ClaimsRx
clinical & risk management perspectives
January 2008

Emergency Medicine Management of Pregnant Patients

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Original release date: January 2008
Expiration date: January 31, 2009
Estimated time to complete this activity: 1 hour

Learning Objectives

When treating obstetric emergencies, by implementing the risk management recommendations herein, emergency room providers can increase patient safety and reduce their liability risk exposure by:

- Maintaining a heightened awareness of the signs and symptoms of ectopic pregnancy and placental abruption;
- Adopting and adhering to policies and procedures for the treatment of women presenting to the ER with abdominal pain and vaginal bleeding;
- Adopting and adhering to policies and procedures for the treatment of pregnant trauma patients; and
- Creating and maintaining comprehensive medical records.

Target Audience

Emergency department providers.

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Introduction

For various reasons, emergency department providers become responsible for the appropriate diagnosis and treatment of pregnant patients. Some pregnant patients will be there due to trauma, others due to bleeding and abdominal pain, and some will have no idea that they are pregnant. Ectopic pregnancy and placental abruption are two relatively uncommon but potentially devastating conditions that bring pregnant patients to the emergency room (ER) complaining of vaginal bleeding and abdominal pain. Untreated, an ectopic pregnancy almost always results in the fallopian tube's rupture, which can result in hemorrhage, damage to

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the fallopian tubes, infertility and death. Maternal risks associated with placental abruption include massive blood loss, disseminated intravascular coagulopathy, renal failure and maternal death. Placental abruption can be disastrous to the fetus—fetal mortality has been reported as high as 60 percent.[1] The primary means of increasing patient safety and managing the risks that arise with ectopic pregnancy, placental abruption and the traumatic injury of a pregnant patient is providing timely diagnosis and treatment. Doing that requires familiarity with clinical signs and symptoms, policies and procedures for diagnosis and treatment of women of childbearing years presenting to the ER with abdominal pain, vaginal bleeding and/or following a trauma episode, and referral to an obstetrician when appropriate.

Liability claims involving these conditions almost always focus on proving that a delay in diagnosis and treatment either caused or exacerbated a patient's injuries. The defense of these claims requires proof of the patient's presentation and the reasoning behind what is often an inaccurate or incomplete diagnosis. Without written evidence of appropriate medical care, the defense of the claim becomes dependent on the memories of the providers and the patient, which in most cases widely diverge on the issues in contention in a liability claim.

This *Claims Rx* will provide strategies for recognizing the signs and symptoms of ectopic pregnancy and placental abruption. It will also provide methods for reducing the liability risks associated with the treatment of patients with these conditions and with the treatment of pregnant trauma patients who present to the emergency room.

Ectopic Pregnancy

When a fertilized egg implants outside of the uterus (this usually occurs in a fallopian tube) the condition is referred to as ectopic pregnancy. Approximately 10 percent of women who go to the emergency department with vaginal bleeding or pain in the first trimester of pregnancy will have an ectopic pregnancy. Untreated, an ectopic pregnancy almost always results in the fallopian tube's rupture, which can have devastating results, including hemorrhage, damage to the fallopian tubes, infertility and death.[1,2]

Ectopic Pregnancy Statistics:[2]

- Ectopic pregnancy is the third leading cause of maternal death.
- The incidence of ectopic pregnancy has been rising over the last thirty-five years and now accounts for approximately 2 percent of pregnancies.
- The incidence of ectopic pregnancy is highest in women twenty-five to thirty-four years old, and in that group is higher among the older women, women of non-Caucasian heritage and women who have undergone assisted reproduction involving embryo transfer.
- As many as 40 percent of ectopic pregnancies are missed on the patient's first consultation.

Diagnosing Ectopic Pregnancy

The classic clinical presentation of ectopic pregnancy is delayed menses, followed by severe and constant abdominal pain and vaginal bleeding in a patient who has known risk factors, which are:[2]

- History of ectopic pregnancy
- History of tubal infection or surgery
- Abnormalities of the fallopian tubes or endometrium
- History of pelvic inflammatory disease
- History of smoking
- History of spontaneous or medically induced abortion
- Infertility
- Use of an intrauterine device

Unfortunately, a significant percentage of patients with an ectopic pregnancy will bleed at the time of their missed menses and may not realize that they are pregnant, will fail to experience classic symptoms and will not have ectopic pregnancy risk factors.[2] In this difficult patient population, the defense of a missed diagnosis claim will rely on being able to prove that

other emergency physicians in the same circumstances would have treated the patient in the same way. In other words, the patient's presentation was so unusual, that it was not below the standard of care to miss the ectopic pregnancy diagnosis. This defense, however, requires proof of the patient's presentation and the reasoning behind the inaccurate or incomplete diagnosis and possibly unnecessary treatment. Complete medical records are the best evidence.

Ancillary Tests for Suspected Ectopic Pregnancy

When a patient presents with bleeding, abdominal pain and a positive pregnancy test, history and physical examination are not sensitive enough to locate the pregnancy. Ultrasonography and hormonal assays are commonly used ancillary tests for suspected ectopic pregnancy in the first trimester.[2]

Ultrasonography

Transvaginal ultrasonography is more sensitive and identifies intrauterine pregnancy (IUP) earlier than transabdominal ultrasonography. Transvaginal ultrasonography has been shown to be diagnostic of IUP in up to 80 percent of patients in the first trimester of pregnancy who are seen in the emergency room.[2]

- Diagnostic signs of an IUP
  - "Double" gestational sac
  - Intrauterine fetal pole or yolk sac
  - Heartbeat
- Diagnostic signs of ectopic pregnancy
  - Ectopic fetal heart activity
  - Ectopic fetal pole
- Suggestive signs of ectopic pregnancy
  - Moderate to large amount of fluid in the cul-de-sac
  - Adnexal mass without IUP
- Indeterminate signs of ectopic pregnancy
  - Empty uterus
  - Nonspecific fluid collections
  - Echogenic material
  - Abnormal or single gestational sac.[2]

Human Chorionic Gonadotropin (hCG) Level Testing

Correlating sonographic results with quantitative hCG measurements increases the probability of diagnosing an ectopic pregnancy. HCG, a hormone made by chorionic cells in the fetal part of the placenta, is produced during pregnancy. In approximately 85 percent of normal pregnancies, the hCG level will double every 1.8 to 3 days in the first 6 to 7 weeks of pregnancy. Levels that fall or double slowly suggest an abnormal pregnancy.[2] If the transvaginal ultrasound is indeterminate and the hCG level is higher than 1,500 mIU per mL, an ectopic pregnancy can be suspected.[3]

Failure to Diagnose Ectopic Pregnancy Professional Liability Claims

In a failure to diagnose ectopic pregnancy medical liability claim, the patient's lawyer will be looking for evidence to correlate the delays in diagnosing and treating the ectopic pregnancy with the severity of the injury suffered by the patient. The patient must prove that the delay/failure to diagnose the ecoptic pregnancy was below the standard of care, and that the delay/failure to diagnose caused her damages. In these claims, the ability to show timeliness of diagnosis and treatment is paramount to a successful defense. A patient record that clearly sets forth an appropriate diagnostic and treatment process supports the defense of both standard of care and causation allegations.

Case Study #1 - Ectopic Pregnancy

Allegation: *Delayed diagnosis of ectopic pregnancy results in ruptured fallopian tube and patient death.*

The patient, a thirty-five-year-old woman, presented to the ER with a primary complaint of severe and consistent abdominal pains. The patient was examined by Provider #1, an emergency medicine physician. During the history, she reported that she had had a dilation and curettage (D & C) to terminate a pregnancy one month previously. When asked if she could again be pregnant, she reported that she had abstained from sexual activity since the D & C because she had been "spotting." She reported two prior medically induced

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abortions and a number of miscarriages. Hospital policy directed the administration of a pregnancy test to all women of childbearing years presenting to the ER with abdominal pain and vaginal bleeding, but Provider #1, assuming it was impossible for the patient to be pregnant, relied on the patient's report and did not administer a pregnancy test.

Provider #1 diagnosed appendicitis and recommended an appendectomy. The appendectomy was performed without complication and the patient was discharged from the hospital. The patient continued to experience abdominal pain and vaginal bleeding. Approximately one month later, the patient's husband called the ER and talked to Provider #2. He described his wife as being in significant abdominal and shoulder pain, vomiting, very pale and sweating. He did not tell Provider #2 that his wife had been bleeding vaginally. Provider #2, who did not review the patient's chart, and thus was unaware of the prior ER visit and appendectomy, suspected a stomach flu and recommended an over-the-counter medication for indigestion. He advised the patient's husband to bring her to the emergency department if the condition worsened.

That evening, the patient's husband was unable to rouse her from a nap. He called 911 and tried to resuscitate her. Although the paramedics were able to get a heartbeat, they lost it and she arrived at the hospital in full cardiac arrest. A pregnancy test was done, which was positive. Ruptured ectopic pregnancy was diagnosed. She died from the complications the next day. The husband brought a wrongful death claim against the providers and the hospital claiming their negligent failure to diagnose the patient's ectopic pregnancy caused her death.[4]

Discussion

The foregoing case highlights a common issue in failure to diagnose ectopic pregnancy claims: because of a recent D & C or some other situation, the provider overlooks the possibility of the patient being pregnant and fails to order a pregnancy test.

Defending this case was complicated by a number of issues:

1. Provider #1 failed to administer a pregnancy test, which was in violation of hospital policy.
2. Despite having ectopic pregnancy symptoms and risk factors, ectopic pregnancy was never in the differential diagnosis.
3. The patient had an unnecessary appendectomy.
4. Provider #2, without a complete description of the patient's condition, and without reviewing the patient's medical record, provided inappropriate medical advice over the telephone.

Rather than risk an unfavorable verdict, the defendants in this case decided to settle the claim.

Placental Abruption

In a normal pregnancy, the placenta separates from the uterus immediately after birth. If the placenta begins to detach before birth, it is referred to as placental abruption. When an abruption occurs, the uterus bleeds from the site of detachment. Commonly, the blood passes through the cervix and out of the vagina. In approximately 10 percent of placental abruption cases, the blood is trapped behind the placenta and the patient does not experience vaginal bleeding. Placental abruption occurs in approximately 0.6 to 1.25 percent of pregnancies and is the leading cause of fetal death.[1] Risk factors for placental abruption are most clearly associated with preeclampsia and hypertension. Additional risk factors include: prior placental abruption, diabetes, smoking, cocaine use and advanced maternal age. However, the majority of patients who experience a placental abruption do not exhibit these risk factors.[1]

The Signs and Symptoms of Placental Abruption

Placental abruption is diagnosed by clinical presentation and confirmed by examination of the placenta following delivery.[1] By percentage, placental abruption symptoms have been shown to occur with approximately the following incidence:[5]

- Vaginal bleeding – 80 percent
- Abdominal pain, back pain, uterine tenderness – 70 percent
- Fetal distress – 60 percent
- Abnormal contractions – 35 percent
- Fetal death – 15 percent

Placental abruption generally occurs in the third trimester of pregnancy, although it can begin any time after 20 weeks of pregnacy.[1]

According to *Rosen's Emergency Medicine*, 6th edition, the following procedure should be followed when a patient in the later stages of pregnancy presents to the emergency department with vaginal bleeding:[2]

- Assess maternal hemodynamic status.
- Assess fetal well-being.
- Obtain a baseline hemoglobin level.
- Send blood for type and crossmatch.
- Order baseline coagulation studies, including platelet count, prothrombin time and partial thromboplastin time.
- Determine fibrinogen level and presence of fibrin split products.
  - Normal fibrinogen level in pregnancy is 400 to 450 mg/dL. Values below 300 mg/dL indicate significant consumption of coagulation factors.
- If the patient is Rh-negative and has not received Rh immunoglobin prophylaxis, within 72 hours 300 mg of Rh immune globulin should be administered (unless the father is known to be Rh-negative).
- Transfuse the patient if appropriate.
- Transfer the patient to the obstetric unit.

Case Study #2 – Trauma and Placental Abruption

Allegation: *Failure to timely diagnose placental abruption-related fetal distress results in birth injuries.*

The patient, a pregnant thirty-year-old at 37 to 38 weeks gestation with an unremarkable prenatal course, presented to the hospital emergency room at 5:00 p.m. She had been in a minor car accident two hours earlier and was complaining of abdominal pain. When she arrived at the emergency department she was 80 percent effaced, one centimeter dilated and at negative 2 station. There was no vaginal bleeding. A fetal heart rate monitor was started at 8:00 p.m., and the patient's midwife was contacted. Nursing notes indicated that the fetal heart rate was 140-150 with good variability. (Expert review, however, determined that the fetal monitor strips (FMS) did not meet the criteria for reactivity at this time.) The nurse reported no abnormalities to the midwife. Based on the nurse's report, the midwife advised oral hydration.

At 9:00 p.m., when the patient refused further liquids, a nurse contacted the midwife. Nursing notes at the time of the call reported that the FMS showed a heart rate of between 130 and 145 with variability. The midwife asked if she needed to come to the hospital to examine the patient, but the nurse declined, again reporting no abnormalities. The midwife ordered IV fluids. (Expert review determined that at this time the FMS was fairly flat with decelerations to 110.) Shortly after the telephone conversation, nursing notes indicated that the patient began vomiting.

At 10:00 p.m., the midwife independently decided to visit the patient because she knew a shift change was imminent. She found the patient pale and with gray mottling. The patient could not feel contractions and the midwife realized that the FMS showed decelerations. The midwife alerted the obstetrician on staff, who arrived in moments. He determined that an emergency c-section was necessary due to a suspected placental abruption. The decision to incision time was 21 minutes. The baby was delivered with Apgars at 1, 5 and 10 minutes of 0, 4 and 7. Placental abruption was confirmed after delivery.

Although the mother filed a malpractice claim against the hospital, midwife and obstetrician, the child in this case was ultimately determined to have suffered no permanent injury. Based on the lack of permanent injury, the mother chose to drop the claim.

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Discussion

In a claim involving failure to diagnose and treat placental abruption resulting in birth injury, the patient's lawyer will be looking for evidence to correlate the delays in diagnosing and treating the placental abruption to the damages suffered by the mother and fetus. Like a failure to diagnose and treat ectopic pregnancy claim, the plaintiff must prove that the delay/failure to diagnose/treat the placental abruption was below the standard of care and that the delay/failure caused the maternal and/or fetal injuries. Documentation that clearly shows timely diagnosis and treatment will be the best proof that the care provided met or exceeded the standard of care. Additionally, FMS that indicate preexisting fetal distress can strengthen a causation defense. For example, if an FMS is already showing fetal distress when the patient arrives at the emergency department, an argument can be made that the fetus had preexisting injuries. In order to make this argument, however, the monitoring must start shortly after the patient arrives at the emergency department.

Defense of the Midwife

Had this case proceeded, the defense of the midwife would depend on whether she could show that the nursing staff had failed to accurately report both the mother's and fetus's deteriorating conditions. To her advantage were her detailed notes of her interaction with the nurses and their consistent affirmation of the patient's stability and a normal FMS. She had documented her reasoning and the time of each chart entry. Defense experts who reviewed the case felt that standing alone, the medical chart showed that the midwife had met the standard of care, and injuries suffered by the fetus could not be attributed to any treatment by the midwife.

Defense of the Obstetrician

Experts were completely supportive of the obstetrician's care.

Defense of the Hospital

Experts who reviewed this case felt that based on the medical record, this was a clear case of negligence on the part of the nursing staff. When questioned, the involved nurses stated that it would have been their standard practice to inform a patient's midwife of the patient's increasing abdominal pain and vomiting. However, there was nothing in the nurses' notes detailing what had been relayed to the midwife. It also appeared that the nursing staff had simply misinterpreted the FMS. Furthermore, the nursing notes indicated FMS readings at a time when no monitoring was being done. Finally, according to experts and hospital policy and protocol, an obstetrician should have been called in three hours prior to the time he was called. Taken together, this all made for a very strong case against the nurses and the hospital as their employer.

As this case indicates, the severity of an injury to the mother or child is a significant factor in the viability of a medical liability claim based on a traumatic birth. In this case, despite the fairly clear medical negligence on the part of the nurses, the mother decided not to pursue a claim. Luckily, neither she nor her child suffered permanent injuries.

Trauma During Pregnancy

Although only about 5 percent of women will experience trauma during pregnancy, it is the main cause of nonobstetric mortality among pregnant women.[6] Studies indicate that 55 percent of trauma in pregnant patients is caused by car accidents, 22 percent by assault, 22 percent by falls and 1 percent by burns.[6] The more severe the trauma, the greater the fetal morbidity and mortality, although even minor maternal trauma can affect fetal well-being. Prevention is a major aspect of protecting the mother and fetus from abdominal trauma during pregnancy. Unfortunately, the best prevention efforts will not keep all pregnant trauma patients out of the emergency department.

A pregnant trauma patient presents unique challenges to the ER provider not only because of the anatomical (the uterus shifts internal organs upward) and

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Algorithm for Emergency Department Management of Trauma in Pregnancy

Algorithm reproduced with the permission of Dr. Mark Pearlman

ED Management: Trauma in Pregnancy
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1. Prehospital
- Activate trauma team
- Include ob notification

2. Stabilization
- A,B,C,D (Deflect uterus to left)
- Maintain circulatory volume
- Secure cervical spine if head or neck injury is suspected

↓

3. Complete Exam
- Control external hemorrhage
- Identify/stabilize serious injuries
- Examine uterus/Evaluate for uterine rupture (shock, fetal distress or death, uterine tenderness, peritoneal irritation)
- Pelvic exam to identify ruptured membranes or vaginal bleeding
- Obtain initial blood work

4. Fetal Evaluation

< 23-24 weeks → Document fetal heart tones

> 23-24 weeks → **Initiate fetal monitoring**
- Can transfer to L&D unit when stable (if applicable)

↓

Presence of:
- More than four uterine contractions in any 1 hr (>23-24 weeks)
- Rupture of amniotic membranes
- Vaginal bleeding
- Serious maternal injury
- Significant abdominal/uterine pain
- Fetal tachycardia, late decelerations, non-reassuring FHTs

5. Disposition

- Hospitalize
- Continue to monitor
- Intervene as appropriate

- Other definitive treatment (may be done concomitant with monitoring):
  - Suture lacerations
  - Necessary X-rays
  - Consider RhoGAM in Rh-negative women

Trauma Prevention

Automobile Accidents – Counseling Patients about Proper Seatbelt Use

"Correct use of the seat belt during pregnancy requires that the lap belt be placed across the upper thighs and under the abdomen, and that the shoulder belt be placed to the side of the uterus, between the breasts, and over the mid-portion of the clavicle."[1] Studies have shown that proper seat belt use reduces morbidity and mortality among pregnant women and their unborn infants.[1] However, many pregnant women do not use seatbelts and a majority of their healthcare providers do not provide information on correct seatbelt use.[1,2] Evidence indicates that proper seatbelt wear increases with physician counseling on the topic and such counseling is recommended by both the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG).

Domestic Violence – Screening Pregnant Patients

Most pregnant assault victims who present to the emergency department have been injured by a boyfriend or spouse. Unfortunately, the frequency and intensity of domestic abuse often increases during pregnancy. Abuse has been linked to a greater incidence of placental abruption, uterine rupture and maternal death.[2] In addition to pregnancy-related conditions, abuse has been linked to diminished prenatal care, premature and low birth weight infants.[2]

Prenatal care providers and emergency room providers, who often have multiple exposures to a particular abuse victim, are in an excellent position to refer these patients to resources they can use to protect themselves and their fetuses from further harm.

Screening tools for domestic violence are available in English and Spanish on the American College of Obstetrics and Gynecology website at: www.acog.org/departments/dept_notice.cfm?recno=17&bulletin=585 (accessed 11/15/2007).

[1] 2002 PRAMS Surveillance Report: Multistate Exhibits Prenatal Care Counseling: Seat Belt Use During Pregnancy. Available on the Center for Disease Control and Prevention website at: www.cdc.gov/PRAMS/2002PRAMSSurvReport/MultiStateExhibits/Multistates6.htm#ch6fn14 (accessed 11/17/2007).

[2] Cusick S, Tibbles C. Trauma in Pregnancy. Emerg Med Clin N Am 2007; 25: 861–872.

(Pregnant Patients. . . continued from page 6)

physiological changes (including cardiopulmonary and hemodynamic system alterations), but also because there is a second patient to consider—the fetus. A pregnant trauma patient also presents with unique injuries to be considered in the differential diagnosis, including placental abruption and uterine rupture. These various pregnancy-related issues will play a significant role in resuscitation, diagnosis and treatment strategies.[6]

Resuscitation

The management of the pregnant trauma patient who has arrested is a team effort. Immediate involvement of an obstetrician significantly increases patient safety. It is very difficult to do effective CPR (cardiopulmonary resuscitation) in a pregnant patient of 20 weeks gestational age or more. Aortocaval compression from the gravid uterus may result in no venous return and therefore no response to BLS/ACLS (Basic Life Support/Advanced Cardiac Life Support). In this situation, immediate delivery (within 4 to 5 minutes) may prove life saving to the mother. Beneficial changes after delivery include immediate relief of aortocaval compression with consequent improved venous return and cardiac output, improved pulmonary mechanics and decreased oxygen demand. Also, the fetus of 24 or more weeks' gestational age has the best chance of intact survival when delivery occurs less than five minutes after maternal cardiac arrest.[7] The American Heart Association's 2005 guidelines state that when maternal cardiac arrest is not immediately reversed by BLS and ACLS: "The resuscitation leader should consider the need for an emergency hysterotomy (cesarean delivery) protocol as soon as a pregnant woman develops cardiac arrest." They further emphasize: "... you will lose both mother and infant if you cannot restore blood flow to the mother's heart. Note that four to five minutes is the maximum time rescuers will have to determine if the arrest can be reversed by BLS interventions. The rescue team is not required to wait for this time to elapse before initiating emergency hysterotomy."[8]

Focus on Health Literacy: Effective Communication with Low Literacy Pregnant Patients

"Health literacy" is the ability to understand and integrate health information to make appropriate healthcare decisions. Nearly half of all American adults—90 million people—have difficulty understanding and acting upon health information.[9] Patients with a reading level below the ninth grade are considered to be within this patient population with deficits in health literacy. Because most patient information is written at a higher grade level, these patients will struggle with most written patient materials. When a patient is pregnant, adequate communication between her and her provider is vital. Unfortunately, low health literacy can create a significant communication barrier between provider and patient. Helping a woman make lifestyle changes and fully engage in prenatal care are crucial aspects of maximizing the safety of both the mother and fetus.

Studies have indicated that assessment of health literacy is typically not performed by providers. Further, that providers are likely to overestimate a patient's level of health literacy.[7] If the health literacy of a pregnant patient is assessed, however, providers can identify those patients who need extra help and then utilize interventions and instruments to optimize the patient's medical decision-making capacity. Basic health literacy strategies suggested by Weiss, et al. can be employed by providers, such as:[10]

1. Speaking slowly and spending a small amount of additional time with each patient.
2. Using plain, nonmedical language.
3. Showing or drawing pictures.
4. Limiting the amount of information provided to pertinent tasks at hand.
5. Repeating the information
6. Confirming the patient's comprehension by asking them to repeat back instructions.
7. Creating a shame-free environment by making patients feel comfortable asking questions.

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ACOG Practice Bulletin Number 77, January 2007

Screening for Fetal Chromosomal Abnormalities

Failure to offer or properly interpret a particular test or series of tests, resulting in a failure to identify an abnormality in the fetus, can expose the provider to a "wrongful birth" claim. In these claims, the parents of a disabled child allege that they would have aborted the fetus had they been aware of the disability. The damages amounts in these cases can be extremely high. For example, a Florida jury recently awarded a family $21 million in a wrongful birth case involving a failure to test for Smith-Lemli-Opitz syndrome, a disease that causes developmental delays and a variety of birth abnormalities.[1]

Prenatal testing will be more fully addressed in a future issue of *Claims Rx*. In this issue we highlight the American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin Number 77, released at the beginning of 2007, which deals with screening for fetal chromosomal abnormalities.[2] Practice Bulletin Number 77 replaces Practice Bulletin Number 27, May 2001 and Committee Opinion Number 296, July 2004.

Practice Bulletin 77 discusses the advantages and disadvantages of various chromosomal abnormality screening tests and provides some guidance on factors that indicate which screening test should be offered.[3] The new bulletin recommends that all pregnant women consider less invasive screening options for assessing their risk for Down syndrome, and that the screening occur before the twentieth week of pregnancy. Deborah Driscoll, MD, lead author of the bulletin and vice chairperson of ACOG's Committee on Practice Bulletins - Obstetrics, states "this new recommendation says that the maternal age of 35 should no longer be used by itself as a cut-off to determine who is offered screening versus who is offered invasive diagnostic testing."[3] ACOG also advises that all pregnant women should have the option of invasive diagnostic testing, given that "a woman's decision to have an amniocentesis or chorionic villus sampling (CVS) is based on many factors, such as a family or personal history of birth defects, the risk that the fetus will have a chromosome abnormality or an inherited condition, and the risk of pregnancy loss from an invasive procedure."[3]

[1] General Injury Verdicts in the News. Available on the Total Injury website at: www.totalinjury.com/verdicts_gen.asp (accessed 11/15/2007).

[2] Practice Bulletin #77, "Screening for Fetal Chromosomal Abnormalities" is published in the January 2007 issue of Obstetrics & Gynecology.

[3] ACOG News Release. New Recommendations for Down Syndrome Call for Screening of All Pregnant Women. January 2, 2007. www.acog.org/from_home/publications/press_releases/nr01-02-07-1.cfm (accessed 11/15/2007).

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8. Enlisting the aid of others (patient's family, friends) to promote understanding.

Using health-literacy-level-appropriate materials is an excellent means to increase patient comprehension and recall. For low-literacy pregnant patients, providers can access materials and communication strategies through The What to Expect Foundation's Baby Basics Program, which is a comprehensive prenatal health literacy program that teaches healthcare providers and educators how to use health literacy strategies to effectively communicate with pregnant patients. More information on the Baby Basics Program can be accessed on their website at: www.babybasics.org (accessed 10/15/2007). ■

Notes

[1] Ananth C, Wilcox A. Placental Abruption and Perinatal Mortality in the United States Am J Epidemiol. 2001; 153(4) 332-7.

[2] Houry D, Abbott J. Acute Complications of Pregnancy. Marx: Rosen's Emergency Medicine: Concepts and Clinical Practice, 6th ed. Chapter 177.

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[10] Weiss BD. American Medical Association Foundation and American Medical Association. Health Literacy: A Manual for Clinicians, vol.2, 2007. (Table 13, Page 29). Available at: http://www.ama-assn.org/ama1/pub/upload/mm/367/healthlitclinicians.pdf (accessed: 11/17/ 2007).

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ClaimsRx
clinical & risk management perspectives
January 2008

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