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Editorial

Indemnification of Risk by Obstetrical Providers

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Editorial

When providing medical expert review of obstetrical cases that result in an adverse fetal outcome, one is expected to determine whether or not the obstetrical provider met established standards of care. The two most common adverse outcomes encountered in such cases are hypoxic ischemic encephalopathy and neonatal brachial plexus palsy [1]. The injuries associated with such cases, cerebral palsy and upper extremity dysfunction, have long range consequences for the newborn and are often associated with large financial settlements.

The American College of Obstetrics and Gynecology in conjunction with the American Academy of Pediatrics have published task force recommendations on Neonatal Encephalopathy and Neurological Outcome and Neonatal Brachial Plexus Palsy [2]. Although neither is proposed as a body of rigid rules, they provide guidance to the clinician. The first publication, Neonatal Encephalopathy and Neurological Outcome, provides scientific information regarding the causes of neurological injury, and the association of cerebral palsy with maternal intrapartum fever, acute intrapartum events and shoulder dystocia. No evidence was presented demonstrating that electronic FHR monitoring decreases the rate of neonatal encephalopathy. Moderate variability and accelerations were cited as reassuring features of the fetal heart rate that reliably exclude damaging degrees of hypoxia-induced metabolic acidemia. Criteria were set forth that should be met in order to state with a reasonable degree of medical probability that the neurological injuries sustained by the newborn were due to intrapartum factors.

Despite nomenclature changes and practice bulletins and articles proposing various algorithms for the management of fetal heart rate tracings in labor, a majority of electronic monitoring tracings contain both reassuring and non-reassuring elements and a high level of clinical judgement is required to evaluate them. This judgement must take in to account not only the tracing itself, but the progress of labor, other events which may be occurring on the labor and delivery unit, one's skill in performing operative vaginal delivery, the availability of anesthesia and other factors that impact the ability to expedite delivery.

In addition, a significant factor for the risk of hypoxic encephalopathy is the ability of the labor and delivery unit to respond to obstetrical emergencies such as cord prolapse, uterine rupture, severe abruption and shoulder dystocia. None of these are predictable and any one of them may occur coincident with another emergency. Labor and delivery units differ immensely in their ability to perform STAT cesarean deliveries. As medical care has entered the corporate world, staffing of labor and delivery units, anesthesia services, and training of ancillary personnel falls under an administrative umbrella. The complexities of electronic medical records, Pyxis machines, and a collaborative practice models has made a five minute "decision-to-incision" very difficult to accomplish. No longer does the physician call the shots.

The second publication, Neonatal Brachial Plexus Palsy, deals with the causes and prevention of brachial plexus injuries, with some focus on the prediction and avoidance of shoulder dystocia. Because there is no reliable method to determine fetal weight, nor to determine the exact three dimensions of the female pelvis, shoulder dystocia is an unpredictable and unpreventable obstetrical emergency. In addition, many brachial plexus injuries result from maternal expulsive forces, not traction at the time of delivery.

The standards for the prevention of brachial plexus injuries are similarly distressing. ACOG proposes estimated fetal weight cutoffs of 4,500 grams and 5,000 grams for diabetic and non-diabetic pregnancies, respectively, for offering cesarean delivery. Over a forty year career, I can count on my fingers how many babies over eleven pounds I have delivered, yet this is the critical weight for offering a cesarean in a non-diabetic patient. The current standard of care allows for a certain percentage of permanent brachial plexus injuries as acceptable and unpreventable.

Our current, published standards of care do not provide for the prevention of a significant number of long-term newborn injuries. There is not, and never has been, a truly evidenced based standard of care for the management of labor that guarantees outcomes. There is only risk and how much one is willing to assume. In early pregnancy, we approach things in a more mathematical fashion. For example, prenatal genetic screening has always been based on mathematical risk and today is based on applied mathematics. Most physicians do not have the mathematical ability to understand these calculations, let alone patients. However, we discuss the risk with patients and allow them to decide what testing to have. Why then do we not discuss the mathematical risks with patients at the other end of the pregnancy, that is, in regard to the delivery process? The risk of having a child with a disability due to a problem that occurred in labor is statistically relevant.

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Instead, we foster a tacit perception by the patient and her family that when she arrives in labor and delivery she will deliver an intact newborn 100% of the time. If this does not occur the blame falls upon the physician and other health providers. Obstetricians are, in a sense, indemnifying the delivery process, both financially, by paying high malpractice premiums, and conceptually, by pretending to have control over a process which, by and large, involves chance. As my wise friend, Dr. Jean Hauser, once said, "Sometimes you are just the poor smuck at the end of the bed".

Yet, in the legal arena, the physician is often held accountable, regardless. From an attorney's perspective, the purpose of medical malpractice insurance is to provide recompense for injury. Isn't that why one buys insurance? Despite task force opinions regarding neonatal injury, an expert witness for the plaintiff will often present a different standard of care, referencing the damaged child as evidence for his or her expertise. Unpreventable and unavoidable do not hold much weight in the courtroom when there is a child with disabilities.

To make matters worse, whereas in the past it was win or lose, in today's legal environment attorneys are able to structure a "high-low" agreement before the case goes to trial. Thus, the plaintiff's attorney is guaranteed an award that will compensate for any out-of-pocket pretrial expenses and his time, allowing him to take on cases with less merit but the potential for a high award without risking anything. The insurance company can avoid a monumental settlement. There is no benefit to the physician from such an agreement, which can be made without their consent, but one must remember, the physician is just a contestant in the legal arena, where, win or lose, the game goes on.

Is it hubris which causes us to act as though we can guarantee outcomes, instead of publicizing the fact that there is an inherent risk to having a baby, and despite all our best efforts we cannot mitigate all of that risk? Should patients not be informed of the mathematical risks they are taking upon entering the labor and delivery suite and be allowed to choose which risks to take? In an age when patient autonomy has become the primary guiding ethical principle, would it not make sense to give each patient the option of how their child is delivered, in the same fashion that we allow them to choose which screening tests they elect in early pregnancy?

Why should obstetricians indemnify the unpreventable risks associated with having a baby? Rather than obstetricians bearing the costs of prematurity, hypoxic encephalopathy and brachial plexus injuries through the inefficient contrivance of malpractice insurance, another insurance system should be developed, similar tono-fault car insurance which insures against unpredictable events. The patient could be compensated without the need for the courts to get involved and funds would be provided for all babies with disabilities. The responsibility for overseeing quality medical care should not fall to the courts, which are poorly suited to recognize which unfortunate cases were managed improperly and which were caused by factors beyond our control.

Such reforms would place the indemnification of risk where it belongs and add much to the psychological health of practicing obstetricians, who recognize the inconsistency between expectations and reality within our specialty and the unfair financial burden we are made to bear.

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