SECOND OF 2 PARTS

More strategies to avoid malpractice hazards on labor and delivery

4 problematic L & D cases: Occasions for the authors to talk about keeping clear of charges that you are the cause of injury during birth

Martin L. Gimovsky, MD, and Alexis C. Gimovsky, MD

IN THIS ARTICLE

CASE 1 Pregestational diabetes, large baby, birth injury

A 31-year-old gravida 1 is admitted to labor and delivery. She is at 39-5/7 weeks' gestation, dated by last menstrual period and early sonogram. The woman is a pregestational diabetic and uses insulin to control her blood glucose level.

Three weeks before admission, ultrasonography (US) revealed an estimated fetal weight of 3,650 g—at the 71st percentile for gestational age.

After an unremarkable course of labor, delivery is complicated by severe shoulder dystocia. The newborn has a birth weight of 4,985 g and sustains an Erb's palsy-type injury. The mother develops a rectovaginal fistula after a fourth-degree tear.

Editor's note: *You can read the first part of this article, which appeared in the December 2010 issue of OBG MANAGEMENT, through the "PAST ISSUES" link on the top-of-page toolbar at* **www.obgmanagement.com.**

Dr. Martin Gimovsky is Vice Chair and Program Director of the Department of Obstetrics and Gynecology at Newark Beth Israel Medical Center, Newark, NJ, and Clinical Professor of Obstetrics, Gynecology, and Reproductive Medicine at Mount Sinai School of Medicine, New York, NY.

Dr. Alexis Gimovsky is a house officer in the Department of Obstetrics and Gynecology at George Washington University Medical Center, Washington, DC.

The authors report no financial relationships relevant to this article.

In the first part of this article, we discussed how an **allegation** of malpractice can arise because of an unexpected event or outcome for a mother in your care, or her baby, apart from any specific clinical action you undertook. We offered an example: Counseling that you provide about options for prenatal care that falls short of full understanding by the patient.

In this article, we enter the realm of the hands-on practice of medicine and discuss **causation:** namely, the actions of a physician, in the course of managing labor and delivering a baby, that put that physician at risk of a charge of malpractice because the medical care **1)** is inconsistent with current medical practice and thus **2)** harmed mother or newborn.

Let's return to the opening case above and discuss key considerations for the physician. Three more cases follow that, with analysis and recommendations.

Considerations in CASE 1

- A woman who has pregestational diabetes should receive ongoing counseling about the risks of fetal anomalies, macrosomia, and problems in the neonatal period. **Be certain that she understands that these risks can be ameliorated, but not eliminated, with careful blood glucose control.**

CONTINUED ON PAGE 46

A selected glossary of clinical care guidelines

Term	What does it mean?
"Best practice"	A process or activity that is believed to be more effective at delivering a particular outcome than any other when applied to a particular condition or circumstance. The idea? With proper processes, checks, and testing, a desired outcome can be delivered with fewer problems and unforeseen complications than otherwise possible.[5]
"Evidence-based care"	The best available process or activity arising from both 1) individual expertise and 2) best external evidence derived from systematic research.[6]
"Standard of care"	A clinical practice to maximize success and minimize risk, applied to professional decision-making.[7]
"Uniformity of practice"	Use of systematic, literature-based research findings to develop an approach that is efficacious and safe; that maximizes benefit; and that minimizes risk.[8]

FAST TRACK

Although we all believe that our experience is our best teacher, we may best serve patients if we sample knowledge and wisdom from controlled clinical trials and from the experiences of others

- The fetus of a diabetic gravida develops a relative decrease in the ratio of head circumference-to-abdominal circumference that predisposes it to shoulder dystocia. **Cesarean delivery can decrease, but not eliminate, the risk of traumatic birth injury in a diabetic mother.** (Of course, cesarean delivery will, on its own, substantially increase the risk of maternal morbidity—including at any subsequent cesarean delivery.)

What do they mean? Terms and concepts intended to bolster your work and protect you

It's not easy to define what constitutes "best care" in a given clinical circumstance. Generalizations are useful, but they may possess an inherent weakness: "Best practices," "evidence-based care," "standardization of care," and "uniformity of care" usually apply more usefully to populations than individuals.

Such concepts derive from broader applications in economics, politics, and science. They are useful to define a reasonable spectrum of anticipated practices, and they certainly have an expanding role in the care of patients and in medical education (**TABLE**). **Clinical guidelines** serve as strategies that may be very helpful to the clinician. All of us understand and implement appropriate care in the great majority of clinical scenarios, but none of us are, or can be, expert in *all* situations. Referencing and using guidelines can fill a need for a functional starting point when expertise is lacking or falls short.

Best practices result from evidence-directed decision-making. This concept logically yields a desirable *uniformity* of practice. Although we all believe that our experience is our best teacher, we may best serve patients if we sample knowledge and wisdom from controlled clinical trials and from the experiences of others. What is accepted *local* practice must also be considered important when you devise a plan of care.[1,2]

Consider the management of **breech presentation** that is recognized at the 36th week antepartum visit: Discussion with the patient should include **1)** reference to concerns with congenital anomalies and genetic syndromes, **2)** in-utero growth and development, and **3)** the delivery process. The management algorithm may include external cephalic version, elective cesarean delivery before onset of labor, or cesarean delivery after onset of labor. Each approach has advocates—based on expert opinion clinical trials.

Management options may vary from institution to institution, however, because of limited availability of certain services—such as the expertise required for a trial of external cephalic version, the availability of on-site cesarean delivery capabilities, and patient and clinician preferences.

Uniformity of care, based on best practices, can therefore simplify the care process and decrease the risk that *may* be associated with individual experience-based management. Adhering to a uniform practice augments the clinician's knowledge and allows for

enhanced nursing and therapeutic efficiency.

The greatest benefit of using an evidence-based, widely accepted approach, however, is the potential to diminish poor practice and consequent malpractice exposure for both clinicians and the hospital.

Note: Although your adherence to **clinical guidelines**, best practices, and uniformity of care ought to be consistent with established standards of care, don't automatically consider any deviation a lapse or failing because it's understood and accepted that some local variability exists in practice.

Prelude to birth: Triage and admission

Triage. Most women in labor arrive at the hospital or birthing center to an area set aside for labor and delivery triage. There, **1)** recording of the chief complaint and vital signs and **2)** completion of a brief history and physical generate a call to the clinician.

The record produced in triage should be scrutinized carefully for accuracy. Clarify, in as timely a manner as possible, any errors in:

- timing (possibly because of different clocks set to different times)
- the precise capture of the chief complaint
- reporting difficulty or ease in reaching the responsible clinician.

Whether these records are electronic or paper, **an addendum marked with the time is always acceptable.** Never attempt to correct a record! Always utilize a late entry or addendum.

Admission. After the patient is admitted, she generally undergoes an admission protocol, specific to the hospital, regarding her situation. This includes:

- the history
- special requests
- any previously agreed-on plan of care
- any problems that have developed since her last prenatal visit.

This protocol is generally completed by a nurse, resident, nurse practitioner, or physician assistant.

Hospitals generally request input from the attending physician on the specifics of the admission, based on those hospital protocols. There may be some room to individualize the admission process to labor and delivery.

4 pillars of care during labor

In general, labor is defined as progressive dilation of the cervix. Several parameters serve as guidelines regarding adequate progress through the various stages of labor.

Fetal monitoring. Continuous evaluation of the fetus during labor is a routine part of intrapartum care. Recording and observing the FHR tracing is an accepted—and expected—practice. Documentation of the FHR in the medical record is specifically required, and should include both the physician's and nursing notes.

Anesthesia care. The patient's preference and the availability of options allows for several accepted practices regarding anesthesia and analgesia during L & D. Does she want epidural anesthesia during labor, for example? Intravenous narcotics? Her choice is an important facet of your provision of care.

However, such choice requires the patient to give consent and to understand the risk-benefit equation. Documentation by nursing of the patient's consent and understanding should be complete, including discussion and administration. Anesthesia staff should be clear, complete, and legible in making a record.

Neonatal care. If logistics permit, a member of the pediatrics service should be routinely available to see the newborn at delivery. The patient should view the pediatrician and obstetrician as partners working as a team for the benefit of the mother and her family. This can enhance the patient's understanding and confidence about the well being of her baby.

Documentation. Although deficient documentation does not, itself, lead to a finding of malpractice, appropriate documentation plays an important role in demonstrating that clinical practices have addressed issues about both allegation and causation of potential adverse outcomes.

We cannot overemphasize that nursing documentation should complement and be

Never attempt to correct a record! Always utilize a late entry or addendum marked with the time

consistent with notes made by the physician. That said, nursing notes are not a substitute for the physician's notes. Practices that integrate the written comments of nursing and physician into a single set of progress notes facilitate this complementary interaction.

3 more clinical scenarios

CASE 2 Admitted at term with contractions

The initial exam determines that this 21-year-old gravida 1 is 2/80/-1. Re-examination in 3 hours finds her at 3-4/80/0.

She requests pain relief and states that she wants epidural anesthesia.

Evaluation 2 hours later suggests secondary arrest of dilation. Oxytocin is begun.

Soon after, late decelerations are observed on the FHR monitor.

Use of exogenous oxytocin in L & D is a double-edged sword: The drug can enhance the safety and efficacy of labor and delivery for mother and fetus, but using it in an unregulated manner (in terms of its indication *and* administration) can subject both to increased risk.

In fact, it is fair to say that **the most widespread and potentially dangerous intervention during labor is the administration of oxytocin.** Many expert opinions, guidelines, and strategies have been put forward about intrapartum use of oxytocin. These include consideration of:

- indications
- dosage (including the maximum)
- interval
- fetal response
- ultimately, the availability of a physician during administration to manage any problem that arises.

FAST TRACK

Always be available in L & D for the first 30 minutes that oxytocin is being administered

Considerations in CASE 2

- Always **clearly indicate the reason for using oxytocin:** Is this an induction? Or an augmentation? Was there evidence of fetal well-being, or non-reassurance, before oxytocin was administered? Certainly, there are circumstances in which either fetal status or non-progression of labor (or both) are an indication for oxytocin. A clear, concise, and properly timed progress note is always appropriate under these circumstances.
- **Discuss treatment with the patient.** Does she understand why this therapy is being recommended? Does she agree to its use? And does she understand what the alternatives are?
- **Verify that nursing has accurately charted this process.** Ensure that the nursing staff's notes are complete and are consistent with yours.
- Simplify the entire process: **Use premixed solution and protocol-driven orders**. Know what the standards and protocols are in your department. Minimizing patient-to-patient variability should lessen the risk of error.
- **Always be available in L & D for the first 30 minutes that oxytocin is being administered.** If a problem with excessive uterine activity is going to occur, it is most likely to do so upon initial administration.
- **Monitor the FHR continuously.** At the first suggestion of a change in fetal status, discontinue oxytocin. Perform a pelvic exam to reassess the situation. Understand and apply appropriate in-utero resuscitative measures (IV fluids, O_2, change in maternal position). Depending on circumstances, you can consider a restart of oxytocin after the FHR returns to its pre-oxytocin pattern.
- **Monitor uterine response to oxytocin.** If the membranes are ruptured and if it is clinically feasible, an intrauterine pressure transducer will allow you to more objectively assess the uterine response to oxytocin and make decisions on that basis. Determine beforehand whether the patient is agreeable to this intervention.
- When oxytocin is used for augmentation, **reassess labor within 4 hours of achieving a satisfactory pattern.** If minimal progress is not made, assess the clinical situation to determine why oxytocin, at an adequate response level, has

failed to return labor to a normal active phase slope. Are there minor degrees of malposition? Is there an element of cephalopelvic disproportion? Recall that progress in labor is dependent on multiple factors.

- **Chart the process concurrently.** Specify options for delivery before delivery.

CASE 3 Spontaneous delivery arrests after delivery of the head

The patient is a multipara with three prior normal vaginal deliveries. Her diabetic screen is negative. At admission, the estimated fetal weight was 3,628 g—in the same range as her other deliveries. A nuchal cord is absent.

After the patient assumes the McRobert's position, delivery is accomplished with suprapubic pressure. Weakness is noted in the newborn's right upper extremity. Birth weight is 3,515 g.

Maneuvers to manage shoulder dystocia should be part of all clinicians' skill set. The sequence of those maneuvers, and their timing, are subject to some variation. Efficacy seems to be related most to recognizing and performing each maneuver properly.

Guidelines for managing shoulder dystocia should include reference to **1)** the initial evaluation of the patient on admission to labor and delivery and **2)** the delivery itself.[3]

FAST TRACK

Consider delivering all women at term in the McRobert's position, prophylactically

Considerations in CASE 3

- Before you admit them to L & D, counsel patients who have diabetes, morbid obesity (body mass index >40), or birth trauma in a prior delivery, or who have had a prior large infant (>9 lb birth weight), about the risk of shoulder dystocia. Present possible alternatives, and draw the patient into the conversation.
- Consider delivering all women at term in the McRobert's position, prophylactically.
- Always check for a nuchal cord after delivery of the head. If you find one, reduce it if possible. Take a few seconds and carefully assess the situation before you cut the umbilical cord.
- Lateral traction on the fetus' head has the potential to cause tension on the brachial plexus, or make it worse. Gentle rotation of the head (<90 degrees) can move the shoulders into a more favorable location for delivery. Don't rush—call for assistance! Continuously explain to the patient what you are doing; reassure her about the process.
- Use suprapubic pressure wisely. The anterior shoulder may be dislodged by direct downward force; suprapubic force in a lateral direction may also dislodge the shoulder. Apply force from above the patient's pelvis. Your assistant will have the best mechanical advantage by standing on a stool.
- Is an episiotomy or episioproctotomy advantageous? In attempting to reach either the anterior or posterior shoulder vaginally, individualized assessment is called for.
- When the posterior shoulder cannot be satisfactorily engaged and moved, try doing so with the anterior shoulder. Insert your hand between the symphysis and the fetal head and place downward pressure on the head to dislodge it and complete the delivery.
- If it becomes necessary to attempt delivery by direct traction on the posterior hand or arm, try to avoid extension. Maintain flexion and move the upper extremity across the fetal chest before you attempt extension.
- Repeat these maneuvers a second time before you attempt cephalic replacement or other maneuvers. Remember to move with deliberate speed to lessen the risk of making the injury worse. Have pediatric support present. Continue speaking with and reassuring the patient.
- Under anesthesia in the operating room, perform a hysterotomy incision. With an assistant working through the vagina, combine the forces available to complete the delivery.
- After delivery is complete, take time to write a note. (Speak with the patient and her family first, however.) Read the notes

written by nursing. If they are not available when you write your note, mention that. Add a second note later, when nursing notes become available.

CASE 4 Meconium-stained fluid

A 35-year-old multigravida is 6 to 7 cm dilated. Her membranes have just spontaneously ruptured; you note copious meconium-stained fluid. The FHR demonstrates recurrent variable decelerations; baseline fetal heart rate remains normal.

The description and implications of various FHR patterns are important when documenting the fetal metabolic state during the birth process. Current guidelines have attempted to simplify, standardize, and clarify the interpretation of the FHR tracing.[4]

Considerations in CASE 4

- Explain the situation to the patient. Perform a pelvic examination. If possible, wait for nursing assistance to ensure accurate documentation.
- Reassure the patient; help her move to a lateral position. Observe the FHR monitor for a response.
- Administer supplemental O_2. Increase IV fluids to facilitate utero-placental perfusion.
- If useful or necessary, consider attaching a fetal scalp electrode to better delineate fetal status.
- When the FHR returns to baseline state (before spontaneous rupture of membranes), perform vibro-acoustic stimulation as a test to support fetal well-being.
- Engage the patient and her family in a discussion about the sequence of events. Depending on the acuity of the situation, allow her to voice her concerns and reiterate what has occurred, and what will occur.
- Outline a plan of management to the patient—verbally and in the record—with clear reference to events that have occurred. Then, *stick to that plan*!
- Carefully review corresponding nursing notes. *Always* write your own assessment of events and actions.

Summing up: Three "keepers"

First, the cornerstones of your effort to reduce malpractice risk are **1)** thoughtful and informed discussion with the patient and **2)** clear, concise documentation.

Second, don't expect to be able to eliminate unnecessary or inappropriate allegations of medical malpractice; the best you can do is limit them.

Third, and most important, remember: The knowledgeable clinician you strive to be will make **appropriate judgments** in a timely fashion and will take **appropriate actions** to provide good medical care.

References

1. Clark SL, Belfort MA, Dildy GA, Meyers JA. Reducing obstetric litigation through alterations in practice patterns. Obstet Gynecol. 2008;112(6):1279–1283.
2. Clark SL, Belfort MA, Byrum SL, Meyers JA, Perlin JB. Improved outcomes, fewer cesarean deliveries, and reduced litigation: results of a new paradigm in patient safety. Am J Obstet Gynecol. 2008;199(2):105.e1–e7.
3. Crofts JF, Fox F, Ellis D. Observations from 450 shoulder dystocia simulations: lessons for skills training. Obstet Gynecol. 2008;112(4):906–912.
4. Macones GA, Hankins GD, Spong CY, Hauth J, Moore T. The 2008 National Institute of Child Health and Human Development workshop report on electronic fetal monitoring. Obstet Gynecol. 2008;112(3):661–666.
5. Best practice. BusinessDictionary.com Web site. 2010. http://www.businessdictionary.com/definition/best-practice.html. Accessed December 17, 2010.
6. Sackett DL, Rosenberg WC, Gray JA, Haynes BR, Richardson WS: Evidence based medicine: what it is and what it isn't. BMJ. 1996;312(7023):71–72.
7. Hayes EJ, Weinstein L. Improving patient safety and uniformity of care by a standardized regimen for the use of oxytocin. Am J Obstet Gynecol. 2008;198(6):622.e1–7.
8. Proctor SJ, Taylor PR. A practical guide to continuous population-based data collection (PACE): a process facilitating uniformity of care and research into practice. QJM. 2000;93(2):67–73.
9. Cohen W, Friedman EA. Management of Labor. Baltimore, MD: University Park Press; 1983.

FAST TRACK

Don't expect to be able to eliminate unnecessary or inappropriate allegations of medical malpractice; the best you can do is limit them