OBSTETRICS
IN THE LEGAL JUNGLE
A Practical Guide For A Difficult Journey

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THE PROBLEM

According to a recent ACOG survey, 90.5% of ACOG Fellows have been sued, and 42.8% of this group have experienced at least one claim resulting from care provided during residency.

Source: ACOG Committee Opinion, No. 497, August 2011
Cerebral Palsy

Cerebral palsy is a disorder that affects the brain and nervous system, leading to potentially severe movement problems in those diagnosed. This disorder is often caused by trauma or health complications before, during, or immediately after birth, but can still affect a child in the first few years of their life while their brain is still developing. While symptoms will not typically worsen as a child grows up, the effects of cerebral palsy can be traumatic, particularly when a child is affected more severely.

Cerebral palsy can be the result of a natural or unavoidable health complication; sadly, this is not usually the case, as the vast majority of children diagnosed with cerebral palsy develop this condition because of another person’s negligence, most often medical professionals. If your child has been diagnosed with cerebral palsy and you believe they developed this condition because of another party’s wrongdoing, we want to put our considerable experience to work for you. Contact the cerebral palsy birth injury attorneys at The Driscoll Firm today by calling 800-305-9800 for the assistance you need.

About Cerebral Palsy

Those with cerebral palsy can be affected in a variety of ways and may experience mild symptoms to extremely severe ones. To learn more about the different ways in which cerebral palsy can affect an individual, you can visit the following pages on:
OBSTETRICS: A HIGH RISK SPECIALITY
Figure 1. Proportion of Physicians Facing a Malpractice Claim Annually, According to Specialty.
TORT REFORM

A National (Federal) and State Issue
A May 2003 Joint Economic Committee of the U.S. Congress noted the following:

In 2001, premiums for medical malpractice topped $21 billion, double the amount ten years earlier.
The growth in aggregate premiums reflects the growth in premiums charged to individual doctors. Table 1 lists the median rate increases for medical liability insurance premiums for the last three years by area of practice. As the data show, internists have experienced three consecutive years of at least 15 percent premium hikes. The typical rate increase has tripled for general surgeons and doubled for obstetricians/gynecologists (Ob/Gyn). The high cost of the current medical liability system most adversely impacts obstetricians, most surgical-related specialties (especially neurosurgeons), and emergency room physicians.

<table>
<thead>
<tr>
<th>Table 1. Median Rate Increases in Malpractice Premiums by Specialty</th>
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<tr>
<td>Internists</td>
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<td>General Surgeons</td>
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<tr>
<td>Obstetricians/Gynecologists</td>
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Source: Medical Liability Monitor.
THE PROPOSED RESOLUTION:

Caps
After 2000, premium rates began to rise across most states on average, but more slowly among the states with certain noneconomic damage caps. In particular, from 2001 to 2002, the average rates of increase in the states with noneconomic damage caps of $250,000 and $500,000 or less were 10 and 9 percent, respectively, compared to 29 percent in the states with limited reforms.\(^2\)

\(^1\) The U.S. General Accounting Office (GAO) released a study in August 2003 on medical malpractice which has been cited in several press accounts as providing evidence that there is no medical malpractice crisis, and hence, no need for the medical malpractice reform now in Congress (H.R. 5 and S. 11). The policy brief offers some perspectives on the GAO report.

\(^2\) GAO report never actually concludes that there is no evidence of a medical malpractice problem. Rather, the GAO report states that it was unable to substantiate anecdotal reports that medical malpractice problems resulted in widespread impediments to the access of health care, a finding consistent with an analysis GAO did of Medicare claims data. However, the same GAO report also includes evidence both that malpractice insurance premiums are rapidly escalating and that caps on noneconomic damage awards appear effective at slowing such growth rates.

\(^3\) After reviewing the GAO’s list of eight states with a cap of $500,000 or less does not include the four states with a cap of $250,000. The analysis further counts 11 states plus the District of Columbia with no cap and no collateral benefit offset rule.
Figure 1. Malpractice Premium Growth Rates, 2001-2002

- General Surgery
  - States with caps of $250,000: 12%
  - States with caps of $500,000 or less: 9%
  - States with no caps: 11%

- Internal Medicine
  - States with caps of $250,000: 10%
  - States with caps of $500,000 or less: 11%
  - States with no caps: 9%

- OB/GYN
  - States with caps of $250,000: 9%
  - States with caps of $500,000 or less: 8%
  - States with no caps: 27%

Source: U.S. General Accounting Office.
The Affordable Care Act does not enact any specific tort reform or a “Lawsuit Abuse Reform”
On page 686 (of 906 pages), the ACA states the following:
Subtitle I—Sense of the Senate Regarding Medical Malpractice

SEC. 6801. SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE.

It is the sense of the Senate that—

(1) health care reform presents an opportunity to address issues related to medical malpractice and medical liability insurance;

(2) States should be encouraged to develop and test alternatives to the existing civil litigation system as a way of improving patient safety, reducing medical errors, encouraging the efficient resolution of disputes, increasing the availability of prompt and fair resolution of disputes, and improving access to liability insurance, while preserving an individual’s right to seek redress in court; and

(3) Congress should consider establishing a State demonstration program to evaluate alternatives to the existing civil litigation system with respect to the resolution of medical malpractice claims.
So the ACA “authorizes” $50 million to study “Medical Liability Reform”

Agency for Healthcare Quality and Research has 2 RFPs, with the planning efforts required to focus on:
Putting patient safety first and working to reduce preventable injuries;

Fostering better communication between doctors and their patients;

Ensuring that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits;

Reducing liability premiums.
Putting patient safety first and working to reduce preventable injuries;

Fostering better communication between doctors and their patients;

Ensuring that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits;

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Reducing liability premiums.
THE NATIONAL COMMISSION ON FISCAL RESPONSIBILITY AND REFORM

The Moment of Truth

DECEMBER 2010
3.3.12 Medical malpractice reform.
(Saves $2 billion in 2015, $17 billion through 2020)
Most experts agree that the current tort system in the United States leads to an increase in health care costs. This is true both because of direct costs – higher malpractice insurance premiums – and indirect costs in the form of over-utilization of diagnostic and related services (sometimes referred to as “defensive medicine”). The Commission recommends an aggressive set of reforms to the tort system.

Among the policies pursued, the following should be included: 1) Modifying the “collateral source” rule to allow outside sources of income collected as a result of an injury (for example workers’ compensation benefits or insurance benefits) to be considered in deciding awards; 2) Imposing a statute of limitations – perhaps one to three years – on medical malpractice lawsuits; 3) Replacing joint-and-several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury; 4) Creating specialized “health courts” for medical malpractice lawsuits; and 5) Allowing “safe haven” rules for providers who follow best practices of care.

Many members of the Commission also believe that we should impose statutory caps on punitive and non-economic damages, and we recommend that Congress consider this approach and evaluate its impact.
Major effort to address the Med Mal “crisis” in the 2000’s

31 states now have caps on non-economic or total damages in Med Mal cases

Between 1992 and 2011, the rate of paid claims per physician dropped by 54% nationwide

However, this data does not include payouts by hospitals or any defense costs
“Damage caps may be a good idea, or a bad idea — but increasingly, they are a small idea — important to physicians, and to those who might bring malpractice suits, but a small element of overall health policy.”

“Even if a national cap were to reduce payouts in no-cap states by 50%, the direct savings would be under 0.10% of national healthcare spending, and falling.”

Source: The Receding Tide of Medical Malpractice Litigation
http://ssrn.com/abstract=2109679
TENNESSEE’S SOLUTION
1. Caps on Noneconomic Damages

Noneconomic damages capped at $750,000 for a civil cases involving injuries, but if the claim is for “catastrophic loss or injury,” the cap is $1,000,000.

T.C.A. 29 – 39 - 102
What are “noneconomic” damages?

A laundry list of non pecuniary (e.g., pain and suffering) damages

There is no cap on “economic” damages.
What are “noneconomic” damages?

A laundry list of non pecuniary (e.g., pain and suffering) damages

There is no cap on “economic” damages.
2. Caps on Punitive Damages

- Higher burden of proof: “clear and convincing evidence” of actions that were: malicious, intentional, fraudulent, or reckless

- Punitive damages capped at the greater of; but not to exceed: $2x$ compensatory damages or $500,000$

T.C.A. 29 – 34 - 104
3. Significant exposure to large verdicts remain: Economic Damages in “Bad Baby” Cases
In bad baby cases, the Tennessee law places no caps in “objectively verifiable pecuniary damages arising from:

- Medical expenses and medical care
- Rehabilitation services
- Loss of earnings and earning capacity

T.C.A. 29 – 39 – 101
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T.C.A. 29 – 39 – 101
Healthcare providers still face exposure to very large verdicts in bad baby lawsuits.

The damages battle:

Life Care Plans
LIFE CARE PLANNING

A certified case manager coordinates the medical care that supports the patient to optimal medical outcome, recovery, and independence. The patient, family, and physician are included in this process to identify the appropriate care and resources and to ensure continuity of care.

A natural progression of these services is the development of a multidisciplinary Life Care Plan that systematically documents the medical needs of disabled individuals. This Plan projects the cost of these goods and services over the individual’s life span.

Yearly totals are projected within this Life Care Plan to a reasonable degree of certainty and are based upon the review of the listed records and depositions, the completion of a home visit on August 9, 2012, and the extensive experience and knowledge of this Certified Case Manager/Life Care Planner. All information contained herein is subject to change upon receipt of further information and/or records.
3.3.12 Medical malpractice reform. 
(Saves $2 billion in 2015, $17 billion through 2020)

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Malpractice Litigation
THE PLAYERS

The Healthcare Providers

Expert Witnesses

The Lawyers

The Law

The Jury

- The Chart

- Fetal Monitor Strips
THE PLAYERS

The Healthcare Providers

Expert Witnesses

The Lawyers

The Law

The Jury
THE PLAYERS

The Healthcare Providers

Expert Witnesses

The Lawyers

The Law

The Jury
THE PLAYERS

The Healthcare Providers

Expert Witnesses

The Lawyers

The Law

The Jury
THE PLAYERS

The Healthcare Providers

Expert Witnesses

The Lawyers

The Law

The Jury
What is “malpractice”?

What can and should you expect when a lawsuit is filed?

What are recurring issues we confront in obstetrical cases?

What can you do to minimize the risk of a lawsuit?

What can you do to protect the record and yourself while delivering care?
WHAT IS “MALPRACTICE”?

The legal definition:

T.C.A. 29-26-115 (a)

(a) In a malpractice action, the claimant shall have the burden of proving by evidence as provided by subsection (b):

(1) The recognized standard of acceptable professional practice in the profession and the specialty thereof, if any, that the defendant practices in the community in which the claimant practices or in a similar community at the time the alleged injury or wrongful action occurred;

(2) That the defendant acted with less than or failed to act with ordinary and reasonable care in accordance with such standard; and

(3) As a proximate result of the defendant's negligent act or omission, the plaintiff suffered injuries which would not otherwise have occurred.

(b) No opinion by a qualified expert shall be admissible against the defendant unless such opinion is based upon the facts presented in the action.
WHAT THIS MEANS:

“Recognized”

“Acceptable”

“Ordinary and Reasonable care”

“Proximate cause”

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Standard of Care

Deviation from SOC

Causation
Tennessee Law: Contiguous State

T.C.A. 29-26-115 (b)

(b) No person in a health care profession requiring licensure under the laws of this state shall be competent to testify in any court of law to establish the facts required to be established by subsection (a), unless the person was licensed to practice in the state or a contiguous bordering state a profession or specialty which would make the person's expert testimony relevant to the issues in the case and had practiced this profession or specialty in one (1) of these states during the year preceding the date that the alleged injury or wrongful act occurred. This rule shall apply to expert witnesses testifying for the defendant as rebuttal witnesses. The court may waive this subsection when it determines that the appropriate witnesses otherwise would not be available.

(c) In a malpractice action as described in subsection (a), there shall be no presumption of negligence on the part of the defendant; provided, there shall
1. Unless the court grants a waiver, an expert witness must be licensed and practice in Tennessee, Virginia, North Carolina, Georgia, Alabama, Mississippi, Arkansas, Missouri, or Kentucky.

2. “Relevant specialty” can include a broad range of specialties. (Credibility/weight vs. admissibility)
ACOG Committee Opinion on Expert Testimony
Expert Testimony*

Committee on Ethics

**ABSTRACT:** It is the duty of obstetricians and gynecologists who testify as expert witnesses on behalf of defendants, the government, or plaintiffs to do so solely in accordance with their judgment on the merits of the case. Obstetrician-gynecologists must limit testimony to their sphere of medical expertise and must be prepared adequately. They must make a clear distinction between medical malpractice and medical maloccurrence. The acceptance of fees that are greatly disproportionate to those customary for professional services can be construed as influencing testimony given by the witness, and it is unethical to accept compensation that is contingent on the outcome of litigation. The potential for personal, professional, and financial rewards from expert testimony may encourage testimony that undermines the distinction between unavoidable maloccurrence and actual medical malpractice.

The American College of Obstetricians and Gynecologists also recognizes, however, that many claims of professional liability represent the response of a litigation-oriented society to a technologically advanced form of health care that has fostered unrealistic expectations.
PROBLEMS WITH EXPERT TESTIMONY

Hindsight Bias
Hindsight bias occurs when a person's estimate of the likelihood of a possible outcome is influenced by knowledge of what outcome actually has occurred even though the person is attempting to ignore this knowledge.
Hindsight bias has been recognised by psychologists for decades, and has been studied more recently by investigators interested in quality assurance in healthcare. In one study, anaesthetist reviewers were provided with sets of cases with the same descriptive facts, but with outcomes randomly assigned to be either bad or neutral. The anaesthetists consistently rated the care in cases with bad outcomes as substandard, whereas they viewed identical care with neutral outcomes as being up to standard. The degree of bias is linked to the severity of the outcome — with severely injured patients, judgements by reviewers tend to be harsher. When reviewers know of an adverse outcome, they tend to trivialise the management dilemmas facing the doctor at the time, overlooking the uncertainties inherent in diagnosis and treatment. Expert opinions frequently include the phrase “it should have been obvious”. It has been suggested that hindsight bias is almost always present when that expression is used.
The exact mechanism by which hindsight bias influences judgment has been termed by one researcher as “creeping determinism,” which is defined as a process in which outcome information is immediately and automatically integrated into a person’s knowledge about the events preceding the outcome [11].
PROBLEMS WITH EXPERT TESTIMONY

Hindsight Bias

Compensation Bias
1. **Notice of claim**

As of 11/11/1111, the first step in a lawsuit is a Notice of Claim.

* Certified letter

* Within statute of limitations

* A lawsuit cannot be filed sooner than 60 days from the date of notice

* Policy purpose: Allow time for investigation and pre-suit resolution

T.C.A. 29
ANATOMY OF A LAWSUIT

2. The complaint – Certificate of Good Faith
   - Notify carrier or risk management.
   - Choice of lawyer.
   - Secure chart.

3. Certificate of Good Faith
4. What to do; what not to do

5. The deposition

   Preparation, more preparation
6. To settle, or not to settle?
   - Consent provision in all SVMIC policies.
   - Risk of excess verdict.

7. Consequences of settlement or adverse jury verdict.
   - National Practitioner Data Bank.
   - State of Tennessee Website.
Practitioner Profile Data

This information is provided by the licensee as required by law.

While searching for information on a particular health care professional, consumers should be aware that there are several locations available to aid them with their research. ([License Verification, Abuse Registry and Monthly Disciplinary Actions](#)) Links to various Internet sites are available from the Department of Health Website home page and from the Health Related Boards Website.

### DESJARLAIS, SCOTT EUGENE

| PRACTICE ADDRESS         | SCOTT E DESJARLAIS MD  
|                         | 386 HWY 38 STE 108  
|                         | JASPER, TN 37347 |

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<th>STAFF PRIVILEGES</th>
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This practitioner currently holds staff privileges at the following hospitals

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<th>HOSPITAL</th>
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<td>COLUMBIA GRANDVIEW MEDICAL CTR</td>
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This practitioner currently participates in the following TennCare plans

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**FINAL DISCIPLINARY ACTION**

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Some studies have shown that there is no significant correlation between malpractice history and a doctor's competence. At the same time, the Legislature believes that consumers should have access to malpractice information. In these profiles, the Department has given you information about both the malpractice history of the physician's specialty and the physician's history of payments. The Legislature has placed payment amounts into three statistical categories: below average, average, and above average. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high quality care by selecting a doctor based solely on malpractice history.

When considering malpractice data, please keep in mind:

- Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make individual doctor's history more meaningful.
- The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to move through the legal system.
- Some doctors work primarily with high risk patients. These doctors may have malpractice histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.
- Settlement of a claim may occur for a variety of reasons which do not necessarily reflect negatively on the professional competence or conduct of the provider. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information provided in this report, and malpractice generally, with your doctor. The Department can refer you to other articles on this subject.

The Health Department started getting reports for claims paid after May, 1998.

In accordance to TCA 63-51-105A5A:

Settlements valued below $10,000 for all professions (with the exceptions of $25,000 for Dentist, $50,000 for Chiropractors and $75,000 for Medical Doctors and Osteopaths) are not included here.

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### OPTIONAL INFORMATION

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RECURRING ISSUES

Communication

- Physician to physician
- Nurse to physician
- Physician to nurse
ABSTRACT: Handoff communication, which includes up-to-date information regarding patient care, treatment and service, condition, and any recent or anticipated changes, should be interactive to allow for discussion between the giver and receiver of patient information. It requires a process for verification of the received information, including read-back or other methods as appropriate.

One of the leading causes of the breakdown in communication is 66% of all reported adverse events related to 2004 and complete, clearly communicating their communication skills, not only with each other, but also when interacting with other members of the health care team. Awareness of the importance and challenges of effective communication and implementation of effective communication processes, especially as it relates to hand-offs, will decrease errors that result in adverse events and provide a safer patient. Barriers to effective communication include factors such as lack of time, hierarchies, defensiveness, varying communication styles, distraction, fatigue, conflict, and workload.
The material patient presented to the hospital at

36 5/7 weeks after experiencing a gush of blood that saturated her

2 ½ hours later, she delivered by C-section a severely compromised

who expired days later due to consequences of placental abruption.

The attending OB did not examine the patient until 2 hours and 12

minutes after admission.
MAJOR ISSUE: COMMUNICATION

Physician to physician (3 OBs)

Nurse to physician
OB #1:
- Courtesy visit to patient
- Reviewed strips
- Learned history of bleeding
- Speaks with OB #2 by phone

OB #1’s version:
“I called OB #2 to say I was the patient’s employer, that I was close to the hospital, and if there was an emergency, I could get there as fast as anybody.”
OB #1

- Courtesy visit to patient
- Reviewed strips
- Learned history of bleeding
- Speaks with OB #2 by phone

OB #2’s version

“I was told by OB #1 that the patient came in with some vaginal bleeding, the strip looks reassuring. I told OB #1 I would call my partner and report to him, and that one of us would be in to evaluate the patient.”
OB #2

- At office when receives call from L&D Nurse

- Is not maternal patient’s OB, but is partner to OB #3, who is the attending

OB #2’s version

“My office staff puts L&D nurses call to me, and was told the patient had some bleeding, the strip is reassuring, and I ordered lab work and get her admitted.”
OB #2  - At office when receives call from L&D Nurse

- Is not maternal patient’s OB, but is partner to OB #3, who is the attending

L&D Nurse’s version

“I told OB #2 the patient complained of abdominal pain, had presented with bright red blood on her groin and thigh, and the uterus did not relax between contractions. He said he or OB #3 would be in to see the patient.”
OB #2 - Calls OB #3, who is in operating room

OB #2’s version

“I called OB #3 in the OR at another hospital and passed off the information from the nurse and OB #1, and OB #3 said: ‘I will take care of it’. I said “I am available if you need me.”
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<tr>
<th>OB #2</th>
<th>- Calls OB #3, who is in operating room</th>
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**OB #3’s version**

“OB #2 called me while I was in the OR, said she presented with some bleeding, that OB #1 had been there and the FHR was reassuring. I would have been concerned about a large amount of vaginal bleeding, but placental abruption was in the back of my mind.”
OB #3

- Remained at the hospital for 2 surgeries
- L&D nurse called with report

**OB #3’s version**

“I paged while in the OR and spoke with the nurse. She did not tell me anything alarming nor did she convey the feeling she was alarmed. If a nurse is concerned, most of the time they say “get your butt here” or “we need to do a C-section.”
OB #3
- Remained at the hospital for 2 surgeries
- L&D nurse called with report

L&D Nurses version
“I reported the patients right side pain and her worsening status, including an episode of bleeding, late decelerations that responded to interventions, decreased variability and change in baseline, membrane was intact, and labor was not progressing.”
- Remained at the hospital for 2 surgeries

- L&D nurse called with report

L&D Nurses version

“I asked him if he would be coming to the hospital, and he said he would after his second surgery. I asked him if he wanted me to prep for a C-Section and he said go ahead but he hoped for a vaginal delivery.”
Patient’s Expert:

Depending on whose version to believe, he blames everybody.

OB obligated to evaluate the maternal patient with her history or ask an OB to do so.
OB’s Expert:

- It’s the nurse’s fault.

- At times, an OB nurse should demand a doctor come to the hospital.
Nurse’s OB Expert:

The nurse shares responsibility, but the OB is primarily responsible.

With the history, OB should evaluate the patient and if abruption is in the differential, OB should stay until delivery.
1. Managing your day.

2. Reliance on L&D nurses.

3. Personality and human nature.

4. Documentation.
AN AVOIDABLE EVENT

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4. Documentation.
1. As an employee of the hospital

- Acting in course and scope of employment
- Almost never has personal assets at risk
- Very rarely named as an individual defendant
2. **Independent Duty**

- Essentially same legal duties owed under the same law as the OB
- Nurse and physician expert witnesses
3. Comparative Fault: An Incentive To Criticize

- The jury decides – and apportions fault
- Team approach in delivering care
- The blame game
4. L&D Nurses: Increasing Responsibility and Risk Exposure

A. OB Triage (Telephone Medicare)

  - Documentation
  - Communication
  - Verification
B. Patient Handoffs – Nurse to Nurse

C. Night Shift – Communication with OB

- Reporting data to the OB
- Effective communication
- Dealing with the obstinate physician
- To demand or not to demand
- Documentation
- Chain of command
Cerebral Palsy:

When is it caused by an acute intrapartum hypoxic event:
Neonatal Encephalopathy and Cerebral Palsy: Defining the Pathogenesis and Pathophysiology
1. Evidence of a metabolic acidosis in fetal umbilical cord arterial blood obtained at delivery (pH < 7 and base deficit > 12 mmol/L)

2. Early onset of severe or moderate neonatal encephalopathy in infants born at 34 or more weeks of gestation
3. Cerebral palsy of the spastic quadriplegic or dyskinetic type

4. Exclusion of other identifiable etiologies such as trauma, coagulation disorders, infectious conditions, or genetic disorders
Criteria that collectively suggest an intrapartum timing (within close proximity to labor and delivery, eg, 0 – 48 hours) but that are nonspecific to asphyxial insults

1. A sentinel (signal) hypoxic event occurring immediately before or during labor

2. A sudden and sustained fetal bradycardia or the absence of fetal heart rate variability in the presence of persistent, late, or variable decelerations, usually after a hypoxic sentinel event when the pattern was previously normal
Criteria that collectively suggest an intrapartum timing (within close proximity to labor and delivery, eg, 0 – 48 hours) but that are nonspecific to asphyxial insults

3. Apgar scores of 0-3 beyond 5 minutes

4. Onset of multisystem involvement within 72 hours of birth

5. Early imaging study showing evidence of acute nonfocal cerebral abnormality
The Next NECP Task Force Will Update the 2003 Report

Two new chapters:

Neuroradiology

Placental Pathology
The Future

More data

Same risk