COPIC Tip:

Specialty Focus: Obstetrics and Gynecology

This article is part of a new series that provides a summary of common areas of risk for particular medical specialties and strategies on how to address these.

Case Study 1
A 28-year-old G1 P0000 female presents in active labor after an uncomplicated pregnancy. She progressed adequately in labor, getting an epidural at 6cm dilatation. After delivery of the fetal head, the head partially withdraws back into the birth canal (turtle head) and this was immediately noted. A modified McRoberts maneuver was done with suprapubic pressure without success. This was followed by a Woods’ corkscrew maneuver. Ultimately, delivery of the posterior arm was successful with delivery of the shoulders and trunk of the infant. The infant was noted to have brachial plexus palsy which was ultimately found to be permanent. Because it was a very difficult delivery, the physician wrote a quick note and went to the nursery to check on the baby. Unfortunately, the documentation by the physician did not include the procedures that were done and in what order, and did not mention which shoulder was anterior.

Case Study 2
The patient is a 76-year-old Caucasian female with a history significant for hypertension. In Nov. 2005, she was diagnosed with a pelvic mass measuring 10x9x8cm and uterine fibroids. On Dec. 15, 2005, she had an open total hysterectomy and bilateral removal of ovaries, fallopian tubes and pelvic mass. This surgery was thought to be uneventful. Over the next four days, the patient progressed but remained without flatus or bowel movement. She was given Milk of Magnesia/Dulcolax. On Dec. 19, she complained of constipation, but had minimal flatus and a small bowel movement. She was moderately distended and a three-way X-ray revealed “moderately extensive free intraperitoneal air,” presumably secondary to the surgery. The patient’s condition did not improve significantly and CT scans of the pelvis, abdomen, and chest were done. Ultimately, the patient was diagnosed with a perforated bowel with peritonitis and sepsis. She was hospitalized for two months due to additional complications.

Overview
These two cases show common challenges COPIC has seen in the past. Almost half of all dollars paid out for defense and indemnity for OB/GYN physicians are a result of care in labor and delivery. Unfortunately, poor documentation can make it difficult to tell if the standard of care was met as illustrated in the first case. To support documentation, a delivery note addendum checklist may have helped in this case. This would have captured the chronological details of what happened during the procedure to support the decisions made.

Related to the second case, slightly more than 25% of dollars paid out in OB/GYN medical liability cases relate to technical performance and complications of gynecologic surgery with the most common being failure to rescue.

This is why COPIC has developed an OB/GYN Specialty Focus one-sheet to identify common areas of risk and guidance on how to address them. The below information is organized into two different sections:

- Key areas for errors and litigation
- Strategies to reduce errors

If this is relevant to your practice, we encourage you to download this material and share it with other practitioners in your setting as well as other members of your staff.
Obstetrics and Gynecology

KEY AREAS for errors and litigation

- Prenatal care
  - Antenatal diagnosis of fetal anomaly
  - Genetic screening
  - Group B strep
  - Prematurity management

- Technical performance and complications of gynecologic surgery
  - Injury to internal organs, sepsis/infection/abscess, mesh erosions, or unexpected/poor results

- Diagnosis and treatment of non-obstetric conditions, usually in the office setting
  - Delayed diagnosis of malignancy, severe infectious disease, and severe medical illnesses

- Labor and Delivery
  - Improper interpretation of FHR tracing
  - Failure to respond to an abnormal FHR tracing in a timely fashion
  - Complications of TOLAC

STRATEGIES to reduce errors

- Document discussion of appropriate fetal anomaly screening and diagnostic tests/procedures and either completion or informed refusal
- Document discussion of appropriate prenatal screening & either completion or informed refusal
- Transmit results to patient and L&D
- Document good indication for procedure, informed consent, and patient specific risks
- Document pros/cons of the procedure and alternatives
- Early recognition of complications
- Utilize preoperative checklist for every procedure
- Risk specific screening and document completion or informed refusal
- Standardized tickler/tracking systems
- Once there is an incidental finding, track it through the process
- Systematic work up of symptomatic findings

- Assure that you and your team are well trained in FHR interpretation
- Periodic FHR tracing course for all team members
- Assure good communication among the team, including anesthesia
- Document the thought process when the decision is to continue labor
- Document informed consent in the prenatal chart, including any facility specific risks
- Written informed consent form as well
- All members of the team should be in-house

continued
**KEY AREAS for errors and litigation**

- Complications of operative vaginal delivery
- Administration of oxytocin, magnesium sulfate and misoprostol
- Neurologically impaired infants
- Shoulder dystocia
- General guidelines

**STRATEGIES to reduce errors**

- Checklist to assist in the documentation of the indication, patient counseling, the procedure and post-procedure assessment
- Standardized orders and checklists for administration and monitoring
- Document indications and patient counseling
- Send cord gases when there is a depressed newborn and as indicated
- Send the placenta to pathology when there is a depressed newborn and for specific indications such as shoulder dystocia, sepsis, twins, etc.
- Checklist to assist with documentation when shoulder dystocia is encountered including which shoulder was anterior and that no fundal pressure was used
- Briefs and huddles while patients are in labor to assure good communication amongst the team
- Debrief, particularly when there is an adverse outcome of any type such as neonatal compromise, maternal hemorrhage, or shoulder dystocia