expect in a world dominated by litigation. Clinical task performance and professional certification information is readily available—in patient records and other documentation. Because the patient record and the entire claim file was present, it was easy to assess the quality of the documentation. And—since a claim or suit had been filed—facts regarding the undesirable clinical outcome were available.

On the other hand, facts less commonly considered in litigation were more poorly captured. The MedTeams Teamwork Failure Checklist³ (e.g., *Was the team leader clearly established? Did caregivers offer assistance to an overloaded teammate? Was the team involved in decision making? Was the plan communicated to team? Did the team use “check backs” to ensure accurate communication?*) was usable, but

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difficulties were encountered. Files often had limited information describing the coordination, communications, and interactions of the caregivers. And the claim files were virtually silent on clinician bedside manner, and provided limited insight into patient involvement in decisions.

The prototype Person Care Failure Checklist (e.g., *Did caregivers take time to answer the patient's questions? Was clinical information explained in clear simple language? Was the patient's family treated with respect?*) was deemed unusable for assessing bedside manner.

Figure 2 summarizes the status of fact availability in the reviewed labor and delivery claim files. The table reflects the judgment of the clinicians who have been systematically reviewing the claim files for teamwork failures. At some future date, questions will be developed to help capture the missing information.

Future Actions and Directions

The immediate goals are to complete the assessment of teamwork failures that contributed to clinical errors in labor and delivery units and to continue the design and development of the validation project. On the horizon, however, are much broader issues of great importance. In the not distant future, the increasing concern for patient safety and patient rights will almost certainly bring about greater attention to all of the factors mentioned above. Clearly, new directions are emerging. For example:

- The health care community will become dramatically more attentive to the “complex care system” model of error origin.
- Patient involvement in decision making will become a greater point of focus in the health care process.
- Increased national visibility of patient safety issues will increase the pressures and opportunities for proactive risk management efforts.
- Proactive risk management will induce significant cooperation between clinicians and risk management personnel as they seek to analyze and understand system problems and solutions.
- Risk managers from different facilities will collaborate to share claims data and conduct studies to gain care delivery system insights.
- Analysis efforts will involve other “third party” participants with particular technical expertise (e.g., human factors engineers, health policy analysts, architects).

Figure 2

Availability of Facts in Closed Labor and Delivery Claim Files							
Functional Area of Interest							
Claim File Capture of Facts	Clinical Task Performance	Clinician Credentials (skills)	Teamwork Actions	Care Documentation	Patient Outcome	Clinician Bedside Manner	Patient Involvement in Decisions
Good	X	X		X	X		
Fair			X				X
Poor						X	
None							

- The sophistication of risk case and claim-based analysis will grow.
- The range and classes of data captured in claim files will expand significantly to support these analyses. ■

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- 4 Dynamics Research Corporation (DRC) is the MedTeams Program leader, the chief scientist is Robert Simon. The labor and delivery unit of Beth Israel-Deaconess Medical Center in Boston is the lead clinical unit from the civilian sector. The labor and delivery unit at Madigan Army Medical Center in Tacoma, WA is the clinical leader for participating military hospitals.
- 5 Facilities with labor and delivery units interested in participating in the MedTeams Labor and Delivery Teamwork Validation Study should contact Susan Caffrey at 978-475-9090, ext.1227 or by e-mail to: scaffrey@drc.com.
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Video Dramatizes CRICO Obstetrical Cases

True stories from CRICO closed claims files make the 17-minute videotape “First, Do No Harm” a dramatic way to begin discussions of patient safety issues with both clinician and non-clinician groups. The script is based on three cases from the CRICO files combined into the story of one young couple. The story begins as they are finishing a late-term obstetrical appointment and ends with the young husband in a surgical waiting area as the care team fights for the life of his wife and baby.

While “First, Do No Harm” is drawn from three obstetrical cases, all specialties can find lessons about common system breakdowns, pressures, and communication failures. The video debuted at the June 2000 Partnership for Patient Safety (P4PS) conference. Since then, RMF staff have facilitated discussions based on the video at a dozen or more programs (including Grand Rounds) at many of the Harvard hospitals.

The video (and, soon, a discussion guide) is available without charge to Harvard institutions and their employees and CRICO-insured physicians. Contact RMF Director of Education, Peggy Martin at 1-617-495-5100, ext. 214, or by e-mail to: pmartin@rmf.harvard.edu.

Outside the CRICO system, the video can be purchased from P4PS by calling (312) 543-5532.

Challenging Junk Science Testimony

by Susan Donnelly, J.D.

Susan Donnelly is a partner with Murphy and Riley, in Boston

Traditionally, once an expert witness in a medical malpractice trial demonstrated reasonable credentials, he or she was allowed to opine as to all medical issues in the case. But, through a series of decisions beginning in 1993, courts have been invited to examine the basis of an expert's opinion to assess its scientific reliability *before* allowing that evidence before the jury. In other words, challenging "junk science" is becoming more common.

Both sides in a malpractice trial must educate the jury as to the pertinent medical science and its applicability to the case at hand. This is done through expert witnesses. The experts must describe for the jury the appropriate care and treatment that the physician should have provided, the manner in which the physician deviated from that standard (the negligence), and how the plaintiff's injuries are causally related to that negligence. Expert testimony should not be based upon conjecture or speculation.

Counsel should extensively evaluate the proffered opinions of an opposing expert and mount a challenge if those opinions do not meet the criteria for presentation in court.

The Trial Judge as the Junk Science Gatekeeper

The precedential *Daubert* case specifically designated the trial judge as gatekeeper for determining the admissibility of expert evidence.¹ The Massachusetts Supreme Judicial Court, in *Commonwealth v. Lanigan*² endorsed the trial court's gatekeeping role and affirmed the trial judge's obligation to make "a preliminary assessment of whether the reasoning or methodology underlying the testimony is scientifically valid and of whether that reasoning or methodology properly can be applied to the facts in issue."³

The highest court has stated that "a party seeking to introduce scientific evidence may lay a foundation either by showing that the underlying scientific theory is generally accepted within the relevant scientific community, or by showing that the theory is reliable or valid through other means."⁴ It also says "that a person qualifies as an expert does not endow his testimony with magical qualities."⁵⁻⁶ The trial judge's gatekeeping function is the same regardless of the expert's methodology in reaching his conclusion, clinical experience and observations included.⁷ Opinions regarding medical causation are classic examples of testimony that must be subject to *Lanigan* analysis.⁸

It remains incumbent upon defendants to a malpractice case to continue to bring to the trial court's attention its "gatekeeping" function by way of solidly based motions to exclude expert opinions. Though courts will often be reluctant to grant such motions *in toto*, the ensuing trial can be successful due to the pre-trial preparation of *Daubert*/*Lanigan* motions.

Late Onset GBS

One recent case that led to a challenge of expert testimony involved a newborn afflicted with permanent neurological damage caused by Group B streptococcal (GBS) infection. The defendants included a prenatal obstetrician, delivery obstetrician, and initial evaluating pediatrician.

Both sides agreed as to the events leading up to the boy's diagnosis of meningitis and sepsis due to Group B streptococcal disease. And, both parties agreed that the mother tested positive for GBS in her 28th week of pregnancy. The group of obstetricians caring for her were aware of the results of the GBS culture. During labor and delivery, the mother was not treated with antibiotics as she did not evidence any of the factors (known in 1993) to increase the risk of transmission of GBS from mother to baby.

The infant, after birth and indeed for 23 days, was asymptomatic and by all accounts, healthy. At 23 days, he became lethargic and irritable, would not eat, and developed a fever. At the hospital, he was diagnosed with meningitis and sepsis due to GBS infection. He subsequently developed severe and permanent neurological damage.

The defensibility of the case rested with the diagnosis of late-onset GBS infection. The physicians caring for the infant during his initial hospitalization had documented this diagnosis. Experts retained by the defendants in the fields of obstetrics and pediatric infectious disease unequivocally informed counsel that in 1993, and even in 2000, medical science has no way to predict or prevent an infant's acquisition of late onset GBS infection.

The plaintiffs' expert obstetricians, pediatricians, and adult infectious disease specialists were all prepared to testify that treatment of the mother with antibiotics during labor and delivery and/or treatment of the infant with a course of antibiotics shortly after birth would have prevented the acquisition of late-onset GBS disease.

Questionable Opinions

No scientific data support the proposition that administering antibiotics to a GBS colonized pregnant woman in labor prevents late-onset disease. All treatment guidelines and recommendations have focused upon decreasing the incidence of early-onset disease and have been based upon studies demonstrating efficacy of intrapartum antibiotic chemoprophylaxis toward early-onset disease.

The overall rate of late-onset disease, in contrast, changed little over the same time period, with no evidence of a significant decline in the incidence of late-onset disease as a result of perinatal preventive measures. Moreover, recent

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data confirm no significant changes in the rate of late-onset Group B streptococcal disease or neonatal infections from other bacteria after the introduction of prophylactic treatment of mothers with risk factors and treatment of full term neonates with a course of antibiotics.⁹

With the factual and scientific background demonstrating that the defendants met the appropriate standards of care, and further, that late onset GBS disease is neither predictable nor preventable, the defendants sought to subject the plaintiffs' expert opinions to a *Daubert/Lanigan* analysis.

The Daubert Test

The defendants alerted the court that they were challenging the plaintiffs' expert evidence, particularly as to causation. Reciprocal expert depositions were conducted. Using those depositions, defense counsel focused primarily upon the reliability prong of the *Daubert* test. Specifically, the questions to the experts probed:

- 1 whether the theory or technique underlying the expert opinion can and has been tested, and the outcome of any testing;
- 2 its error rate and the existence of any controls or standardization;
- 3 whether it has been subjected to peer review and publication; and
- 4 whether the theory or technique underlying the opinion is generally accepted in the relevant scientific community.¹⁰

For this last factor, the expert's own experience with GBS infections, generally, and late-onset, specifically, was explored. The plaintiffs' experts' depositions demonstrated their reliance upon their personal knowledge of GBS and how it is transmitted. These experts testified that their theories, while not the subject of peer-reviewed or other publications, were generally accepted in the relevant medical community.

Following the depositions, the plaintiffs decided their pediatric experts would offer opinions only as to standard of care, foregoing opinions as to causation. Testimony by these experts demonstrated that neither had ever cared for an infant with late-onset GBS disease nor had they ever dealt with a similar clinical presentation. Therefore, any of their opinions were, admittedly, speculation.

Court Decision and Implications

Before the trial commenced, the court issued its decision on the Defendants' Motion to Exclude Expert Testimony. The court, relying upon *Daubert*, noted that an "expert must be able to demonstrate that his conclusions 'have a

reliable basis in the knowledge and experience of his discipline.'"¹¹ The court further noted that "'knowledge' is defined as connoting 'more than subjective belief or unsupported speculation'"¹² and that "[u]nsupported assertions by an expert do not constitute general acceptance."¹³ The court observed that although none of the plaintiffs' experts could cite to any literature to support his conclusions, this deficiency went to the *weight* of the evidence, not to its *admissibility*. The court found that each of the experts had sufficient education, training, experience, and familiarity with the subject matter to proffer expert testimony.

At trial, the motions to exclude were renewed on a witness-by-witness basis. Indeed, as to the adult infectious disease expert, additional questioning was conducted before she testified in front of the jury. After listening to her anticipated testimony, the court precluded her testimony on standard of care. As for the remainder of plaintiffs' experts, the defense was able to use the framework of the *Daubert* motion to cross-examine and impeach the plaintiffs' experts and their opinions. While the experts were allowed to testify, information gathered in the course of preparing arguments to exclude persuaded the jury that the witnesses were not credible.

The jury found in favor of all defendants.

Conclusion

The case above illustrates a neonatal disease process that is not preventable by medical intervention. The challenge to plaintiffs' theories through preparation of a *Daubert/Lanigan* motion to exclude expert testimony was therefore appropriate and necessary. Although the effect of such a motion was not completely appreciated until the jury spoke, the framework of the motion created a successful guide for the presentation of defense experts and the impeachment of plaintiffs' experts. Efforts to exclude opinions should be undertaken whenever the opinions can be demonstrated to be scientifically unreliable. ■

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Labor and Delivery Documentation

A mother with numerous prenatal complications delivered a premature baby with severe neurological damage.

By Pat Curran, R.N., and Peggy Martin, M.Ed.

Pat Curran is a General Claim Representative for Risk Management Foundation, Peggy Berry Martin is Director of Education for RMF.

Clinical Sequence

A 32-year-old woman, pregnant with her third child, arrived at the hospital with contractions a month prior to her due date.

While her two previous pregnancies were unremarkable, this one had been complicated by severe vomiting in the first trimester with a loss of 17 pounds, requiring hospitalization. She'd had repeated urinary tract infections which were treated with Macrochantin. Two weeks before she presented to the hospital, the patient had missed an appointment that was scheduled to include an ultrasound.

On admission, the electronic fetal heart monitor (EFM) showed fetal tachycardia. An hour later, amniotic fluid removed under ultrasound visualization contained meconium. The biophysical profile was 5/10, showing that the fetus was in some distress. After the ultrasound, the EFM tracing showed that tachycardia continued and the baseline was flat. The patient was examined by the two residents caring for her (one of whom had seen her in the prenatal clinic) and she began to receive oxygen. Artificial rupture of membranes revealed thick meconium.

The chief resident decided to induce labor with Pitocin. The attending physician noted in the record that any suspicious decelerations of the fetal heart rate would warrant a cesarean section. Approximately four hours after admission, Pitocin induction was begun. A fetal scalp pH showed results within normal limits (7.35 and 7.41).

A female infant was born 30 minutes later with Apgars of 1, 4, and 5. She was sent directly to the special care nursery. A cord blood gas pH (directly following birth) was 7.32. The infant had a gastrostomy tube placed for feeding and remained in the hospital for 10 weeks, being treated for respiratory difficulties and meconium aspiration. She was diagnosed with severely depressed neurologic function, hypoxic-ischemic encephalopathy, and subsequently exhibited severely delayed development.

Claim Sequence

Three years later, the mother brought suit against two residents and an attending physician. She alleged that they failed to deliver the infant by cesarean section immediately after the ultrasound results—along with the non-reassuring EFM results—showed that the fetus was in distress. The failure to respond to these indications, they alleged, caused the infant to suffer an “asphyxic insult, resulting in neurologic permanent damage.”

Disposition

The trial was held seven years after the girl's birth. The jury returned a verdict against one of the residents and the attending over the amount of the policy coverage. The matter was appealed and finally resolved within the policy limits.

Discussion Points

The lack of documentation is often cited as a reason that a perinatal case was difficult to defend. This case illustrates how what *was* and what *wasn't* documented affected the care and the case defense.

1) These record entries were raised by the plaintiff at trial:

- ◆ EFM results showed fetal tachycardia with no variability.
- ◆ Staff attending wrote “proceed to delivery and go to a cesarean if suspicious decelerations appear.”
- ◆ Radiological report of the ultrasound that read “worrisome picture of fetus in distress; small for gestational age, unexplained tachycardia, biophysical profile 5/10.”
- ◆ Records subsequent to the delivery state over and over that there was “fetal distress and birth asphyxia.”

It is unclear from the documentation in the chart that this infant was suffering from birth asphyxia as defined by the American College of Obstetrics and Gynecology and the American Academy of Pediatrics (see Page 4). If, instead, the child was damaged in utero—before her mother presented to the hospital in premature labor—any alleged delay in doing a C-section would not have impacted the injuries to this infant.

2) Two helpful pieces of information that were in the record showed that the scalp pH prior to birth was within normal limits and that the cord pH after the birth was also normal.

However, in the face of the repeatedly written diagnosis of birth asphyxia, these two documented values were insufficient to convince the jury that the standard of care was met in this case.

3) What was missing or inadequate in the record:

- ◆ An explanation of the plan of care in light of fetal tachycardia and the biophysical profile.
- ◆ Documentation of attending supervision of the residents.
- ◆ Why Pitocin and vaginal delivery was pursued when the EFM was described as “ominous” elsewhere in the record.
- ◆ Why a C-section was not considered appropriate after membranes ruptured and thick meconium was present.
- ◆ Why scalp pH was reassuring and consistent with decision to proceed with normal delivery.
- ◆ What the mother and/or family was told during the labor and what the mother consented to.
- ◆ What the mother and/or family were told after the infant was born and transferred to another facility.

Contemporaneous documentation becomes even more important in cases involving perinatal injuries because claims and suits may be brought years after the birth when memories are not fresh and when providers have moved to other facilities. By the time this case went to court, none of the providers remembered the details. They had to rely on a record that was inadequate, especially as to the rationale for the decisions that were made at the time of care.