Medical Malpractice Insurers Address VBAC Risks

BY MARY ELLEN SCHNEIDER
Senior Writer

The malpractice insurance crisis is prompting a small number of professional liability insurers to institute strict standards for performing vaginal birth after cesarean section.

And an Oklahoma insurer last month has gone as far as excluding coverage for the procedure, citing a high number of claims associated with allegations of failure to perform a timely cesarean.

For its part, Northwest Physicians Mutual Insurance Company in Oregon still covers vaginal birth after cesarean section (VBAC), but it instituted a requirement in late 2003 that physicians and nurse-midwives who provide obstetric care must submit verification that the hospital where they practice is able to meet specific criteria. To continue to be covered to perform VBAC, physicians and the facilities in which they perform VBAC have to demonstrate that a physician capable of monitoring and performing an emergency cesarean delivery is present in the hospital or on the hospital's campus throughout active labor.

The insurer bases its certification on a practice bulletin issued by the American College of Obstetricians and Gynecologists (ACOG), which recommends that a physician capable of monitoring labor and performing an emergency cesarean be "immediately available" throughout active labor.

"Given the associated risks and elective nature of performing this procedure, coverage for the performance of VBACs will only be offered under specific criteria," William Gallagher, M.D., president and chair of Northwest Physicians Mutual, said in a letter to physicians.

For N. Michelle Sang, M.D., an ob.gyn. in Portland, Ore., who is insured through Northwest Physicians Mutual, this change means she and her colleagues are a lot more selective about providing VBAC.

Since she is affiliated with two hospitals, it's not practical to expect to be in one hospital for a patient's labor and delivery, she said. As a result, Dr. Sang and her colleagues in the practice have their patients sign a contract acknowledging that they might not be able to undergo VBAC.

"We tell our patients that we cannot guarantee a trial of labor if their physician is not available—regardless of the call schedule—or if there are multiple patients in labor at more than one hospital for our office," Dr. Sang said.

Although some physicians in her group are offering VBAC to any patient who is a good candidate, most of them only offer VBAC to patients who have already had a successful VBAC.

For Northwest Physicians Mutual, the decision to require adherence to the ACOG practice bulletin was primarily a patient-safety issue, Dr. Gallagher said. The company's board had considered instituting a full exclusion of VBAC but decided against it. "We're not really in the business to tell doctors what they can do and can't do," he said.

Northwest Physicians Mutual isn't the only company asking physicians to certify that they will follow the recommendations laid out in the ACOG bulletin.

ProAssurance, a professional liability insurer that operates in a number of southern states, has a similar policy that requires physicians to sign endorsements saying they will follow the ACOG recommendations.

The company recently phased in this policy in Georgia, Virginia, North Carolina, Texas, and Tennessee. The change in policy is part of the company's ongoing evaluation of medical liability, said Frank O'Neil, a spokesman for ProAssurance.

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Dr. N. Michelle Sang has her patients sign a contract acknowledging they might not be able to undergo a trial of labor.

The Utah Medical Insurance Association has developed its own guidelines that physicians must adhere to as part of their policy. VBAC is subject to special guidelines, along with other high-risk obstetric procedures, because it is a huge area of litigation and loss around the country, said Steven L. Clark, M.D., a Salt Lake City–based perinatal advisor for the Utah Medical Insurance Association and medical director of perinatal medicine for the Hospital Corporation of America.

Physicians are covered to perform VBAC only if they follow certain conditions such as not using prostaglandin agents, performing continuous electronic fetal heart rate monitoring, being within 5 minutes of the operating room throughout the patient's labor, and providing informed consent to the patient. In addition, VBAC for twin gestations is prohibited.

Dr. Clark said his company's guidelines aren't particularly strict and are similar to requirements in place by hospitals. "Our view of this … that this is basically a tertiary hospital procedure," he said.

In Oklahoma, the Physicians Liability Insurance Corp. (PLICO) has taken its policy a step further by excluding from its malpractice coverage all VBAC procedures except in the case of an emergency. The new policy went into effect on Jan. 1.

The decision was based on a number of factors, said PLICO President and CEO Carl Hook, M.D., including ACOG's practice bulletin on VBAC, which was issued in 1999 and revised last year, and statistics showing an increased risk of uterine rupture when women undergoing VBAC receive uterine muscle contraction medications to assist labor.

Claims were also a factor. In 2003, about half of PLICO's losses were paid on claims in which failure to perform a timely cesarean was alleged, Dr. Hook said.

But Dana Stone, M.D., an ob.gyn. in Oklahoma City, said she is concerned that coverage is being denied for a reasonable medical procedure.

Dr. Stone said she doesn't believe she can continue to offer VBAC in light of this restriction. To date, Dr. Stone said she hasn't had a patient ask to change doctors because she can't perform VBAC, but she says her colleagues have had patients who are seeking new physicians as a result.

These types of restrictions imposed by insurers aren't widespread, said Albert L. Strunk, M.D., vice president of ACOG's fellowship activities. In many cases, companies recommend adherence to practice guidelines, but the process is informal, he said.

Although the educational efforts for improving patient safety and care can be helpful, Dr. Strunk said, practice parameters that have as their primary goal the protection of the insurance company are inappropriate. It's also inappropriate for the insurer to impose practice requirements that would impair physicians in exercising their judgment in terms of patient safety, Dr. Strunk said. ■

Know Your Hospital's Protocol for Use of Pitocin in Labor

BY SHERRY BOSCHERT
San Francisco Bureau

CABO SAN LUCAS, MEXICO — Before you write an order for Pitocin administration to induce or augment labor, be sure you know your hospital's protocol for Pitocin use, Dennis J. Sinclitico, J.D., said.

In the three most recent obstetrical malpractice cases in which he served as a defense attorney, the physicians gave nurses orders for Pitocin (oxytocin) that contradicted the hospital's protocol, he said at a conference on obstetrics, gynecology, perinatal medicine, neonatology, and the law.

That contradiction forces nurses to make decisions about the utilization, titration, and discontinuation of Pitocin "without the comfort and background of their own protocol," he noted. Often, there is no further physician involvement besides orders to "call me when you're ready" for delivery.

Basically, abandoning nurses with contradictory orders is "a terrible mistake and indefensible in many instances," said Mr. Sinclitico, a defense lawyer in Long Beach, Calif.

If you want to leave orders for Pitocin use that differ from the hospital's protocol, document why you think your approach to management is appropriate.

If you want to leave orders for Pitocin use that differ from the hospital's protocol, document why you think your approach to management is important and appropriate. Give the nurses written instructions documenting that your orders differ from the protocol, and tell them how and when to adjust, titrate, or discontinue the Pitocin dosage. Provide written instructions on how and when the nurses should contact you.

Pitocin is a player in virtually every case he defends, even if it is not a relevant factor, Mr. Sinclitico noted. "I can't remember a case recently in which Pitocin was not ordered in some fashion," he said at the meeting, sponsored by Boston University and the Center for Human Genetics.

The biggest problem he sees in the cases he defends that involve Pitocin administration stem from insufficient response to findings on the fetal heart rate monitoring strip. Fifteen, 20, or 60 minutes go by before nurses or physicians respond to a potential problem identified by the strip, and the health care workers leave insufficient documentation about the course of events, their timing, and reasons for acting or not acting.

"If I have a practice tip for you, it would be to go back to your hospital and emphasize the notion that if you're going to allow nurses to make those judgments, they should be made appropriately and in a timely fashion," he said.

Because individual responses to Pitocin differ, the dose must be monitored carefully and adjusted as needed. Used properly, Pitocin can prevent the need for cesarean section in some deliveries. Risks from the force of contractions induced by Pitocin include potentially greater reductions in uterine blood flow than occur with natural contractions, which can lead to a greater reduction in oxygen for the fetus and possible fetal distress. ■