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Forum

Risk Management Foundation of the Harvard Medical Institutions

Ob/Gyn Claims Review

Issue Editors: Sally Trombly and Robert Hanscom

CRICO Obstetric and Gynecology Claims Review

by
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Physicians practicing obstetrics and gynecology have, historically, been the clinicians most susceptible to malpractice claims. Ob/gyn claims impart significant emotional and fiscal effects on the individuals and health delivery systems involved. Because such claims often encompass impairments to newborns, or to a woman's reproductive capabilities, separating the emotional impact of the outcomes from the assessment of care rendered can be difficult.

Not surprisingly, settlements and jury awards in ob/gyn-related cases trend considerably higher than the average for all malpractice payments. Understanding the etiology of this category of claims and developing strategies for defending appropriate care is a primary focus of Risk Management Foundation of the Harvard Medical Institutions (RMF).

Figure 1

CRICO Ob/Gyn Claims 1989-98

14% of (all) CRICO claims involve Ob/Gyn defendants
15% of CRICO defendants are Ob/Gyn specialists
23% of CRICO incurred losses stem from Ob/Gyn claims

CASES N=270	Obstetrics	Gynecology
Claims	149	121
Defendants	311	235
Closed Cases	91	74
Closed with payment	50 (55%)	25 (34%)
Total incurred losses	$73M	$26M
Outpatient cases	21%	62%

DEFENDANTS N=301	Obstetrics	Gynecology
Staff MDs	163	138
Residents	36	18
Fellows	6	8
Institutions	79	62
Non-physician clinicians	27	9
Total	311	235

RM ISSUES* (Top 5)	Obstetrics	Gynecology
Clinical judgment	155 (40%)	78 (27%)
Documentation	62 (16%)	29 (10%)
Communication	42 (11%)	53 (18%)
Technical skills	33 (9%)	52 (18%)
Clinical systems	27 (7%)	21 (7%)

PAYMENTS	Obstetrics	Gynecology
$1-$99,999	15	9
$100,000-$499,999	19	12
$500,000-$999,999	7	3
$1,000,000+	9	1
Total	50	25

*N= 677: some cases involve more than one risk management issue

CRICO's Ob/Gyn Claims Experience

Forum examined CRICO's ob/gyn-related claims from 1989-1998.[1] Over the course of that decade, the percent of ob/gyn claims, defendants, and incurred losses[2] has remained fairly stable. Nevertheless, claims filed against the five percent of CRICO-insured physicians who specialize in ob/gyn consistently represent a disproportionate percentage of CRICO's total incurred losses.

Since 1989, the 270 claims related to obstetric or gynecologic care compose 14 percent of all CRICO claims (*see Figure 1*), but more than *23 percent* of incurred losses. (By comparison, anesthesia-related claims compose five percent of all CRICO claims and less than six percent of losses.) These unbalanced percentages are consistent with those found in the national ob/gyn claims analysis by the Physician Insurers Association of America.[3]

Obstetric Claims

Obstetric claims continue to account for almost 75 percent of the total incurred losses in the ob/gyn category with claims involving neurologically impaired neonates accounting for approximately 75 percent of the total obstetric losses.

The most common allegation in the obstetric claims reviewed is "Delay in Treatment of Fetal Distress," a major reason why "clinical judgment" is the most common risk management issue identified in these claims.

Examples of Obstetric Claims

Case 1

A patient with a history of increased blood pressure during the last weeks of her pregnancy was admitted for induction during her 41st week because of oligohydramnios. Eighteen hours later, the baby was delivered through thick meconium. Fetal tracings indicated a deterioration during the final hour prior to delivery. The child experienced growth retardation, left hemiplegia, mild spastic quadriplegia, and—later on—speech problems. Suit was brought against two Ob/Gyns alleging delay in the treatment of fetal distress. Legal discovery for the case revealed a disagreement among the clinicians as to whether the Ob/Gyn was notified of the fetal tracings. The case was settled in the high range.[4]

Case 2
After the birth of a baby with "probable alloimmune thrombocytopenia," Platelet Pla-1 phenotype and direct/indirect platelet antibody studies were ordered for the 30-year-old mother. Prior to her second pregnancy, the mother was seen by her Ob/Gyn for a "preconception general assessment." At 28 weeks, she was hospitalized for fetal intracranial bleeding and was diagnosed as Pla-1 negative and treated. The baby was born five weeks later, but died as a result of alloimmune thrombocytopenia. Whether the Pla-1 phenotype test was done is unclear. Suit was brought against two Ob/Gyns and the institution, alleging failure to diagnose and failure to warn of risks to any future children. The case was settled in the mid range.

Over the most recent five-year period, an increased number of obstetric claims have involved permanent injuries, leading to higher losses in claims resolved with payment.

Settlements and jury awards in ob/gyn-related cases trend considerably higher than the average for all malpractice payments.

Gynecology Claims

The percent of gynecology claims involving high severity injuries (including death) has decreased; since 1993, the majority of gynecology claims have involved temporary major injuries and permanent minor injuries.

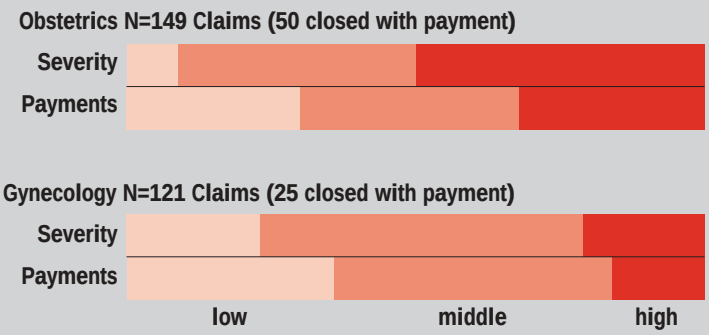
Even though the most common plaintiff allegation in gynecologic claims is "Improper Performance of Surgery," RMF's evaluation indicates that inadequate technical performance is less frequently evident in these cases than in the past. In the past five years, claims alleging inadequate clinical systems, such as improper handling of test results, have also decreased. However, claims citing a poor coordination of care are *more* prevalent. This is most commonly seen in cases involving a suspicious breast lump (N=5).

Inadequate communication by providers with their colleagues or patients has also been identified as an issue in a greater number of gynecology cases. Between providers and patients, this issue often manifests as inadequate informed consent. As with the obstetrics claims, patient assessment issues and insufficient documentation are common among the gynecology claims.

Obstetric claims involve more severe injuries, higher payments

Figure 2

Distribution of Injury Severity and Indemnity Payments Among CRICO's Ob/Gyn Claims: 1989-98



Examples of Gynecology Claims

Case 3 *A recently purchased laser was used for endometrial ablation on a 48-year-old patient admitted to day surgery. This was the insured's first attempt at this procedure and the patient may not have been informed of this or that the insured's assistant would perform 50 percent or more of the procedure. Three days post-op, the patient was readmitted to surgery for uterine and small bowel perforations with peritonitis. Her suit against the Ob/Gyn alleging improper performance was settled in the mid range.*

Case 4 *A 64-year-old patient underwent a TAH-BSO for a benign right adnexal mass with torsion. A junior resident performed the majority of the procedure under the supervision of the chief resident and staff gynecologist. The patient sustained an injury to the right ureter. One week after discharge the patient was readmitted for a right nephrectomy. A suit was brought against the two general surgery residents and staff gynecologist alleging improper performance of surgery. The suit went to trial and the jury found in favor of the defense.*

Quality Improvement Initiatives

Although ob/gyn claims continue to account for a disproportionately high percentage of losses, overall, their frequency is not increasing. Nevertheless, on average two or three ob/gyn-related claims are filed against CRICO's 346 insured ob/gyns each month. To work toward reducing preventable events, RMF is assisting the quality improvement efforts initiated by CRICO-insured institutions and Ob/Gyn specialists. Specifically, they are targeting potential improvements in the communication with colleagues and patients, documentation, and technical performance. ■

Notes & References

1 Controlled Risk Insurance Company (CRICO) provides professional liability insurance to health care institutions, their employees, and affiliated physicians.

2 Incurred losses are equal to indemnity reserves and payments plus expense reserves and payments.

3 Preston, SH. Malpractice danger zones—why primary care is more vulnerable than ever. *Medical Economics*. 1998;106-25.

4 Low range: < $99,999; Mid range: $100,000 - $499,000; High range: >$499,999.

Malpractice Fear as an Impediment to Team-based Care

by
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The thousands of women who have reached the end of their normal pregnancies come to birthing hospitals expecting healthy newborns. And we deliver them. Day after day, the birth logs reveal normal Apgar scores. When, infrequently, the perfect outcome doesn't occur, we caregivers look to see if we could have performed better. Because the frequency of malpractice litigation is higher for those in obstetrics compared with most other specialties, we should not be surprised that "malpractice fear" is actually an impediment to optimal team performance.

Team-based Care In Labor and Delivery

Current thinking advocates a team approach to complex multi-professional activities—such as intrapartum care—in which long intervals of routine surveillance of normally progressing labors are interrupted by short, tense bursts of crisis. While team-based care is in evidence on most labor and delivery units, if looked at closely, these teams appear to function best when labors are progressing normally and healthy newborns are delivered.

Delivering clinicians, the labor and delivery nurses, the parents, and other support personnel share a "team glow" over the smooth and almost effortless manner in which the combined efforts of all have led to such a wonderful outcome. Because these "uneventful" cases are so common, the professionals affirm, without actually discussing it, that the team is functioning well.

But just as the crew that sails only on days with fair winds and calm seas may believe "they did it," the labor and delivery team's assessment of its teamwork may not be valid for those days when luck and conditions change. And it is at those times of crisis, when pathophysiology and obstetric complications lead to adverse outcomes, that the shadow of potential malpractice litigation impedes team care.

In a "real" team situation, take baseball for example, a group of people with a known and accepted hierarchy have an acknowledged understanding of each other's abilities. They work and practice together, including simulating complex situations: double plays, rundowns, and relays from center field. When those situations arise during a game, the players know what to expect from each other.

Contrast this to the typical, ad hoc maternity "team." The individuals assembled to care, as a group, for a particular laboring patient probably know one another. It is likely they have delivered normal babies together, but it is unlikely that they will have shared emergency or crisis episodes with any frequency.

Based upon all those good experiences with healthy outcomes, each professional probably thinks his or her role is well-defined. They think they know what to expect from their teammates, and often feel no need to communicate or negotiate their role.

Who Leads, and Why?

So, when faced with a crisis, how does an underpracticed, ad hoc team respond? What roles will be played by each team member? Historically, it has been the obstetrician who leads, because eventually it is the obstetrician who delivers the baby. But, while obstetricians most commonly deal with fetal emergencies and rightfully should be in a leadership role for these situations, this is not so for maternal crises. An obstetrician's exposure to acute maternal illness diminishes in time and the skills necessary for dealing with such acute emergencies may grow rusty. Simultaneously, nurses have expanded their roles and education and are being trained to handle sicker and sicker patients. And anesthesiologists are playing a more crucial role in acute crisis on labor and delivery units. Their training and skills are invaluable.

Sadly, in a crisis, the logic behind rationally organizing the team is often impeded by the fear of malpractice litigation. Simply put, whichever clinician feels most at risk from a lawsuit will try to maintain a leadership role. And if all professionals feel at risk, then all may pull (lead) in opposite directions. This may not be a comforting answer, but, at least occasionally, it reflects real life.

The obstetrician concludes "If I am going to be sued, then I want to remain in control." Nurses, concerned about their own growing liability risk, are going to act in what they perceive is the patient's best interest, even if this is in conflict with the obstetrician's view. And in many cases, the resolution of an obstetrics crisis requires a hemodynamically stable and pain-free patient—a prime responsibility of the obstetric anesthesiologist.

So…who is in charge? Everyone is!

Creating a team response to crises on labor and delivery units is not an insurmountable problem. Other acute care hospital units have solved it. Talking to colleagues in MICUs and SICUs certainly is a good source for labor and delivery personnel. Overcoming the impeding effect of malpractice fears should be possible when we realize that the very litigation we fear is made more likely by the lack of communication and planning for crisis situations that require a different team relationship than for the normal labor and delivery situation. ■

When Philosophical Differences Become a Liability Issue

by
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What happens when the members of the team of clinicians involved in a mother-to-be's care disagree among themselves about crucial aspects of her care during active labor and delivery? If the outcome of the birth is imperfect or unexpected, such disputes are likely to be targeted as factors in the adverse event. Care that may have been handled appropriately may become difficult to defend if the parents witnessed or overheard a disagreement among members of the care team.

Erosion of Cohesive Care

Most hospital-born babies arrive over a prolonged period of time. As the mother moves from one stage of labor into another, numerous caregivers are directly or indirectly involved in her care. As hours elapse and the numbers of providers increase, the importance of team-based care is heightened. If the cohesiveness of the care team begins to erode, communication around critical elements in a baby's delivery process may also deteriorate. And poor communication among providers, studies have shown, is a leading cause of certain types of adverse events.[1]

What factors keep a care team from functioning—and communicating—in an optimal manner? Sometimes it may be as basic as a lack of expertise on the part of a particular clinician; he or she observed something but misinterpreted its significance. At other times, however, team functionality is broken down by philosophical differences related to the delivery of the patient's care. Attempting to resolve those differences in the midst of urgent patient care benefits no one and potentially heightens risk.

Certainly, conflict over treatment strategies has a place in medicine, but that place is not within earshot of the patient.

Airing a Philosophical Difference

One example of those philosophical differences is the ongoing debate over electronic fetal monitoring (EFM) versus intermittent auscultation. Many caregivers hold strong opinions and are primed to defend their preferences. But for a woman in labor, the potential for a less than optimum outcome is not related to who is right or wrong about the issue, but rather to the splintering it may create in how the care team interacts and executes plans.[2]

Quite possibly, RNs and certified nurse midwives caring for the same patients are likely to approach monitoring of the status of the unborn fetus differently. Obstetricians fall into both camps on the monitoring debate and often are outspoken as to which side they support. Certainly, conflict over treatment strategies has a place in medicine, but that place is not within earshot of the patient (or any patients). If the philosophical disagreements carry over into public disputes as to how a specific delivery should be managed, and if the patient becomes aware of these disagreements, they can lead to anxiety and mistrust. Such mistrust will most certainly be intensified if an adverse birth-related event occurs. Those initial emotions can quickly shift, with parents openly blaming the care team for what transpired—even if the differing opinions did nothing to contribute to the bad outcome.

A Cohesive Care Team

No care team is going to be perfectly matched in its philosophical approaches to the various components of patient care. But those differences need to be constantly placed into a productive context: take stock of where the disagreements exist and understand that they will not be resolved during any particular delivery. While discussion and debate will continue, a team must not allow anything to disrupt its ability to deliver effective team-based care.

Notes & References

1 Smith-Pittman MH. Nurses and litigation. *Journal of Nursing Law.* 1998;5(2):17.

2 Smith LS. Collaboration: the key to assertive communication. *Medical Surgical Nursing.* 1997;6(6):373.

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Introducing New Theories in the Defense of Ob/Gyn Claims

by
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Given the potential for catastrophic injury in certain adverse outcomes, obstetric cases may be involved in an award of significant monetary damages more frequently than those of other specialties. Identifying the factors causing or influencing adverse outcomes is an important challenge to researchers, clinicians, and those defending lawsuits alleging negligence on the part of these health care providers.

The search for answers to improve the outcome of health care delivery may lead to breakthrough discoveries, or novel hypotheses for further testing and refining. As science advances through ongoing research, this evolving information eventually becomes available for use by clinicians serving as experts in malpractice cases and attorneys preparing cases for trial. Depending on the complexity of the research and clinical situation, using a new theory to explain the causes or effects of an adverse outcome presents special challenges in education of the jury.

Defending Cerebral Palsy Claims

Among the more difficult malpractice cases to resolve are those alleging that a child's cerebral palsy is the result of acts or omissions by caregivers during the labor and delivery process. The sympathy factor and the potential for costly medical care over many years can be very difficult to overcome, even when other plausible causes for the medical problems and outcome are present.

As an example of a new theory explaining cerebral palsy, researchers now hypothesize that there is a link between maternal prenatal intrauterine infection and neonatal brain damage.[1] The degree of maternal infection may or may not be clinically apparent, but substances called cytokines produced by the immune system in response to the maternal infection can exert a harmful effect on the developing brain of the unborn child. Researchers theorize that this scenario may be particularly likely if the fetal exposure to cytokines occurs between weeks 28 and 32 of gestation—when the brain's maturation is at a highly susceptible stage. Symptoms of the neonatal brain damage then become apparent at a later date, at which time prior maternal infection may not be considered regarding causation.

Depending on the complexity of the research and clinical situation, using a new theory to explain the causes or effects of an adverse outcome presents special challenges in education of the jury.

Introducing New Medical Theories in Court

Medical malpractice cases require expert testimony regarding the appropriate standard of care in the situation under scrutiny. Advances in science refine the knowledge base of practitioners and may offer new insights to the causal elements of certain adverse outcomes. But it can take a significant amount of time for a theory to become acknowledged, and even longer for it to become widely accepted. Medical researchers, medical experts, and defense attorneys each have to develop techniques to help colleagues and jurors understand and accept a new or novel scientific theory.

The Role of Experts

In malpractice litigation, a jury is ordinarily the "trier of fact" in a case that goes to trial. The jury is charged with weighing the evidence and making its decision based on the judge's instructions regarding the applicable rules of law. In cases alleging medical negligence, the role of a medical expert is to help the jury comprehend sophisticated medical and technical information well beyond a lay person's common knowledge. This testimony enables a jury to appropriately weigh all of the evidence and reach its conclusions on the case.

Expert witnesses must demonstrate a baseline level of credentials and/or experience to have their medical inferences or conclusions admitted into evidence. The credibility of the witness, however, and the validity of the testimony is left up to the jury. Over the years, courts have struggled to keep "junk science" out of evidence, while recognizing that valid scientific advances and novel approaches should not be ignored during the period it takes for a new premise to be accepted throughout the relevant professional community.

Today, a trial judge has considerable discretion in determining whether expert testimony on a particular theory, including theories that are considered novel, is admissible. Factors the judge may consider include whether the theory or technique:

- can be (and has been) tested;
- has been subjected to peer review and publication;
- has a high known or potential rate of error;
- has standards controlling its application; and
- enjoys a general acceptance within a relevant scientific community.[2]

Building the Expert's Rapport with the Jury

Even if an expert is allowed to testify on a novel theory, that individual must be able to explain it to a jury in understandable terms and gain their acceptance of it. Areas of the country with a reputation for ongoing academic research and medical innovation, such as Massachusetts, may find juries somewhat more receptive to introduction of new theories in medical malpractice cases.

A medical expert who is identified with ongoing work on a particular subject will likely have more credibility and success educating the jury than someone describing a third party's research. This credibility can prove invaluable in building a trusting relationship between a medical expert and the jury listening to the theory being presented.

Recognizing that juries are anxious to make the correct decision—but can easily become frustrated by highly technical information—an expert might consider the following techniques to help explain the possible role of a relatively new theory. The first method is to explain the theory in terms that are simplified, but not so simple as to lose meaning. One way is to use an analogy relating the theory to a common experience.

For example, to explain the role of maternal prenatal infection in causing cerebral palsy, an expert could begin by describing how injuries occurring during crucial time periods in the development of a fetus can result in significant, and permanent injury to the child. To relate this to something lay people can envision, the expert could then explain how each phase of brain development depends on the phases that have preceded it: much like building a house, where small areas of damage to the supporting beams of a building will result in a high risk of later problems.

The second aspect of presenting a new theory is to clearly relate the theory to the clinical situation of the case. After step one indicates how early damage can be widespread and significant, an expert could discuss the common experience of infection triggering inflammation and cellular reaction and point out the extra sensitivity of the developing fetus.

Using large, clearly organized diagrams, the expert could show the release of inflammatory mediators from cells, and their impact on developing brain tissue. Illustrating the progression of antenatal inflammation to subsequent cellular damage, death, and permanent injury can help make a powerful impression, while ensuring that the jury has the tools to understand this sequence and progression.

Today, a trial judge has considerable discretion in determining whether expert testimony on a particular theory, including theories that are considered novel, is admissible.

Educating Counsel

Experienced defense attorneys will be very familiar with the widely accepted medical theories pervasive in cases they litigate, but may need help understanding the nuances and technicalities of a new line of thinking in order to effectively question the expert and prepare for any challenges to that expert's testimony.

Throughout any case, defense attorneys have an ongoing role as conduit of information to the jury. Because litigators must be able to do this within the confines of formal legal processes, a defined, collaborative strategy and methods for the expert and defense counsel to relay what are frequently complex medical facts and theories may be useful. This may best serve the needs of the jury while furthering the understanding of the materials presented through expert testimony, even when that information may be new to many of the parties involved. ■

Notes & References

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2 *Kumho Tire Co. v. Carmichal* 119 S. Ct. 1167 (1999) discussing *Daubert v. Merrill Dow Pharmaceuticals*, 113 S. Ct. 2786, 509 U.S. 579 (1993).

What Women Want from Their Ob/Gyns

by
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Heidi Kruckenberg is pursuing a master's degree in women's studies and sociology at Brandeis University, in Waltham, Massachusetts.

What are women looking for in ob/gyn care? How can obstetrician/gynecologists provide optimum care while maintaining patient relationships that can withstand an unexpected or less-than-perfect outcome? *Forum* interviewed 14 women, ages 21 to 55, about their experience and expectations for ob/gyn care. They were asked about four general categories: communication, annual pelvic exam, prenatal visits, and delivery and surgery. A sampling of their responses follows.

CRICO Ob/Gyn Claims 1989-98 N=270

Top 5 Communication Issues

- Communication among providers regarding patient's condition
- Communication between the patient (or family) and the provider
- Communication via telephone
- Inadequate informed consent for surgical/invasive procedures
- Poor rapport (including unsympathetic response to patient)

Example Case 1
At 18 weeks, a pregnant patient called urgent care with complaints of abdominal pain. A day later the patient presented to urgent care with abdominal pain and vaginal bleeding. Due to miscommunication between clinicians, the patient was not seen (even though she was in an exam room) but instead was instructed to go back to work and wait for a call. The patient subsequently presented to a hospital where an ultrasound showed fetal demise at 13 weeks. A suit was brought against the internist and the institution. The suit was settled in the low range on behalf of the institution.

Example Case 2
A patient undergoing chemotherapy treatment for acute myelogenous leukemia during her fifth month of pregnancy engaged in sexual intercourse. Three days later, the patient and baby died from sepsis with clostridium speticum. The husband subsequently stated that the MD did not inform them to refrain from sexual relations. A suit was brought against the hematologist and ob/gyn. It went to trial and resulted in a defense verdict.

What communication skills improve your relationship with your Ob/Gyn?

Remember me even if I only see you once a year.

Speak with me before I undress. I'm more likely to be candid, helpful, and comfortable when I'm dressed.

Make it comfortable for me to ask any kind of question and answer me thoroughly—in terms I can understand—no jargon.

Explain what is happening with my body...hot flashes and menopause, fibrocystic breasts, hormone therapy, etc.

Share information about all aspects of my health. I work at a cancer research center, but I expect you to know at least as much as I do about women's health risks, particularly cancer. Give me the cutting-edge info.

If I had a concern during my last visit, ask me about it during the next visit.

Remember important clinical events in my life so I don't have to remind you repeatedly. Give me thorough information about my condition or any treatment I may need.

Good eye contact, a non-rushed manner, and sharing something personal helps to establish a better relationship.

Do not make me feel guilty for my problems. When I asked how I might have developed a yeast infection, my physician included the possibility that my husband was "sleeping around."

Be on time, know my history, and do not make me feel rushed.

Understand that I may not bring up embarrassing topics on my own. Ask about sexual activity regardless of age or status (e.g., "Do you experience discomfort or pain?" "Do you need birth control?").

Do not be condescending or "punish" me for making mistakes sexually.

Remind me when it's time for my annual pelvic exam.

Ask me about everything: birth control, sex, diet, relationships, drinking. Send me follow-up information when you find something that relates to what we discussed. Look at pictures of my kids; act more like a friend.

Be honest! Before my cancer surgery, I asked my surgeon if I was going to die. She said, "You will not die during this hospitalization, but you have a very bad disease. I won't know how bad it is until I operate."

Share details of my lab results—even if I don't understand any of the results (and I don't)—give me the feeling that there are no secrets.

When you or your office calls with my results, don't mess around with small talk. Cut to the chase.

Treat me holistically: ask how are things going in my life.

What can the physician do to make your pelvic exam more comfortable?

It's never a comfortable experience.

Put booties on the stirrups so they won't be ice cold.

Warm your tools, please.

Carry on a conversation during the pelvic exam, so I'm not thinking about it.

Explain what you're doing and what's next. Tell me what you're looking to test, find, discover, and how long it takes for results. I especially appreciate being warned that something will be painful before the procedure so that I can be prepared.

No small talk. Don't ask me how my day is going.

What are the elements of a good prenatal visit?

Establish a routine: weighing in, blood pressure, history, etc. If everything is OK, tell me that everything is OK.

Allot time for my questions and education. Explain what will happen at delivery. Introduce me to your practice partners so that I have some familiarity with them.

Involve the father in the discussions.

Encourage me to bring in written questions for each of my visits…and answer them. Give me materials to read or watch that help educate me and allay my fears.

First, be up-to-date on the latest procedures to help with my particular problem. Second, relate to me emotionally; allow me to be worried and concerned, and to ask lots of questions.

Give me counseling about food and nutrition. Tell me a little about the "baby blues" so I know what to expect if I get them. Talk to me about me.

Do not be in a hurry during my prenatal exams (my OB once ate his breakfast during the consultation). I want your undivided attention.

Act happy and upbeat.

See me at every visit I make to the OB office. Do not ask me to explain my situation and progress to a different clinician each time.

Do not freak out and tell me I'm too old to have a baby. Allow me to make decisions about my body and pregnancy.

After the baby's born, come visit me in the hospital.

What do you expect from your Ob/Gyn during delivery or surgery?

Take the time to talk with me and honestly express your concerns about my situation.

During delivery, I need caring and help. Also, alleviate any pain you can.

Communicate what you know, when you know it, to me and my family.

Maintain communication with the other doctors involved in my care.

Be there (or have someone there) for me as soon as I enter the hospital. My Ob/Gyn had a policy that he would wait for the second call from the hospital staff before heading over. Well, with my first child, by the time he got to the delivery room, it was almost too late. Fortunately he changed his policy before my second delivery. He got there earlier and gave me his undivided attention.

Before my surgery assure me that I can "do it," but also allow me to ask lots of questions and answer them sincerely and sensitively.

Never leave my bedside. If I have a complication, be present every step of the way.

Conclusion

While some of the above comments seem to be contradictory, the recurring theme from the women *Forum* spoke with was they want their physician to adapt to their preferences and help them learn about their health. Creating a team-type relationship between patients and physicians allows women to feel they are a partner in their own care and that their efforts to endure a surgery or deliver a baby are as important as the physician's. ■

Closed Claim Abstract

Continuity of Care in Labor and Delivery

A week after induction of labor and VBAC delivery of a 34-week breech stillborn, a patient with a history of DES exposure was found to have an area of uterine rupture.

Clinical Sequence

A 33-year-old mother of one with a history of diethylstilbestrol (DES) exposure was found to have a fetal demise at approximately 34 weeks gestation, presumably related to a cord accident. After a discussion among the patient, her husband, and the obstetrician who had delivered her first baby by cesarean section, a decision was made to attempt induction and vaginal delivery. Pitocin induction was begun by a physician in the obstetrics group practice treating the patient, and then assumed by a covering physician outside that practice.

As the induction proceeded, the patient developed increasing pain and bleeding. The covering obstetrician noted in the record the possibility of a placental abruption. In the differential diagnosis, uterine rupture was among the more remote possibilities, given the stability of the patient's vital signs and continued progression of labor.

Coagulation studies were monitored during labor and did not indicate excessive bleeding problems. A low grade fever resulted in the administration of antibiotics prior to delivery. The stillborn fetus was delivered by a member of the obstetrics group practice. The patient was discharged the next day, and returned three days later complaining of chills, fever, and pain. She received additional antibiotics and declined to have an ultrasound done.

Seven days after her discharge (nine days after the delivery), her fever recurred and she was re-admitted to the hospital for triple intravenous antibiotics. Ultrasound at that time showed a mass within the uterine cavity and disruption of the uterine wall in an area not near the previous cesarean section scar. Further studies indicated major reconstructive surgery would be needed if another pregnancy was contemplated.

Claim Sequence

The patient brought suit against the covering obstetrician who managed the time period spanning induction and labor. She alleged labor was improperly managed, resulting in a ruptured uterus, which then went undetected until an ultrasound a week after discharge.

Disposition

Following trial, the jury returned a verdict in favor of the defendant.

Discussion Points

Continuity of Care: Given the fetal demise, the patient was, understandably, anxious to deliver. Unfortunately, the defendant who was providing weekend coverage for the patient's obstetrical group had not previously treated the patient.

The convergence of extreme emotional and physical stress makes it difficult for a patient and an unfamiliar physician to build a relationship quickly. In the face of a complication that the patient may see as life-altering, the lack of an ongoing relationship may promote consideration of legal recourse. Helping obstetrical patients understand the coverage arrangements and having them meet the providers in advance, or at least giving them information about them, can help alleviate some of this stress.

Clinical Judgment: Medical literature does not support increased incidence of uterine rupture due to DES exposure, therefore, the obstetrician did not have a high index of suspicion for it in this case.

Physicians are held to the standard of care practiced by their peers at the time the care was rendered. Literature and practice guidelines that support the decision-making process for care alleged to be negligent can deter litigation or significantly bolster the defense of such claims.

Documentation: The jury adopted the defense expert's view that the only management indicated was an induction and vaginal delivery. They rejected the plaintiff's theory that a cesarean section delivery was not fully considered.

A known fetal demise makes the mother's well-being and safety the only concern in selection of the delivery method. Documentation of discussions with the patient and the primary obstetrician regarding various options were helpful in defense of the case. The fact that, in hindsight, one avenue would have been better to pursue than another is not indicative of malpractice.

by
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Patient Education

Twins born prematurely had developed *E. Coli* infection in utero. One twin died at eight days of age and the other survived with significant disabilities.

Closed Claim Abstract

Clinical Sequence

A mother with known twin gestation was admitted to the hospital at 27 weeks with symptoms of preterm labor, infection, and pneumonia. Amniocentesis to evaluate the status of the fetuses was recommended, but refused by the parents. The mother was treated with antibiotics for chlamydia and discharged home. Subsequently, the parents engaged in unprotected sexual intercourse.

Three weeks later, the babies were delivered vaginally. Both tested positive for *E. coli* sepsis: one died in the hospital; the surviving twin has visual and hearing impairments, as well as neurological and developmental problems.

Claim Sequence

The parents filed suit against the hospital and the attending obstetrician alleging negligence based on a failure to advise against sexual relations, to recommend complete bed rest for the mother, and to provide home monitoring of fetal heart activity.

The key issue at trial was the patient's risk of getting an infection. The plaintiff's expert testified that had the mother been monitored in the hospital, and given stronger tocolysis to avoid preterm labor, the infection would have been identified and treated and the damage would have been prevented.

Disposition

After the jury had deliberated for a day and a half without a verdict, both sides in the case agreed to enter into a "high/low" agreement. Following another day of deliberations, the jury reported it had found for the defendant on the question of negligence, but it was unable to reach a decision on the question of informed consent. In accordance with the high/low agreement, the case was resolved for the previously agreed upon "low" figure, thus eliminating the prospect of another trial.

Discussion Points

Communication: The parents alleged they refused amniocentesis because they understood the treatment would be the same, with or without the procedure. However, amniocentesis might have identified a subclinical infection of the uterus enabling timely, targeted treatment.

When a test, such as amniocentesis, is offered and refused, the medical record should reflect the extent and scope of discussions and the patient's stated rationale for refusal.

Discharge Instruction: Although the mother testified she had been advised early in her pregnancy not to have sexual relations, the father claimed he had been told protected intercourse was acceptable. Documentation regarding discharge instructions after the preterm labor admission was incomplete.

When medical record documentation fails to support care decisions and instructions, a jury is left to rely on the memory or recall of past events by each side.

Reporting Payment Information: A high/low agreement specifies that payment will be made to the plaintiff regardless of the outcome of a jury trial or other form of case resolution. The low amount is paid in the event of a jury verdict favoring the defendant; the high amount is paid in the event of a decision favoring the plaintiff (regardless of the amount of damages awarded by the jury). In this case, a jury verdict in favor of the defendant (on negligence) resulted in the payment of the low figure.

A high/low agreement is an anomaly in the reporting requirements for the National Practitioner Data Bank (NPDB). When the ultimate finding is in favor of a defendant, the guaranteed low payment is considered by the NPDB to be a contract between an insurer and a plaintiff, and thus not reportable to the NPDB as a payment made on behalf of an individual practitioner.

by
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