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Liability, Accountability, and The Bottom Line: 9 Essentials for Obstetricians in 2014

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The Slippery Slope of Obstetrics

- Delighted
  - “We loved every part of it”
- Disappointed
  - “Everything came out fine, but this place needs work.”
- Disgruntled
  - “Nothing seemed to go right. No way will I recommend it for anyone’s delivery.”
- Disgusted
  - “They really screwed up. They should have sectioned her earlier.”
- Disabled
  - “Our hopes are dashed. Our baby will never be like the other kids.”
- Deposed
  - “Someone did something wrong and now they have to pay.”

Adapted from Brian Wong, MD
The Heat is Always On; The Same Allegations Over and Over

- Failure to respond to fetal distress
- Failure to do a timely delivery
- Improper use of forceps or vacuum
- Improper use of oxytocin
- Failure to conduct proper resuscitation
- Management of shoulder dystocia
When Things Go Wrong: Was it Bad Luck or Bad Medicine?
9 Essentials

1. Embrace high reliability
2. Eliminate incivility
3. Obtain informed consent *during* pregnancy
4. Don’t push pit, especially with tachysystole
5. Get certified
6. Avoid the first section
7. Be there
8. Know when to quit
9. Write it down
1. Embrace High Reliability

A High Reliability Organization (HRO) is an organization that has succeeded in avoiding catastrophes in an environment where normal accidents can be expected due to risk factors and complexity.
Characteristics of HROs

1. Safety oriented culture
2. Operations are a team effort; flattened hierarchy
3. Communications are highly valued; civility rules
4. Always prepared for the unexpected
5. Multidisciplinary review of near-misses and adverse outcomes
6. The “top brass” endorses the culture and provides the resources to make it work
Safety Oriented Culture

- Protocols
- Checklists
- Redundancy
- Simplification
- Standardization - reduced variability
- Attention to human factors
- Accountability
2. Eliminate Incivility

Incivility: Low intensity deviant behaviors that violate mutual respect; rudeness of dubious intention
Current Disruptive Or Intimidating Behavior From Any Professional That Works On Unit (n = 56)

YES = 34 = 61%

NO = 22 = 39%
Have There Been Specific Adverse Outcomes As A Result of The Behavior? (n=31)

- NO = 18 = 58%
- YES = 13 = 42%
Professionals Exhibiting Disruptive Behavior (n = 34)
Horizontal Violence
Nurse Against Nurse

“We eat our young.”

**Overt:** Name-calling, sarcasm, bickering, fault-finding, back-stabbing, criticism, intimidation, gossip, shouting, blaming, put-downs, raising eyebrows, etc.

**Covert:** Unfair assignments, eye-rolling, ignoring, making faces (behind someone’s back), refusal to help, sighing, whining, sarcasm, refusal to work with someone, sabotage, isolation, exclusion, fabrication, etc.

Bartholomew, K. Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young, HCPro, Inc. 2006
3. Have conversations to set realistic expectations *during* pregnancy
Consent Issues

“Lawsuits are not (only) about bad outcomes. They are not about bad relationships. They are about (failed) expectations.” (Crawford, JD, Ann. Surgery, 2003)

- Reduce the chance for negative surprises
- “I’m sorry that one of the complications we discussed has occurred.”
- NEVER, “Oh my God, I never expected that to happen.”
Set Realistic Expectations

- When to go to the hospital
- Coverage – who will be there
- Anesthesia
- OVD
- Cesarean
- Who can be there
- Videotaping
4. Don’t Push Pit, Especially with Tachysystole
Defendant was negligent in one or more of the following particulars:

a. In exposing to unnecessary prolonged intrauterine distress;

b. In failing to recognize or respond to symptoms of fetal hypoxia

c. In failing to timely perform, or arrange, for a cesarean delivery; and,

d. In using pitocin on when defendant knew, or in the exercise of ordinary care, should have known that unborn child was in distress.
On March 16, plaintiff and her unborn child, under the care of defendants and began exhibiting evidence that the unborn child was in distress due to symptoms of reduced oxygenation evidenced in fetal heart monitor tracings. Instead of arranging for a prompt delivery by cesarean section, administered Pitocin.
Oxytocin Excess
Every 15 Minutes???

“Steady-state plasma levels of intravenously administered oxytocin are reached only after 40 minutes. It follows that any dosing regimen that increases the infusion rate significantly faster than this will…be a blind procedure in which additional drug is given before the full effects of the previous dose can be known.”

(Clark et al, AJOG, 2009)
Oxytocin Package Insert

- “The initial dose should be 0.5 – 1 mu/min.
- …rates up to 6 mu/min give the same oxytocin levels that are found in spontaneous labor. At term, higher infusion rates should be given with great care, and rates exceeding 9-10 mU/min are rarely required.”
UTERINE TACHYSYSTOLE ALGORITHM FOR USE WITH OXYTOCIN ADMINISTRATION

More than 5 uterine contractions in 10 minutes (averaged over a 30-minute window)

YES NO

Is fetal heart rate Category I?

YES NO

- Maternal reposition (left or right lateral)
- IV bolus 500mL LR
- If uterine activity has not returned to normal 15 minutes after above interventions, decrease oxytocin by half; if uterine activity has not returned to normal after 10-15 more minutes, discontinue oxytocin until tachysystole has resolved

- Discontinue oxytocin
- Notify MD/CNM
- Maternal reposition (left or right lateral)
- IV bolus 500mL LR
- Consider O2 10L/min via nonrebreather mask
- If no response, consider Terbutaline 0.25mg subcutaneous

Once tachysystole is resolved

Resume oxytocin at half
5. Get Certified
The EFM Disconnect: 3 am

- “She’s having some subtle lates. I don’t like the variability.”
- “Let’s watch it a little longer. They look like earlys and they return to baseline.”
At the Deposition

• “I was really worried about the tracing.”
• “She described a pretty benign pattern. She really didn’t seem that concerned about the tracing.”
An Introduction to Fetal Heart Rate Monitoring

Hon, Edward Harry
“All medical staff and employees responsible for fetal monitoring interpretation (resident and attending obstetricians, midwives, and labor room and antepartum nurses) were obligated to take this examination within 1 year of employment and pass within 18 months.”

The case for an electronic fetal heart rate monitoring credentialing examination

Richard L. Berkowitz, MD; Mary E. D’Alton, MD; James D. Goldberg, MD; Dan F. O’Keeffe, MD; Jean Spitz, MPH; Richard Depp, MD; Michael P. Nageotte, MD
6. Avoid The First Section
“They did a section…

• ...after a whiff of pit.”
• ...because it was 5 o’clock.”
• ...after one decel.”
• ...because she pushed for an hour and was exhausted.”
• ...because she didn’t want any pain.”
• ...because they get more.”
• ...because no one ever sues for doing a section, only for delaying one.”
Nullip Breeches

Previous Sections

Nullip Inductions

Nullip in labor

The Singleton, Cephalic, Nulliparous Woman After 36 Weeks of Gestation: Contribution to Overall Cesarean Delivery Rates
Brennan, Donal J.; Murphy, Martina; Robson, Michael S.; O’Herlihy, Colm
Avoid The First Section

- Elective inductions with an unfavorable cervix
- Adequate trial of labor – latent phase sections
- Is it really “fetal distress”? (Managing Category II tracings)
- Adopt newer approaches to the second stage
- OB Hospitalists
- Present balanced risks and benefits for elective primary sections
- VBAC approaches
- Management of breeches – versions
- Management of multiples
- 1:1 support in labor (partner, experienced doula, CNM)
The Biggest Changes 1974 - 2008

- Failed nulliparous inductions: increased by 13.37 fold
- Nulliparous in spontaneous labor: increased 3.22 fold
- Other:
  - Multiple pregnancies: 8.27 fold
  - Previous sections: increased by 12.22 fold
  - Multiparous breeches: increased by 10.51 fold
    - Nulliparous breeches: 5.41 fold
Choosing Wisely®

1. Don’t schedule elective, non-medically indicated inductions of labor or cesarean deliveries before 39 weeks 0 days gestational age. Delivery prior to 39 weeks 0 days has been shown to be associated with an increased risk of learning disabilities and a potential increase in morbidity and mortality. There are clear medical indications for delivery prior to 39 weeks 0 days based on maternal and/or fetal conditions. A mature fetal lung test, in the absence of appropriate clinical criteria, is not an indication for delivery.

2. Don’t schedule elective, non-medically indicated inductions of labor between 39 weeks 0 days and 41 weeks 0 days unless the cervix is deemed favorable. Ideally, labor should start on its own initiative whenever possible. Higher cesarean delivery rates result from inductions of labor when the cervix is unfavorable. Health care practitioners should discuss the risks and benefits with their patients before considering inductions of labor without medical indications.
CONCLUSION: “The active phase of labor may not start until 5 cm of cervical dilation in multiparas and even later in nulliparas. A 2-hour threshold for diagnosing labor arrest may be too short before 6 cm of dilation, whereas a 4-hour limit may be too long after 6 cm.” (Zhang, et al., Obstet Gynecol 2010;115:705–10)
Intrapartum management of category II fetal heart rate tracings: towards standardization of care

Steven L. Clark, MD; Michael P. Nageotte, MD; Thomas J. Garite, MD; Roger K. Freeman, MD; David A. Miller, MD; Kathleen R. Simpson, RN, PhD; Michael A. Belfort, MD, PhD; Gary A. Dildy, MD; Julian T. Parer, MD; Richard L. Berkowitz, MD; Mary D’Alton, MD; Dwight J. Rouse, MD; Larry C. Gilstrap, MD; Anthony M. Vintzileos, MD; J. Peter van Dorsten, MD; Frank H. Boehm, MD; Lisa A. Miller, CNM, JD; Gary D. V. Hankins, MD
The Basic Question:

- What is the likelihood of the fetus developing significant acidemia prior to delivery?

- Moderate variability or accelerations = absent fetal acidemia at the point of observation

- 16 footnotes – must be read
  - E.g., Treat minimal to absent variability as one entity.
Preventing the First Cesarean Delivery
Summary of a Joint Eunice Kennedy Shriver National Institute of Child Health and Human Development, Society for Maternal-Fetal Medicine, and American College of Obstetricians and Gynecologists Workshop

Catherine Y. Spong, MD, Vincenzo Berghella, MD, Katharine D. Wonstrom, MD, Brian M. Mercer, MD, and George R. Saade, MD

Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality

A CMQCC White Paper

Elliott Main, MD, Christine Morton, PhD
David Hopkins, PhD, Giovanna Giuliani, MBA, MPH
Kathryn Melso, MS and Jeffrey Gould, MD, MPH

CMQCC
California Maternal Quality Care Collaborative

December 2011
7. Be There
Stay Connected
The required personnel, including nurses, anesthesia personnel, neonatal resuscitation team members, and obstetric attendants, should be in the hospital or readily available.

Guidelines for Perinatal Care, 7th Edition, 2012
For Maternal Emergencies

Hemorrhage & Hypertensive Disease
OB Hospitalists: Ready For Prime Time

- Managing unattended deliveries
- Liaison between nurses and physician
- Emergency cesarean delivery.
- Second opinions
- Providing timely assessments and interventions
- Surgical assistant
- Standing by for neonatal resuscitation
- Supervising residents
- Acting as consultants and back for family physicians, CNMs
- Participating in nursing education
- Emergency call coverage for “walk-in” patients
- Assisting with drills and simulations
Man wins $15.5M after wife's childbirth death

Friday, November 22, 2013

November 22, 2013 (CHICAGO) (WLS) – A Westchester man has been awarded $15.5 million after his 33-year-old wife died during a cesarean section delivery at Midlothian Hospital.
6/10 - management of post partum hemorrhage
Clinical Diamond
(Clark & Hankins)

“Any Hospitalized Patient With Preeclampsia Experiencing Either a Systolic Blood Pressure of 160 or a Diastolic Pressure of 110 Should Receive an Intravenous Antihypertensive Agent Within 15 Minutes”
8. Know When To Quit
• No sequential Instruments
• Second stage length
• IHI vacuum bundle:
  – Maximum application time and number of pop-offs predetermined.
• Exit strategy
  – Cesarean and resuscitation team, OR available
Second Stage Pushing

![Bar chart showing probability of spontaneous vaginal delivery and birth of an infant without sign of asphyxia (pH > 7.10 and 5-minute Apgar score ≥7) at different time points: at the onset of pushing, after 1 hour, after 2 hours, and after 3 hours. The chart indicates the probability statistics were compiled according to pushing duration and the randomization group among women who were undelivered at the beginning of the period. The closed bars represent delayed pushing; the open bars represent immediate pushing.](image)

9. Write It Down
Getting Credit for What You Do Right: The Importance of **Documentation**

- The record proves that your care was *reasonable*.
- To a jury the medical record represents the *truth*.
- Five years later, you will barely remember. It provides your *best memory*. 
“Unsafe acts are...like mosquitoes. You can try to swat them one at a time, but there will always be others to take their place.”

“The only effective remedy is to drain the swamps......”

James T. Reason
Even California Has Its Swamps