

LABOR PAINS: LIABILITY TRENDS IN OBSTETRICS

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No other specialty unit of an acute care hospital carries more risk for patient safety than the obstetrical unit. No other medical specialty is as difficult for Medical Professional Liability underwriters as obstetrics/gynecology (OB/GYN). In obstetrics, the potential for injury is at least double the risk faced in other cases for the simple fact that two lives are at stake: mother and infant. Further exacerbating the risk is the vulnerability of the child. Injuries to the infant are often catastrophic and can entail lifelong care. Plaintiffs in infant injury cases readily win sympathy from juries, and noneconomic damage caps are of little value since life care costs can be easily demonstrated.

While the national environment for Healthcare Professional Liability has improved significantly over the last five years, certain types of claims still tend toward high severity, especially claims involving obstetrics and pediatrics. The plaintiffs' bar seeks out these cases through the media, especially television and internet ads. An informal search for large obstetrics verdicts rendered in 2008 and 2007 found eight verdicts/settlements from six different states totaling more than \$158 million (see Figure 1). The size of these verdicts/settlements is both sobering and instructive.

OBSTETRICS: PRACTICE MACRO TRENDS

OB/GYN is "a discipline dedicated to the broad, integrated medical and surgical care of women's health throughout their lifespan," according to the American College of Obstetrics and Gynecology (ACOG).¹ OB/GYNs can "choose a...practice ranging from primary ambulatory health care to...a focused area of specialization."²

OB/GYN practices can vary broadly but several trends have emerged that have direct or indirect impact on professional liability across the OB/GYN spectrum.



- ❖ The move of OB/GYN physicians from solo to group practice, or employment by hospitals and HMOs affects communication of patient information. Taking after-hours calls and patient handoffs are more complicated in a group practice setting.
- ❖ A pronounced gender shift among OB/GYN practitioners has occurred in recent decades as more and more women have selected what was once a male-dominated specialty. While many patients may prefer a female OB/GYN, this preference has not shielded them from litigation. The percentage of female obstetricians facing malpractice claims is almost double that of all physician specialties combined, according to the Physician Insurers Association of America (PIAA) (see Figure 2).

FIGURE 1 RECENT LARGE OBSTETRIC VERDICTS/SETTLEMENTS

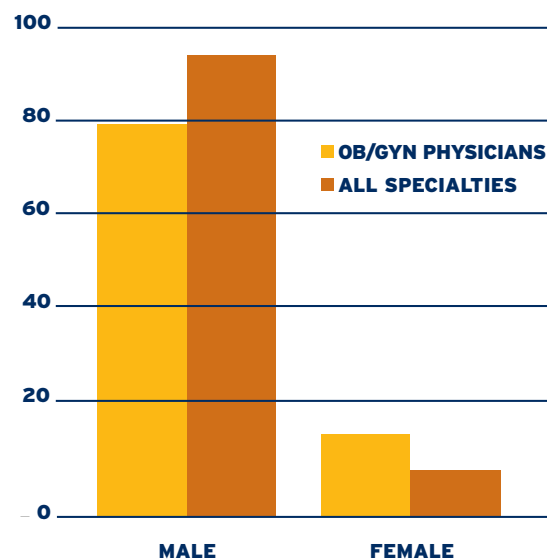
DATE	LOCATION	FACTS	AMOUNT
7/08	NEW YORK	IMPROPER USE OF FORCEPS	\$19.6M (V)
7/08	WISCONSIN	IMPROPER MONITORING, DELAY IN C-SECTION	\$18.2M (S)
6/08	FLORIDA	NURSING DELAY IN CALLING THE OB	\$35M (V)
5/08	OHIO	IMPROPER MONITORING BY NURSING STAFF	\$10M (S)
5/08	OHIO	IMPROPER MANAGEMENT OF LABOR	\$22.6M (V)
1/08	ILLINOIS	IMPROPER MONITORING BY THE OB AND NURSING STAFF	\$21.5M (V)
9/07	IOWA	IMPROPER MONITORING; DELAY IN C-SECTION	\$13.5M (V)
4/07	ILLINOIS	IMPROPER MONITORING BY NURSING STAFF AND THE OB	\$18M (S)

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- ❖ Like other specialties, OB/GYNs must deal with several general trends in medicine.
 - ◆ The explosion of new information in their field
 - ◆ Advances in information technology, including electronic medical records
 - ◆ Significant cuts in reimbursement, leading to increased patient volumes to make up revenue
 - ◆ Difficulty balancing office practice and surgical practice
 - ◆ Increased use of hospitalists and physician extenders such as physician assistants and midwives³
- ❖ Notable clinical trends in obstetrics include increased genetic testing, the prevalence of obesity in teenage and adult women, the dramatic rise in the number of cesarean deliveries, the controversy of vaginal birth after cesarean (VBAC) delivery, and findings on the causes of neonatal encephalopathy and cerebral palsy.
- ❖ Foremost among the challenges to this specialty may be the high cost of malpractice premiums. Obstetricians saw a four-fold increase in malpractice premiums from 1975 to 2000.⁴ Neurosurgery is the only other specialty rivaling OB/GYN in this regard. Many obstetricians pay annual premiums of more than \$80,000; premiums exceeding \$100,000 are not uncommon.⁵

FIGURE 2 PIAA: OBSTETRICS AND GYNECOLOGIC SURGERY

PHYSICIAN CLAIMS BY GENDER



Source: PIAA, 2008

FIGURE 3 PIAA: COMPARATIVE CLAIM PAYMENT ANALYSIS

CLAIMS CLOSED BETWEEN 1985 AND 2007: ALL SPECIALTIES

SPECIALTY GROUP	CLOSED CLAIMS	% PAID TO CLOSED	TOTAL INDEMNITY	AVERAGE INDEMNITY
ANESTHESIOLOGY	8,866	32.43	\$636,193,819	\$221,285
CARDIOVASCULAR AND THORACIC SURGERY	6,960	23.59	356,739,943	217,259
CARDIOVASCULAR DISEASES - NONSURGICAL	4,248	18.13	191,183,963	248,291
DENTISTS	838	43.56	14,869,780	40,739
DERMATOLOGY	2,620	28.89	101,440,748	134,004
EMERGENCY MEDICINE	3,991	26.28	202,049,937	192,612
GASTROENTEROLOGY	2,354	18.05	88,121,039	207,344
GENERAL AND FAMILY PRACTICE	26,658	32.02	1,365,943,314	160,040
GENERAL SURGERY	24,177	34.43	1,488,680,092	179,381
GYNECOLOGY	2,723	30.55	128,848,958	154,864
INTERNAL MEDICINE	31,299	25.25	1,644,739,599	208,142
NEUROLOGY - NONSURGICAL	3,658	21.20	245,969,868	317,406
NEUROSURGERY	5,431	28.17	477,770,521	312,268
OBSTETRIC AND GYNECOLOGIC SURGERY	31,486	35.31	3,086,138,311	277,580
OPHTHALMOLOGY	6,703	28.72	347,735,112	180,642
ORAL SURGERY	62	32.26	538,583	26,929
ORTHOPEDIC SURGERY	21,848	29.18	1,042,180,835	163,479
OTHER NONSURGICAL SPECIALTIES	2,234	22.96	96,717,958	188,534
OTORHINOLARYNGOLOGY	3,819	31.42	241,644,424	201,370
PARAPROFESSIONAL	376	23.14	18,194,867	209,136
PATHOLOGY	1,633	28.23	112,847,595	244,789
PEDIATRICS	6,794	27.92	505,084,556	266,254
PLASTIC SURGERY	8,683	26.27	262,301,626	114,994
PSYCHIATRY	2,276	20.12	74,568,108	162,812
RADIATION THERAPY	2,212	28.03	172,036,688	277,479
RADIOLOGY	12,970	29.20	736,138,969	194,386
RESIDENT/INTERN	130	32.31	2,515,932	59,903
UROLOGIC SURGERY	5,577	29.41	285,782,192	174,245
TOTALS:	230,624	29.56	\$13,926,975,337	\$204,268

Source: PIAA, 2008

CLOSED CLAIM TRENDS

Obstetrics ranked first among all specialties for the number of claims reported and for the total amount of indemnity paid, according to a PIAA study of closed malpractice claims. Of every medical specialty (excluding dentistry, where claims are comparatively small), obstetrics had the highest percentage of claims closed with payment at 35.31% – 5.5% higher than the norm for all specialty groups. OB/GYN had the third highest average indemnity after neurology and neurosurgery⁶ (see Figure 3). The PIAA publishes annual Risk Management Reviews on many physician specialties. Their cumulative study, the Data Sharing System, has aggregated more than 230,000 closed malpractice claims since 1985, studying 28 medical specialties.

Closed claim statistics for 2007 show no improvement. In that year, the average indemnity payment on behalf of OB/GYN physicians was \$424,560, 19.8% higher than the overall average indemnity payment for all physician specialties at \$340,769. Closed claims on behalf of OB/GYNs constituted a large percentage of all claims reported to the PIAA in 2007 at 12.2% and constituted 18.9% of all indemnity dollars paid out. The PIAA noted that these percentages have remained virtually unchanged from a decade ago, although indemnity payments for OB/GYN have increased from 31.9% to 33.7% in that time frame.

FIGURE 4 PIAA: OBSTETRIC AND GYNECOLOGIC SURGERY

CLAIMS BY 10 MOST PREVALENT PATIENT CONDITIONS CUMULATIVE ANALYSIS: JANUARY 1, 1985 - DECEMBER 31, 2007

CONDITION	TOTAL CLAIMS	% PAID TO CLOSED	TOTAL INDEMNITY	AVERAGE INDEMNITY
PREGNANCY	3,485	29.31	\$227,274,870	\$250,027
BRAIN-DAMAGED INFANT	3,140	49.39	799,125,396	565,152
STERILIZATION, ADMISSION OR OFFICE TREATMENT FOR DISORDERS OF MENSTRUATION AND OTHER	1,064	31.84	26,983,455	82,267
ABNORMAL BLEEDING FROM FEMALE GENITAL TRACT	940	33.53	47,664,839	165,502
MALIGNANT NEOPLASMS OF THE FEMALE BREAST	868	43.95	95,093,127	267,116
ECTOPIC PREGNANCY	814	33.51	21,067,504	81,657
FETAL DISTRESS	816	44.24	137,483,847	411,828
BENIGN NEOPLASMS OF UTERUS	772	35.89	47,263,218	186,811
ENDOMETRIOSIS	668	27.86	24,951,245	144,227
DELIVERY, NORMAL, OF SINGLE GESTATION	619	32.92	46,754,971	254,103
TOTALS:	13,186	37.25	\$1,473,662,274	\$327,699

Source: PIAA, 2008

FIGURE 5 PIAA: OBSTETRIC AND GYNECOLOGIC SURGERY

CLAIMS BY 10 MOST PREVALENT PROCEDURES PERFORMED CUMULATIVE ANALYSIS: JANUARY 1, 1985 - DECEMBER 31, 2007

PROCEDURES PERFORMED	TOTAL CLAIMS	% PAID TO CLOSED	TOTAL INDEMNITY	AVERAGE INDEMNITY
CESAREAN SECTION DELIVERIES	4,959	38.70	\$708,547,550	\$411,948
OPERATIVE PROCEDURES ON THE UTERUS	4,861	35.23	219,567,779	138,180
MANUALLY ASSISTED DELIVERIES	3,424	38.54	468,642,496	400,892
MISCELLANEOUS MANUAL EXAMINATIONS AND NON-OPERATIVE PROCEDURES	3,362	31.24	327,565,970	343,361
DIAGNOSTIC INTERVIEW, EVALUATION, CONSULT	3,250	27.95	220,621,902	265,490
OPERATIVE PROCEDURES ON THE FALLOPIAN TUBES & OVARIES, EXCLUSIVE OF STERILIZATION	2,523	34.75	105,689,092	126,550
FORCEPS DELIVERIES	1,208	54.44	225,020,304	367,080
TERMINATION OF PREGNANCY	1,004	41.95	46,469,255	115,883
PRESCRIPTION OF MEDICATION	970	31.56	53,963,300	193,417
NO CARE RENDERED	806	11.63	22,053,683	259,455
TOTALS:	26,369	38.18	\$2,398,121,331	\$289,931

Source: PIAA, 2008

In 2007, the percentage of claims closed with payment for all specialties was 27.1%, exceeded by OB/GYN at 33.7%. OB/GYN claims were the most expensive to defend of all specialties in 2007. This specialty also had the largest number of paid claims, 324, as well as the highest total indemnity amount paid at \$137 million.⁷

Further PIAA Obstetrics Findings

❖ The most prevalent OB/GYN patient conditions leading to claims were pregnancy and the brain-damaged infant. Almost half (49.4%) of all claims involving a brain-damaged infant closed with an indemnity payment. Closed claims involving the brain-damaged infant had the highest average payment at \$565,152 (see Figure 4). For claims closed in 2007, pregnancy and the brain-damaged infant were the leading conditions, and claims involving a brain-damaged infant had the highest average payment at \$688,600.⁸

- ❖ The OB/GYN procedure most likely to lead to a claim was cesarean delivery (see Figure 5). Of 31,486 total closed OB/GYN claims, 14.1% involved a cesarean delivery.⁹
- ❖ The most prevalent OB/GYN misadventure was improper performance of a procedure – the primary issue in 33.3% of all claims (see Figure 6). This category led all others in 2007 as well, accounting for 30.1% of closed claims, and 36.7% of all claims closed with indemnity. For those claims involving improper performance, the category most commonly involved was an operative procedure on the uterus, e.g., hysterectomy.¹⁰

Another closed claims analysis was undertaken by The Doctors Company to determine system errors and their impact on 363 malpractice claims from 2004 to 2006. One of the key findings was that of the 34 obstetrics claims, 26% involved non-timely performance of a cesarean section, while communications errors accounted for two-thirds of obstetrics claims system errors.¹¹ Many obstetric claims are in fact caused by poor communication between group physicians (e.g., patient handoffs), unavailable key medical information and nurse-physician communication.

FIGURE 6 PIAA: OBSTETRIC AND GYNECOLOGIC SURGERY

CLAIMS BY 10 MOST PREVALENT MEDICAL MISADVENTURES

MEDICAL MISADVENTURE	TOTAL CLAIMS	% PAID TO CLOSED	TOTAL INDEMNITY	AVERAGE INDEMNITY
IMPROPER PERFORMANCE	10,803	39.67	\$933,193,647	\$235,893
NO MEDICAL MISADVENTURE	6,668	8.06	155,806,414	304,309
ERRORS AT DIAGNOSIS	4,252	36.89	367,324,313	255,086
FAILURE TO SUPERVISE OR MONITOR CASE	2,775	45.87	399,678,356	345,743
DELAY IN PERFORMANCE	2,103	54.86	473,965,579	453,556
NOT PERFORMED	1,747	54.65	311,966,791	351,314
FAILURE TO RECOGNIZE A COMPLICATION OF TREATMENT PERFORMED WHEN NOT INDICATED OR CONTRAINDICATED	1,298	39.55	107,008,759	266,855
SURGICAL FOREIGN BODY LEFT IN PATIENT AFTER PROCEDURE	1,001	47.32	85,531,185	175,990
FAILURE TO INSTRUCT OR COMMUNICATE WITH PATIENT	839	44.81	14,796,273	41,330
TOTALS:	32,426	35.16	\$2,877,878,532	\$276,685

Source: PIAA, 2008



THE IMPACT OF MALPRACTICE

The frequency of high-severity obstetrical malpractice verdicts and the concomitant increase in malpractice premiums has had a profound effect on this specialty. ACOG has stated that 75% of its membership has been sued at least once.¹² In a survey conducted in 2006 with more than 10,000 responses, 64.6% of the practitioners said they had made one or more changes to their practice out of fear of professional liability claims.¹³ Malpractice costs have also caused obstetricians to take early retirement or limit their practice by ceasing to perform deliveries, reducing the number of high-risk patients or not offering VBACs. Some have relocated to states with more favorable malpractice climates.

The impact goes beyond current practice and may affect the availability of obstetrical care in the future.

- ❖ **REDUCED ACCESS TO PRENATAL CARE.** Reduced access to prenatal care has been especially problematic in rural areas.¹⁴ This may compromise the future ability of obstetricians to care for high risk mothers and infants. Timely delivery of care and obstetricians' ability to spend quality time with their patients may be compromised.¹⁵
- ❖ **FEWER OBSTETRICS RESIDENTS.** The decreasing numbers of medical students entering OB/GYN residencies is alarming.¹⁶ The fear of being sued and high malpractice premiums often

factor into medical students' decisions to bypass this specialty, particularly in states with high costs, such as Florida and Pennsylvania.^{17,18} The long term implications for the healthcare delivery system and women's access to obstetrical care are sobering.

HIGHER CESAREAN SECTION RATES

The classic claim scenario resulting in high damages involves litigation brought on behalf of a brain-damaged infant alleging failure to detect fetal distress and/or to perform a cesarean section in a timely manner. In 2004, the cesarean delivery rate in the U.S. reached 29.1%, a dramatic rise from 5.5% in 1970. This percentage translates to roughly 1.2 million cesarean deliveries annually – at a cost to the healthcare delivery system of approximately \$16 billion.¹⁹ Changes in patient populations (e.g., more women 35 and older giving birth) alone do not account for this increase. The public's expectations of a perfect outcome at the time of delivery and the difficulty of defending malpractice cases involving severely injured children have had their impact. Cesarean delivery is often chosen as a form of defensive medicine.^{20,21}

VBACS: CONTROVERSY

Vaginal birth after a cesarean delivery (VBAC) came back into obstetric practice in the 1980s, mostly in an attempt to reduce the rising cesarean delivery rate. Both the National Institute of Health and ACOG supported VBAC trials of labor for appropriate patients.²²

The numbers of VBACs rose into the mid-1990s until reports of uterine rupture began to appear. VBACs have since become controversial, and many hospitals prohibit them. Many obstetricians refuse to let their patients attempt VBAC trials.

The numbers of patients undergoing VBAC continues to fall. Fear of litigation is one of the main reasons, even though elective repeat cesarean delivery has significant morbidity and mortality and may not be safer than a VBAC trial of labor in some patients.²³

CEREBRAL PALSY AND BIRTH ASPHYXIA

The classic claim scenario resulting in high damage obstetrics verdicts involves litigation brought on behalf of a brain-damaged infant alleging failure to detect fetal distress and/or to perform a cesarean section in a timely manner. In recent years, these cases have become a battleground for the expert witnesses on the issue of causation.

CAUSATION DEFENSES

Recent research on the causes of neonatal encephalopathy and cerebral palsy has found that “intrapartum hypoxia is uncommonly the sole cause of neonatal encephalopathy or cerebral palsy,” according to an ACOG Task Force on Neonatal Encephalopathy and Cerebral Palsy, which published its findings in 2003. “Less than a quarter of infants with neonatal encephalopathy have evidence of hypoxia or ischemia at birth...” it stated. The Task Force set forth criteria, especially blood gas analysis, to accurately determine that hypoxia was present close to the time of birth, during labor and delivery. In the past, it was thought that such findings as meconium staining, nonreassuring fetal heart rate patterns, low Apgar scores, and neonatal encephalopathy were frank evidence of birth asphyxia. More current research indicates that they are in fact “the sequelae of pathological processes established before labor.” The Task Force’s report says, “Criticism of the management of labor should not be confused with cerebral palsy causation because the two often may not be linked.”²⁴

This ACOG Task Force’s findings have had a major impact on obstetrics litigation. These cases can now often be defended on the issue of causation.

INAPPROPRIATE TERMINOLOGY

An ACOG Committee Opinion issued in December 2005 expressed concern about ongoing use of the terms “fetal distress” and “birth asphyxia,” recommending abolition of the term “birth asphyxia” as a nonspecific diagnosis and replacement of the term “fetal distress” with the term “nonreassuring fetal status.”²⁵

APGAR SCORES: NOT PREDICTIVE

Apgar scores have been used since the 1950s as a methodology to describe the condition of neonates. ACOG advocates that its use be limited to the delivery room and not beyond as an indication of an acute intrapartum hypoxic event. Low Apgar scores at one and five minutes neither indicate hypoxia nor predict long-term neurologic outcomes.²⁶

EFM HAS LIMITATIONS

The use of intrapartum fetal heart rate monitors is widespread. In 2002, electronic fetal monitoring (EFM) was employed in an estimated 85% of live births. Like any technology, EFM has its limitations. An ACOG Practice Bulletin issued in December 2005 reviewed some of these limitations.

- ❖ The false positive rate of EFM for predicting adverse outcomes is high
- ❖ The use of EFM is associated with an increase in the rate of operative interventions (vacuum, forceps, and cesarean delivery)
- ❖ The use of EFM does not result in a reduction of cerebral palsy case rates

This same bulletin sets forth the guidelines for the frequency of reviewing EFM tracings and their retention as part of the medical record.²⁷

THE 30-MINUTE INTERVAL GUIDELINE

In 1989, ACOG’s Committee on Professional Standards first established “that hospitals with obstetric services should have the capability to begin a cesarean delivery within 30 minutes of the time that the decision is made to perform the procedure.” *The Guidelines for Perinatal Care*, published jointly by the American Academy of Pediatrics and ACOG, and now in its sixth edition, follows that same guideline. Research indicates a lack of evidence for improved maternal and infant outcomes even when this guideline is followed. Nonetheless, the 30-minute response time has become sacrosanct as a medical-legal standard when a cesarean section is required.

Bloom *et al* studied maternal and infant outcomes and found that a cesarean delivery within 30 minutes does not prevent all poor infant outcomes and “by no means guarantees infant safety.” This is consistent with the findings of previous studies that a delay in cesarean delivery exceeding 30 minutes did not necessarily compromise infant outcomes.

SHOULDER DYSTOCIA CASES

Shoulder dystocia, a fetal condition that occurs rarely (0.2% to 3% of all vaginal deliveries) creates difficulty in the delivery after the infant’s head is outside the birth canal due to the size and position of the shoulders.²⁹ Most neonates born with a diagnosis of shoulder dystocia have no sequelae, but for approximately 10% of those cases, the injuries can be severe and permanently crippling, including a fractured clavicle and permanent damage to the brachial plexus, the network of nerves involving the arm, forearm and hand.³⁰

Litigation in these cases will usually take one of two tacks. First, the allegations may contend that the attending obstetrician should have recognized the risk(s) of shoulder dystocia and performed a cesarean section. Second, plaintiffs may allege that injuries to the brachial plexus occurred because of improper delivery technique.³¹



Gherman *et al* state that birth weight appears to be associated with shoulder dystocia but that other risk factors are not predictive except diabetes of the mother and previous incidence of shoulder dystocia.³²

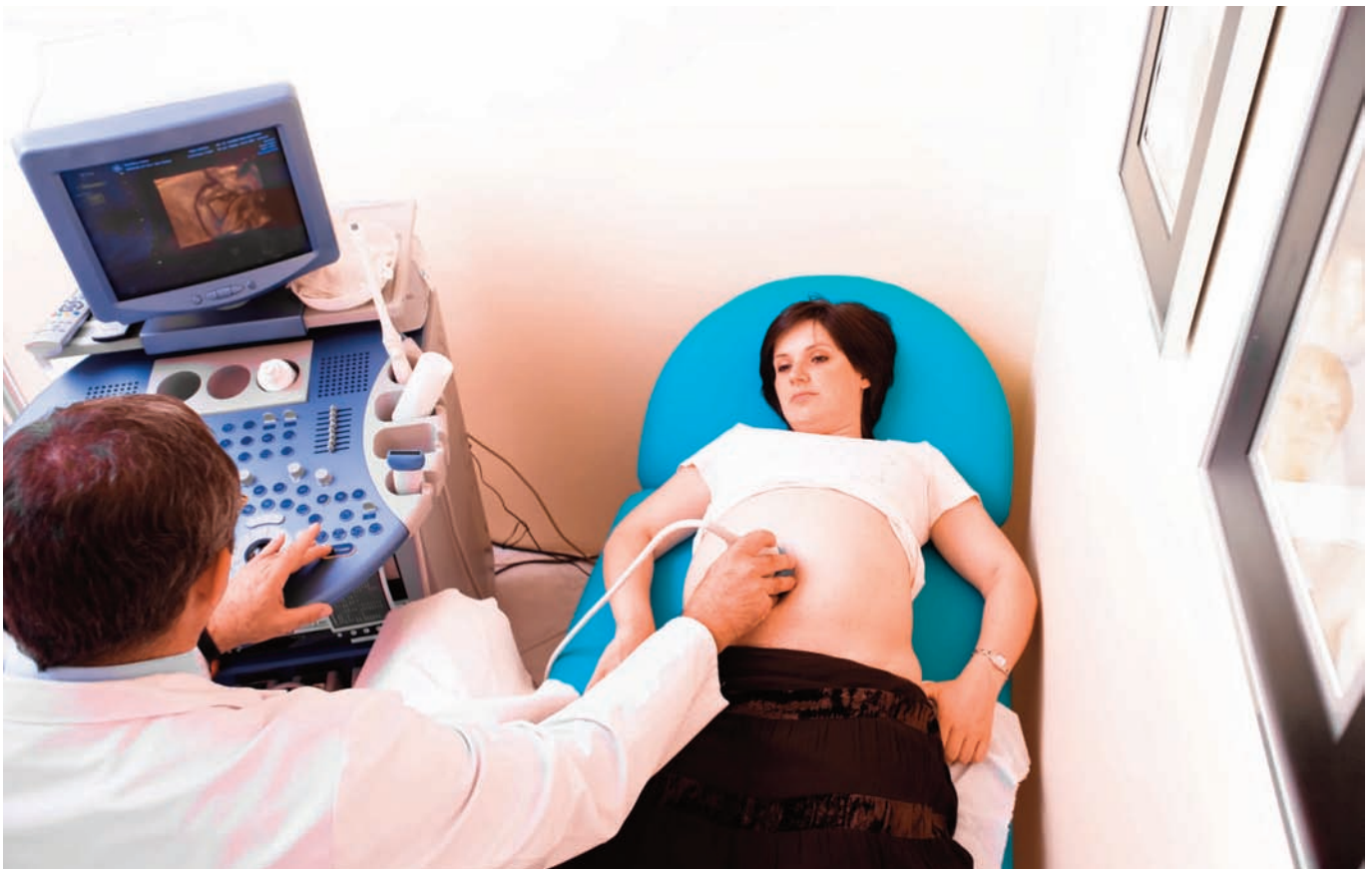
Knox and Simpson advocate the use of team shoulder dystocia drills to prepare for these obstetric emergencies.³³ Labor simulation using mannequins can be of value.^{34 35}

MANAGING OBSTETRICAL RISK: THE FUTURE

No other physician practice specialty or high-risk hospital unit has more claim volatility than obstetrics. Fortunately, many encouraging developments in the area of obstetric risk management and patient safety have emerged, such as simulation training. Patient safety now has a higher profile in obstetrics as reflected in journal articles of recent years. However, a number of authors note that more research is needed on what measures will best promote better patient outcomes.

Investments in obstetric patient safety maximize their return by preventing high-severity claims. Some patient safety approaches that hold promise include:

- ❖ OB rapid response teams³⁶
- ❖ Medical emergency preparedness strategies, such as training, stocking appropriate supplies, early warning systems, and specialized first responders³⁷
- ❖ Team training using crew resource management techniques borrowed from the military and the airline industry³⁸
- ❖ Commercially available clinical informatics systems that promote patient safety at the patient's bedside and in real time



FOOTNOTES

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