SOGC sounds ALARM on legal pitfalls facing ob/gyns

Barbara Sibbald

Two years after being hit with a 24% hike in insurance fees, Canada's obstetricians are making a concerted effort to reduce their legal risk.

In 1997, the Canadian Medical Protective Association (CMPA) hiked dues for obstetrician/gynecologists to $29 280 annually because of a trend toward higher court awards in "bad-baby" cases; although the number of cases involving obstetricians have remained relatively constant recently — an average of 10 cases per year have been decided against obstetricians for the past decade — the size of court awards has not. "In a compromised-baby case, it's not unusual to have a settlement of between $2.5 million and $5 million," said Dr. Doug Bell, the CMPA's administrative assistant secretary-treasurer. "It's increasing every year."

There's no question that ob/gyns are at higher legal risk than other specialists: 1 in 41 CMPA members (2.4%) can expect to be sued by a patient in a given year, compared with roughly 1 in 7 (14.3%) ob/gyns. Historically, 40% of the latter cases have been related to obstetric care and 60% to gynecologic care. These specialists, who number about 1580, account for a fraction of the CMPA's 56 000-plus members but for 22% of disbursements following legal action. For family practitioners who are involved in the management of labour and delivery, the risk of being sued for any reason ranges from 1 in 32 to 1 in 46 per year; historically, 24% of these suits have been related to obstetric care.

In these litigious days, ob/gyns are seeking ways to reduce their risk. Since 1995, 700 of them have taken the Society of Obstetricians and Gynaecologists of Canada (SOGC) ALARM course. During an intensive 2-day ALARM (Advances in Labour and Risk Management) session, these specialists learn the latest clinical guidelines concerning high-risk conditions during labour and delivery, participate in hands-on workshops and group discussions, and write an exam. Topics include risk management, induction of labour, management of labour, assisted vaginal birth, pre-term labour and more.

The ALARM course "has optimized patient well-being and reduced the potential for poor outcomes," said Dr. Ken Milne, the SOGC's associate executive vice-president.

The CMPA's Bell speculates that the ALARM course could mean "a big difference in the prevalence of litigation within 4 to 5 years" — the time it takes for most cases to be settled. Awareness of potential problems is key, he says.

Boosting this awareness was the aim of one recent postgraduate course — "Medicolegal obstetrics: Can we stay out of trouble?" — that was held during the SOGC's 55th Annual Clinical Meeting in Ottawa this summer. Some 23 physicians learned what it takes to stay out of the courts, while another 160 attended 1-hour seminars held during the conference.

Duncan McCuaig

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Red flags

According to CMPA data, only 7% of medicolegal cases proceed to trial, and two-thirds of those are decided in favour of the physician. "A trial is the most horrible experience anyone can have, whether you win or lose," said Dr. Titus Owolabi, chief of obstetrics and gynecology at St. Michael's Hospital in Toronto. "As long as we have practising obstetricians there have to be other strategies to minimize exposure," added Owolabi, who logs significant court time as an expert witness. He supports the SOGC's ALARM course and cautions colleagues to be on the lookout for warning signs. "There will likely be some red flags before a suit is initiated, including an unhappy, dissatisfied patient who writes to your chief, the college or your hospital." He says to contact the CMPA as soon as there is an inkling that something may be wrong. "The sooner they are in the know, the more they can help," he said.

He also advises talking to parents as soon as possible after a difficult birth. The major reason why most people initiate suits is because they want to know what happened, he said.

Breakdown of cases

According to the CMPA, 508 legal cases against obstetricians closed between 1990 and 1998. Bell said the broad experience has allowed the association to reach the following conclusions:

- Induction or augmentation of labour can make a case harder to defend, so physicians are advised to take special care when documenting these cases and to be more attentive to the course of labour. "Induction and augmentation always had a negative impact on defensibility," said Bell. "This doesn't mean you shouldn't do them — just have a valid reason for induction and write a note re: augmentation."
- An Apgar score of less than 3 at 1 minute, or less than 7 at 5 minutes, also adversely affects the defensibility of legal action. A physician who delivers an infant with a low 1- or 5-minute Apgar score should provide superior documentation following the birth to elaborate on the labour and delivery.

"Once you see the Apgar is down, write what you told the nurses and why you did what you did," warned Bell. "If there's no note, it makes the plaintiff's case easier." The note should include information on indications, discussions with patients, physical status, reasons for the medical decision and details about the technique used and the outcome.

"If a physician has a plan and it's documented, it's easier to defend," observed Bell. He also advises writing the time on the note and stating why there was a delay in writing it. For instance, the doctor may want to document the fact that he or she had to leave after delivery to attend another patient.

Types of cases

The majority of obstetric-related legal cases between 1990 and 1998 involved labour and delivery and cases in which the newborn's birth weight was within the normal range (2500 to 4000 g). The single largest category of cases, 154 (30%), involved compromised babies; court-ordered disbursements for them account for 82% of the financial outlay in obstetric cases. Two-thirds of these cases were associated with an Apgar score of less than 3 at 1 minute. The main allegations associated with these cases are what Bell refers to as the "3 delays": a delay in recognition of fetal distress, a delay in the performance of an indicated delivery and a delay in attendance at labour. In 60% of these cases, the critical issues were a delay in recognizing fetal compromise and a consequent delay in delivery. "It's difficult to see at the time," noted Bell.

The second most prevalent type of case (62) involved forceps deliveries. The most difficult cases to defend were failed forceps delivery followed by mid-forceps rotation. In terms of fetal injury, the most difficult cases to defend involved skull fracture or spinal cord injury.

The 37 cases involving shoulder dystocia accounted for the third most common type of obstetrical medicolegal case; 74% of these cases involved infants who weighed 4000 grams or more, and only 24% of the cases resulted in a payment to the plaintiff.

Bell's formula for avoiding lawsuits, or at least defending against them successfully, is as simple as A,B,C,D:

A: Availability to patient;
B: Do you have Business doing what you are doing?;
C: Communicate with your patient when something goes wrong; and
D Documentation.

As soon as a suit is launched, Bell recommends terminating the physician–patient relationship. "The relationship is based on trust, and with litigation there is no trust. Therefore, you should cease caring for the patient."

In addition to the ALARM course and physician education at conferences, the SOGC is also involved in promoting tort reform. Bell says the purpose is not to put less money in the hands of patients injured as a result of malpractice but to "make the process cheaper and quicker." It now takes 3 to 5 years, and some cases much longer, for a case to wind its way through the courts.

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