

# Claims **Rx**

clinical & risk management perspectives

June 2009

## Effective Communication Among Anesthesiologists and Obstetricians

### CME Information

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### Learning Objectives

With the goal of increasing maternal and fetal patient safety while reducing professional liability risk, participants should be able to:

- Implement risk management best practices to increase maternal and fetal well-being during OB anesthesia procedures;
- Implement protocols and procedures to strengthen communication between providers;
- Adopt and adhere to policies and procedures for medical record corrections and addendums; and
- Increase competency for communication with Limited English Speaking patients.

### Target Audience

Providers involved in labor and delivery.

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## Introduction

This *Claims Rx* focuses on three types of medical liability allegations against anesthesiologists providing care during labor and delivery: 1) maternal arrest as a result of epidural anesthesia, 2) maternal arrest as a result of hemorrhage and 3) birth injury due to an anesthesia-related delay during an emergent cesarean section. Inadequate patient safety protocols and inadequate communication among the members of the labor and delivery team are common issues in these claims. NORCAL closed claims and an Illinois appellate court opinion are presented and analyzed below to suggest practice and administrative changes that are designed to increase maternal and infant safety as well as decrease liability risk.

Please note the primary focus of the risk management recommendations in this *Claims Rx* is anesthesiology and obstetrics, although the risk management recommendations will be helpful to all members of the labor and delivery team. For a broader view of birth injury claims, please see the NORCAL Birth Injuries CME monograph, available to NORCAL insureds this summer on the NORCAL website at: [www.norcalmutual.com/cme/](http://www.norcalmutual.com/cme/).

## Maternal Arrest as a Result of Epidural Anesthesia

### Case Study #1

The following NORCAL closed claim illustrates how communication failures among the anesthesiologist, obstetrician and labor and delivery nurses during and after the initiation of epidural anesthesia can increase patient safety risk and professional liability exposure.

*Allegation: The anesthesiologist failed to recognize that the patient was deteriorating following the placement of an epidural, which resulted in the patient arresting and the child suffering brain injuries.*

The patient, a 34-year-old woman in active labor, requested an epidural for pain relief. The patient's primary language was Spanish and she understood very little English. Her husband spoke some English and nurse #1 spoke what she referred to as "labor and delivery Spanish." A translator was neither offered nor requested; so the patient communicated through either her husband or nurse #1.

The anesthesiologist came to the patient's room to place the epidural. He had not consulted with the patient's obstetrician and had not reviewed the patient's chart. He spoke no Spanish and no interpreter was present, so the patient's husband translated for him. The anesthesiologist went over the risks and complications associated with an epidural. The husband indicated that his wife understood and wanted to proceed. She signed a Spanish language anesthesia consent form. The patient was assisted to a sitting position, and an epidural catheter was placed with no return of cerebrospinal fluid, blood, or reported paraesthesia. The anesthesiologist then gave a test dose of local anesthetic.

Although the anesthesiologist believed that the patient tolerated the test dose, after the dose the patient started to complain that she could not breathe through her nose, according to nurse #1 and the husband. The husband also noted that his wife's voice was "breathy." The anesthesiologist was not aware of these complaints, and therefore administered 100 mg fentanyl. He then left the room to get an anesthesiology record at the nurse's station and to check on another patient. After a few minutes, he returned and began his charting on the patient. During the time that he was out of the room, the fetal heart tones (FHT) dropped into the 50s.

When the anesthesiologist came back to the room, nurse #1 and another nurse were attempting to place a scalp monitor in response to the decelerations on the fetal monitor strip. The anesthesiologist did not inquire about the patient's condition, and the nurses did not report the decelerations. Scalp stimulation had no effect on the FHT. An oxygen mask and an O<sub>2</sub> saturation monitor were placed on the mother, but the nurses were unable to obtain the patient's pulse. At this point, nurse #1 informed the anesthesiologist that the patient was not responsive. A code was called. The code team arrived and within three minutes the patient was revived. Twenty-five minutes after the code was called, the baby was delivered by emergency cesarean section.

At birth, the baby was floppy and blue. She had seizure activity shortly after birth. Her diagnosis was neonatal seizures, hypoxic ischemic encephalopathy and hypoventilation. She was ultimately diagnosed

with mixed cerebral palsy with features of active increased tone with spasticity, as well as dystonic posturing. She would require extensive medical and rehabilitation services throughout her lifetime. The mother contended that as a result of the epidural complications, she suffered debilitating headaches, scalp numbness, memory loss and personality changes.

### Issues That Complicated the Defense of This Case

In addition to lack of standard of care support for the anesthesiologist's treatment of this patient, the defense of this case was complicated by the following issues:

- Nurse #1 made changes and additions to the record after the event.
- The anesthesiologist destroyed the original anesthesia record because he believed the timing was not going to be correct. He created a new record based on his memory of the events.
- Nurse #1's and the patient's husband's testimony regarding the events leading up to the code differed from the anesthesiologist's testimony:
  - Nurse #1 and the husband alleged that the anesthesiologist had been advised numerous times that the patient was having trouble breathing, yet ignored them until the patient became unresponsive.
  - The anesthesiologist alleged that he was never informed of any trouble until the patient became unresponsive.
    - It was later surmised that the patient's breathing difficulties may have been communicated in Spanish between the husband, nurse #1 and the patient.
- Both nurse #1 and the anesthesiologist claimed to have been the person who called the code.
- The physician who initially responded to the code and nurse #1 testified that when the code team arrived, the anesthesiologist was not attending to the patient and needed to be told to bag her.

According to the American Heart Association, "the best survival rate for infants over 24 to 25 weeks in gestation occurs when the delivery of the infant occurs no more than 5 minutes after the mother's heart stops beating. This typically requires that the provider begin the hysterotomy about 4 minutes after cardiac arrest."<sup>1</sup> Luckily, the mother in this case had relatively minor permanent injuries following her cardiac arrest. The child, however, might have fared better had the anesthesiologist responded to the mother's respiratory distress and the fetal distress more quickly.

### Risk Management Recommendations

The following risk management recommendations are offered as a means to increase maternal and fetal well-being during epidural (spinal or combined spinal epidural) analgesia/anesthesia:<sup>2,3,4,5</sup>

- An epidural should not be started until the patient has been examined and the fetal status and progress of labor evaluated by a qualified individual. A physician with obstetric privileges to perform operative vaginal or cesarean delivery who concurs with the patient's management and has knowledge of the maternal and fetal status and the progress of labor should be readily available to deal with any obstetric complications that may arise.
- An anesthesiologist should conduct a focused history and physical examination prior to providing anesthesia.
  - The examination should be documented and any maternal conditions that would render the patient "high risk" (e.g., obese, hypertensive, difficult airway) should be identified and planned for.
    - When patient obstetric and/or anesthetic risk has been identified, consultation between the obstetrician and the anesthesiologist should precede anesthesia services.
- Systems should be in place to encourage early and ongoing communication among obstetricians, anesthesiologists and other members of the labor and delivery team.
  - Conduct team communication training.

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(“Case Study #1” . . . continued from page 3)

- An intravenous infusion should be established prior to initiating the epidural, in case complications arise.
- When techniques that include local anesthetics are chosen, appropriate resources for the treatment of complications (e.g., hypotension, systemic toxicity, high spinal anesthesia) should be available.
- If an opioid is added, treatments for related complications (e.g., pruritus, nausea, respiratory depression) should be available.
- A physician with appropriate privileges should be readily available to manage any anesthetic complications from the time the epidural is started until the patient’s postanesthesia condition is satisfactory and stable.
- Because problems generally occur, if at all, within 30 minutes of starting epidural analgesia, patients need to be actively monitored during this time.
- Fetal heart tones should be monitored by a qualified member of the labor and delivery team before and after epidural anesthesia.
- Policies and procedures should be in place to ensure the recognition of maternal respiratory distress and the timely restoration of oxygenation and ventilation.
  - Labor and delivery nurses should know how to assess ventilation, establish an airway and start ventilation.
- Basic airway management equipment should be immediately available during the provision of epidural analgesia. (See box below).
- All members of the labor and delivery team should know where the code cart is located when a patient receives an epidural.
  - The code cart should contain appropriate equipment and drugs.
- Supplemental oxygen should be available, including portable tanks in case the patient needs to be moved.
- Everyone on the labor and delivery team should be aware of how to do CPR on a full-term patient. In addition, uterine displacement (usually left displacement) should be maintained.
- Policies and procedures should be in place to ensure that all patients recovering from an epidural receive appropriate postanesthesia care (see ASA Standards for Postanesthesia Care, available on the ASA website at:  
[www.asahq.org/publicationsAndServices/standards/36.pdf](http://www.asahq.org/publicationsAndServices/standards/36.pdf) (accessed 4/24/2009).

## American Society of Anesthesiologists (ASA) Suggested Resources for Airway Management During the Initial Provision of Neuraxial Anesthesia<sup>2</sup>

- Laryngoscope with assorted blades
- Endotracheal tubes with stylets
- Oxygen source
- Suction source, including tubing and catheters
- Self-inflating bag and mask
- Medications for blood pressure support, muscle relaxation, and hypnosis
- Qualitative carbon dioxide detector
- Pulse oximeter

Note: The ASA Practice Guidelines for Obstetric Anesthesia recommend that airway management resources be customized to meet the needs, preferences and skills of the anesthesiologist and the facility.

## Medical Record Corrections and Alterations

During the normal course of patient treatment, it is sometimes necessary to correct a medical record to accurately reflect the patient's care (e.g., if a notation is made in the wrong patient's chart or if a notation is made based on a lab error). If a provider changes the medical record upon notice of a claim or lawsuit, however, the act of "correcting" or "clarifying" information in the record is considered medical record alteration, which can seriously impact the ability to defend a medical liability lawsuit.

### Medical Record Correction Risk Management

#### Recommendations

- Develop a medical records correction policy based on the following recommendations:
  - Mark the original (erroneous) entry through with a single line. Do not obscure the entry with correction fluid or ink. Do not attempt to write the intended number or word on top of the erroneous one(s) (i.e., "write over").
  - Sign, date and time the new (correct) entry. Never "back date" an entry to the medical record.
  - If appropriate, direct the reader's attention from the original, erroneous entry to the corrected entry, if it is not readily apparent that the subsequent entry is a correction.
  - Never physically remove an erroneous entry that has been entered in a medical record from the patient's chart, after a corrected entry has been added. The earlier (erroneous) entry may have been relied upon by other members of the healthcare team. To physically remove the erroneous entry would therefore falsely represent the integrity of that record.
- Develop policies and procedures that address making an addendum or late entry. Write a note as an addendum if there is a need to write an entry in the record that is not contemporaneous with the finding or treatment being described. Place this addendum entry chronologically in the record, based on when the "late" or out-of-sequence entry is being entered in the

record. At the beginning of the addendum, explain to what the addendum refers. Sign, date and time the addendum entry.

#### Additional Resources

- NORCAL's Medical Records & Practice Management CME monograph. Available at: [www.norcalmutual.com/cme](http://www.norcalmutual.com/cme) or (800) 652-1051, ext. 2244.
- The May 2002 *Claims Rx* entitled "Don't alter medical records: it's fraudulent and you won't get away with it," which is available upon request from the NORCAL Risk Management Department, (800) 652-1051.

#### Providing Appropriate Interpretation

In this case, the anesthesiologist's inability to directly communicate with the patient was a key aspect of his failure to recognize her respiratory distress. Why no interpreter was offered or provided in this case is not clear from the medical record. Although the anesthesiologist expressed his frustration at not being able to understand the patient, her husband or the labor nurse while they were speaking in Spanish as he was administering the epidural, he made no effort to obtain a competent interpreter. Had one been available, he probably would have become aware of the patient's condition. It also would have been more difficult for the patient to legitimately argue that the anesthesiologist had ignored her respiratory complaints.

#### Language Access Laws and Regulations

In addition to medical malpractice liability exposure and diminished patient safety, a provider's failure to secure a competent interpreter can expose the provider to statutory and regulatory violations that can result in fines and in some cases a provider being prohibited from participation in various federally funded programs (e.g., Medicare and Medicaid). The U.S. Department of Health and Human Services (HHS) provides detailed compliance information regarding discrimination against individuals with limited English proficiency (LEP); see the HHS website at: [www.hhs.gov/oct/civilrights/resources/providers/index.html](http://www.hhs.gov/oct/civilrights/resources/providers/index.html) (accessed 4/24/2009).

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*("Case Study #1" . . . continued from page 5)*

The various federal and state laws that mandate language access for patients with LEP include: Title VI of the 1964 Civil Rights Act, Emergency Medical Treatment and Active Labor Act (EMTALA) and the Hill-Burton Act. Every state has enacted laws that address language access in healthcare settings. Some states' laws provide detailed guidance, while others generally recognize a patient's right to understand her healthcare provider. California leads the nation in the number of language access laws.<sup>6</sup> Providers can access a summary of the language access laws in any state on the National Health Law Program website at: [www.healthlaw.org/library/item.174993](http://www.healthlaw.org/library/item.174993) (accessed 4/24/2009).

### **Using Family Members for Interpretation**

Providers can expect to encounter patients who request that a family member or friend interpret, rather than an interpreter deemed competent by the provider. In most cases, the safest course initially is to inform any LEP patient that an interpreter will be made available. If the patient responds by requesting that a friend or family member serve as interpreter, the provider should determine whether that person is competent to provide interpretation. If the friend or family member is competent to interpret, the patient's wishes should be accommodated. It is important to note in the patient's medical record the choice of interpreter, that a competent interpreter was offered and whether there was an emergency or some other reason why a recommended interpreter was not used.<sup>7</sup>

### **Language Access Risk Management Recommendations**

Adequate provider-patient communication leads to greater patient satisfaction, adherence to medical instructions

and better outcomes.<sup>8</sup> Conversely, poor outcomes and professional liability can be linked to inadequate communication.<sup>4</sup> Taking advantage of various resources to develop a greater ability to communicate with LEP patients can lower liability risk and increase patient safety, compliance and satisfaction. The following risk management recommendations are offered to increase language access for LEP patients:

- Identify the foreign languages current patients speak and those that future patients are likely to speak and be prepared to provide interpreters for those languages.
- Develop policies and procedures for identifying LEP patients and providing them with appropriate interpretation and translation services.
- Utilize competent healthcare interpreters whenever possible.
  - Develop policies and procedures for assessing the competency of interpreters.
  - Avoid using family members for interpretation services unless the patient requests it.
    - Some languages do not have words for English language concepts pertaining to medical procedures. In these situations, a child or inexperienced interpreter may not be able to accurately convey the intended meaning.
- Be aware of and comply with state and federal laws that mandate interpretation and translation services for LEP patients.

For additional information about accommodating the language access needs of patients, please see the NORCAL Cultural Competency CME monograph, available to NORCAL insureds this summer on the NORCAL website at: [www.norcalmutual.com/cme/](http://www.norcalmutual.com/cme/).

# Update on California Health Plan Language Access Legislation.

**(Health & Safety Code §§1367.04, 1367.07; Insurance Code §§10133.8, 10133.9, also referred to as Senate Bill 853)**

As of April 1, 2009, all California health, dental and specialty insurers regulated by the California Department of Insurance were required to have a Language Assistance Program (LAP) in place. Many aspects of this new legislation are not applicable to healthcare providers; however, providers should be aware of a number of provisions that can directly impact LEP patient interactions:<sup>1,2</sup>

- Insurers/plans are mandated to contractually require that physicians with whom they contract comply with their LAP. Because insurers are required to provide LEP insureds with qualified interpreter services at all "points of contact," providers need to be prepared to have an interpreter present when necessary.
  - Providers should consult their health plan contracts to determine requirements for the provision of insurer-specific interpreter services and should integrate those requirements into their office policies and procedures.
  - Insurers are responsible for the cost of providing the interpreter, unless the cost of interpretation services has been delegated to the provider and incorporated into the provider's contract.
- Contracting providers are required to document an LEP insured's refusal of an interpreter.
- Contracting providers are required to disclose and update (quarterly) the languages in which they and their employees are fluent.

Providers who are not aware of an insurer's LAP are encouraged to contact that insurer directly for information.

<sup>1</sup>CMA On-Call Document #0813. Foreign Language Interpreters. Available on the CMA website at [www.cmanet.org](http://www.cmanet.org) (accessed 3/3/2009).

<sup>2</sup>California Health & Safety Code §§1367.04, 1367.07; California Insurance Code §§10133.8, 10133.9.

## Maternal Arrest as a Result of Hemorrhage Case Study #2

The following NORCAL closed claim illustrates how communication failures between an anesthesiologist and obstetrician during and after a cesarean section can increase patient safety risk and professional liability exposure.

***Allegation: the obstetrician and anesthesiologist failed to effectively react to and treat the patient's post cesarean section hemorrhage, which resulted in her death.***

An obese, 38-year-old female patient with chronic hypertension presented to obstetrician #1's office for prenatal care. She had had one previous uneventful cesarean section delivery. Her hypertension was well controlled during the pregnancy, which was otherwise uncomplicated. In her 39<sup>th</sup> week of pregnancy, obstetrician #1 admitted her to the hospital for a planned cesarean section.

With the assistance of obstetrician #2 and an anesthesiologist, obstetrician #1 delivered a healthy baby. During the cesarean section, the patient's anterior, low-lying placenta was mostly delivered without incident, but a portion of it had to be "shelled out" (i.e., the obstetrician had to place his hand between the placenta and uterine wall and separate them). There was no clinical evidence of retained placenta, but obstetrician #1 noted extensive bleeding from the wall of the uterus, which he ultimately controlled using sutures. Hemostasis was ultimately confirmed by both obstetricians by observation and by flushing the abdomen with saline.

After the skin was closed, the anesthesiologist informed the obstetricians that the patient had lost an estimated 3000 ml of blood during the delivery (300 to 600 ml is typical). In response, he had infused 4000 ml of crystalloid and had transfused the patient with five units of packed red blood cells. By the end of the case, he administered

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Methergine, Hemabate, phenylephrine and ephedrine. Although the anesthesiologist had indicated to the nurses that the patient's condition was tenuous, he had not communicated this to the obstetricians.

After confirming that the uterus had firmed up and that the patient was hemodynamically stable, the obstetricians left the surgical suite. Obstetrician #1 went to the nursery to talk to the patient's husband. At this point, the patient was lucid, communicating and seemed to be appropriately responding to the transfusions.

The patient was then transferred to a bed to be taken to the ICU for further monitoring due to her blood loss. Shortly thereafter, the patient complained of shortness of breath and chest pain. She then lost consciousness. A code blue was called; after one hour of attempted resuscitation, she was pronounced dead.

On autopsy, 4000 ml of blood were found in the patient's abdomen. Placenta increta was diagnosed microscopically, which the pathologist concluded was the source of the hemorrhaging.

The patient's husband and children filed a wrongful death claim against the anesthesiologist, obstetrician and hospital.

#### Plaintiff's Allegations:

- The anesthesiologist should have informed the obstetrician that he was maintaining the patient's blood pressure with medications.
- The obstetrician failed to vigilantly follow the patient's status following the cesarean section and should have been more aggressive in communicating with the anesthesiologist before he left the operating room.
- The obstetrician failed to recognize that the patient needed a hysterectomy to control the hemorrhaging.
- The anesthesiologist failed to adequately communicate the hemodynamic signs of hemorrhage to the obstetrician and failed to call for assistance.
- The anesthesiologist failed to transfuse enough blood.

- The anesthesiologist failed to contact the obstetrician and bring him back to the operating room when the patient continued to bleed.

Due to lack of standard of care support, this case was settled.

#### Risk Management Recommendations

In the United States, massive hemorrhage during labor and delivery is relatively rare; unfortunately, its incidence is increasing. It is thought that the increase is a result of an increase in cases of placenta previa and placenta accreta related to repeat cesarean sections.<sup>9</sup> The following risk management recommendations are offered as a means to increase maternal safety during and following labor and delivery:<sup>2,9</sup>

- Policies and procedures should be in place to encourage early and ongoing communication among obstetricians, anesthesiologists and other members of the labor and delivery team.
- Policies and procedures should be in place to identify women at increased risk for maternal hemorrhage (e.g., placenta accreta, placenta previa and previous uterine surgery) and prepare for possible hemorrhage in these patients.
  - Although ASA guidelines do not mandate routine blood cross-match for every patient, the guidelines state that decisions regarding ordering a blood type and screen or cross-match should be based on "maternal history, anticipated hemorrhagic complications, and local institutional policies."<sup>2</sup>
- Resources to manage hemorrhagic emergencies should be immediately available to the labor and delivery team. (See box on page 9.)
  - Everyone on the labor and delivery team should know where hemorrhagic emergency equipment is and how it is used.
- Policies and procedures should be in place to ensure that patients recovering from labor and delivery are adequately monitored to identify and avoid hemorrhagic emergencies.

# ASA Suggested Resources for Obstetric Hemorrhagic Emergencies\*

- Large-bore intravenous catheters
- Fluid warmer
- Forced-air body warmer
- Blood bank resource availability
- Equipment for the rapid infusion of intravenous fluids and blood products (e.g., hand-squeezed fluid chambers, hand-inflated pressure bags, and automatic infusion devices)

\* Note: The ASA Practice Guidelines for Obstetric Anesthesia recommend that the items should be customized to meet the specific needs, preferences, and skills of the practitioner and healthcare facility.

## Birth Injury Due to Anesthesia-Related Delay During an Emergent C-Section

### Case Study #3

The following Illinois medical malpractice case<sup>10</sup> illustrates how communication failures among anesthesiology and obstetric providers during labor can increase patient safety risk and professional liability exposure.

*Allegation: A delay in providing anesthesia during an emergent cesarean section resulted in the infant's irreversible brain damage.*

The patient, a 30-year-old woman who had expected to give birth on December 31, presented to the hospital to be induced on the morning of January 5. Obstetrician #1 examined the patient, ordered Pitocin and alerted the hospital staff to the potential for fetal distress and the possible need for an emergency cesarean section. He then left the hospital.

At 6 p.m., obstetrician #1 spoke to the obstetrics resident who was following the patient. The resident reported that although the patient was continuing to have contractions and that there were intermittent periods of increased and decreased fetal heartbeats, in his opinion there were no signs of fetal distress. Obstetrician #1 ordered the Pitocin stopped at 8 p.m. so the patient could eat and rest for the night. The fetal heart monitor was also suspended for the night.

At 8 a.m. on January 6, obstetrician #2 took over the management of the patient's care. He concluded that there was no fetal distress, resumed the Pitocin and also informed the hospital staff of the potential for an emergency cesarean section. He then left the hospital to begin rounds at another hospital.

At 11:30 a.m., the baby's heart rate fell from 140 beats per minute to 50 beats per minute within a three-minute time span. Obstetrician #2 was paged. The anesthesia department was contacted at 11:35. The baby's last audible heartbeat was heard at 11:37. At 11:38, the obstetrics resident took the patient to the operating room. Obstetrician #2 arrived at 11:44 and found preparations for a cesarean section in progress. However, no one from the anesthesia department had arrived. Believing he could delay no longer, at 11:47 obstetrician #2 began cutting through the patient's abdominal wall using a local anesthetic. At 11:50, the anesthesiologist and a certified registered nurse anesthetist (CRNA) arrived and began the general anesthesia.

At 11:51, obstetrician #2 removed the infant from the uterus. The umbilical cord was wrapped so tightly around her neck that it had to be severed rather than unwrapped. The infant was not breathing and had no heart tone. Resuscitation efforts were started immediately. She did not have a normal heart rate until she was 10 minutes of age. She later was diagnosed with cerebral palsy.

(continued on page 10)

("Case Study #3" . . . continued from page 9)

The parents and child filed a medical malpractice action, alleging that the obstetricians administered Pitocin for too long and did not perform a cesarean section soon enough. The plaintiffs also alleged that the hospital's nursing staff had failed to properly monitor the infant's well-being prior to her delivery. Finally, plaintiffs claimed that the hospital was negligent for having failed to make general anesthesia available for the mother's emergency cesarean section on a timely basis.

During litigation the reason for the anesthesia team's delay was revealed: The CRNA testified that he was sitting in the anesthesia workroom reading the newspaper, unaware of the need for emergent anesthesia services until 11:47 a.m., when he was first notified that his services were needed in the operating room. The "first-call" anesthesiologist was paged in the call room at 11:48 a.m. Neither the anesthesiologist nor the CRNA had been advised that the patient's obstetricians had alerted the hospital staff of the patient's possible need for an emergency cesarean section. When the anesthesiologist later raised the issue of the late page to the head of the obstetrics department, he was informed that there were two new secretaries in the department who had not been trained in the proper and most effective way to page the anesthesia team.

### Risk Management Recommendations

Getting an anesthesiologist to an emergency cesarean section as quickly as possible is a critical objective in labor and delivery care. Evidence of communication failures between the obstetric and anesthesiology departments were particularly damaging to the hospital during the trial in this case. Because every minute counts during an

obstetrical emergency, systems ensuring appropriate communication among obstetricians and anesthesiologists are critical. In the above case, had the following risk management strategies been in place, the tragic outcome might not have occurred:

- Have chain of command policies in place that encourage proactive intervention when communication problems are identified.
  - In this case, the fact that the obstetric secretaries were delaying anesthesiology response times was known among the obstetricians working at the hospital, but no one intervened to ensure that the problem was solved.
- Have protocols and procedures in place to continually ensure that every link in the chain of communication is a strong one.
  - The obstetrics department in this case had obviously not instituted an appropriate training program for its secretaries.
- Have protocols and procedures in place that keep all members of the labor and delivery team informed when a patient is at risk for emergent cesarean section.
  - Although the obstetricians attempted to prepare the labor and delivery team for a potential emergency, there were no communication protocols in place to pass the information along to the anesthesiologists who would respond.

For additional information about healthcare team communication, please see the NORCAL Communication and Follow-Up CME monograph, available to NORCAL insureds this summer on the NORCAL website at: [www.norcalmutual.com/cme/](http://www.norcalmutual.com/cme/).

## The Importance of Collecting Umbilical Arterial Blood Gas

In any case where difficulties are encountered during labor and delivery and/or a child is critically ill at birth, umbilical arterial blood gas collection and analysis are highly recommended. Cord blood gas analysis is the most objective method to assess fetal well-being at birth. A normal pH value in the umbilical arterial blood gas, even in the presence of fetal heart rate (FHR) tracing irregularities and low appearance-pulse-grimace-activity-respiration (APGAR) scores practically excludes a causal relationship between the intrapartum period and a subsequent discovery of cerebral palsy. (Cord blood gas analysis will exclude the diagnosis of birth asphyxia (hypoxic-ischemic encephalopathy) in approximately 70 to 80 percent of depressed newborns at term.)<sup>1,2</sup> Consequently, cord blood analysis showing normal pH value can be invaluable in defending malpractice allegations in birth injury claims.

<sup>1,2</sup> Pence S; Kocoglu H; Balat O; Balat A. The effect of delivery on umbilical arterial cord blood gases and lipid peroxides: comparison of vaginal delivery and cesarean section. *Clin Exp Obstet Gynecol* 2002;29(3):212-4. Blickstein I, Green T. Umbilical cord blood gases. *Clin Perinatol* 2007;34:451-459.

## Conclusion

Communication deficits put patients at risk of injury and expose providers to liability risk whenever a patient is receiving healthcare. During labor and delivery, where the passage of minutes can mean the difference between life and death or permanent disability, the need for robust

communication policies and protocols is even more critical. With the goal of increasing patient safety and decreasing potential medical liability exposure, providers are encouraged to consider and, where appropriate, implement the risk management strategies introduced in this month's *Claims Rx*.

### Endnotes

- <sup>1</sup> 2005 American Heart Association guidelines for cardiopulmonary resuscitation and emergency cardiovascular care. *Circulation* 2005; 112(suppl):IV1–203.
- <sup>2</sup> Practice guidelines for obstetric anesthesia: an updated report by the American Society of Anesthesiologists task force on obstetric anesthesia. *Anesthesiology* 2007; 106:843–63.
- <sup>3</sup> Guidelines for Regional Anesthesia in Obstetrics. Available on the ASA website at: [www.asahq.org/publicationsAndServices/standards/45.pdf](http://www.asahq.org/publicationsAndServices/standards/45.pdf) (accessed 4/24/2009).
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- <sup>6</sup> Summary of State Law Requirements Addressing Language Needs in Health Care. Available on the National Health Law Program website at: [www.healthlaw.org/library/item.174993](http://www.healthlaw.org/library/item.174993) (accessed 3/3/2009).
- <sup>7</sup> CMA On-Call Document #0813. Foreign Language Interpreters. Available on the CMA website at [www.cmanet.org](http://www.cmanet.org) (accessed 3/3/2009).
- <sup>8</sup> J.T. Berger. Culture and Ethnicity in Clinical Care. *Arch Intern Med* 1998;158:2085-2090.
- <sup>9</sup> Skupski DW, Lowenwirt IP, Weinbaum FI, et al. Improving hospital systems for the care of women with major obstetric hemorrhage. *Obstet Gynecol* 2006;107:977-83.
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## Complying with the “Red Flags Rule”

As “creditors,” or businesses that provide services and bill later, most healthcare providers will soon be required to be in compliance with the “Red Flags Rule,” a set of Federal Trade Commission (FTC) regulations that requires creditors and financial institutions to develop and implement a written identity theft prevention, detection and mitigation program. Although the FTC had originally slated the regulations to go into effect on May 1, 2009, the agency recently announced that it will delay enforcement of the new regulations until August 1, 2009, to give affected entities more time to develop and implement the programs. The American Medical Association (AMA) plans to use the interim period to try to convince the FTC that physicians should not be viewed as creditors under the regulations. The AMA, the American Hospital Association (AHA), and various other organizations have responded to the regulations by developing informational documents, frequently asked questions and sample policies. To ensure compliance and stay abreast of developments, providers are encouraged to take advantage of these and other available resources:

### AMA

- **Frequently Asked Questions**  
“Protect your patients, protect your practice: What you need to know about the Red Flags Rule”  
[www.ama-assn.org/ama/pub/upload/mm/368/red-flags-rule-edu.pdf](http://www.ama-assn.org/ama/pub/upload/mm/368/red-flags-rule-edu.pdf) (accessed 4/30/2009).
- **Customizable Policies and Procedures**  
“AMA identity theft prevention and detection and Red Flags Rule compliance: Sample policy”  
[www.ama-assn.org/ama/pub/upload/mm/368/red-flags-rule-policy.pdf](http://www.ama-assn.org/ama/pub/upload/mm/368/red-flags-rule-policy.pdf) (accessed 4/30/2009).

### AHA

- **Customizable Policies and Procedures**  
“Red Flags Rule Resources”  
[www.aha.org/aha/advocacy/compliance/redflags.html](http://www.aha.org/aha/advocacy/compliance/redflags.html) (accessed 4/30/2009). Click on “Sample Policy: Red Flags Identity Theft Prevention Program.”

### CMA

- **Toolkit**  
“California Medical Association”  
Available to members at: [www.calphys.org/html/cc874.asp](http://www.calphys.org/html/cc874.asp) (accessed 4/30/2009). Click on “Red Flags Rule Toolkit.”

### FTC

- **Informational Guidance**  
“Fighting Fraud with the Red Flags Rule: A How-To Guide for Business”  
[www.ftc.gov/bcp/edu/pubs/business/idtheft/bus23.shtm](http://www.ftc.gov/bcp/edu/pubs/business/idtheft/bus23.shtm) (accessed 4/30/2009)
- **News Release**  
“FTC Will Grant Three-Month Delay of Enforcement of ‘Red Flags’ Rule Requiring Creditors and Financial Institutions to Adopt Identity Theft Prevention Programs”  
<http://www.ftc.gov/opa/2009/04/redflagsrule.shtm> (accessed 5/4/2009)

**Claims Rx**  
**Evaluation and CME Attestation Form**  
Effective Communication among  
Anesthesiologists and Obstetricians

**Original Release Date: June 2009**  
**Expiration Date: June 30, 2010**

In order to receive CME credit,\* you must fill out this form in its entirety and return it to NORCAL by the expiration date above. For faster receipt of your CME certificate, go to [www.norcalmutual.com/cme](http://www.norcalmutual.com/cme) and submit the form electronically. Alternatively, you can mail or fax this form, receiving your CME certificate in 7-10 business days.

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\*Receipt of CME credit is limited to NORCAL policyholders.

**Target Audience:** Providers involved in labor and delivery.

**1. Educational Outcomes:**

Overall, degree to which the material presented is applicable in your practice setting:

*Not applicable* | 1 | 2 | 3 | 4 | 5 | *Very applicable*

**2. Application of Risk Management Strategies**

Understanding that this CME activity is designed to increase maternal and fetal patient safety and reduce your professional liability risk, after reading this publication select the risk management strategies you plan to implement in your practice (check yes or no for each):

Risk Management Strategies	Yes	No
Conduct focused history and physical prior to initiating anesthesia, documenting and planning for known "high risk" factors (e.g., obese, hypertensive, difficult airway).		
Implement and adhere to policies and procedures to identify and manage maternal respiratory distress.		
Implement and adhere to policies and procedures for post-anesthesia care.		
Implement and adhere to protocols and procedures that strengthen communication between providers during labor and delivery.		
Adopt and adhere to policies on medical records corrections and addendums.		
Develop policies and procedures (based on state and federal laws) for identifying LEP patients and providing them with appropriate interpretation and translation services.		

**3. Other Strategies to Minimize Risk**

The June Claims Rx focuses on inadequate patient safety protocols and inadequate communication among the members of the labor and delivery team. The risk management recommendations for the medical specialty areas of anesthesiology and obstetrics are the primary focus, although the risk management recommendations herein are relevant to all medical specialties. These include the importance of a well-documented medical record, adherence to practice guidelines and/or policies and procedures toward the delivery of a specific medical procedure, communication between providers in the delivery of care, and providing care to LEP patients.

There are additional risk management resources available to you in the topic areas of medical record documentation, health literacy, communication and preventing birth injuries at [www.norcalmutual.com/cme](http://www.norcalmutual.com/cme) or by contacting a NORCAL Risk Management Specialist at (800) 652-1051, ext. 2244.

**4. Was this activity free of commercial bias?** Yes No

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Signature

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