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Legal trends in obstetric anesthesia: International perspective

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Summary

The United States of America has more lawyers per capita than any other country in the world. As a result it should not come as a surprise that the United States has become the most litigious country in the world. A medical malpractice lawsuit is a civil action taken by the patient (or an authorized representative of behalf of the patient) seeking monetary damages for injuries claimed to have resulted from negligent treatment. Obstetric anesthesia has become a recognized subspecialty of anesthesiology. Perhaps no other subspecialty of anesthesiology provides more personal gratification and clinical challenges than the practice of obstetric anesthesia. However, in addition to clinical challenges obstetric anesthesia is laden with medico-legal liability. Obstetric anesthesiologists are frequently named in claims involving bad neonatal outcomes. Obstetric anesthesia is also the most common subspecialty of practice to be ceased due to medico-legal concerns. This review article attempts to highlight the influence of the current medico-legal climate on the practice of obstetric anesthesia - worldwide. *Anestezjologia i Ratownictwo 2008; 2: 226-231.*

Keywords: anesthesia, obstetric, general, regional, labor analgesia, complications, medico-legal, malpractice, law suit, medical malpractice

Introduction: medicine and law

The United States has more lawyers per capita than any other country in the world [1,2]. As a result it should not come as a surprise that the United States is the most litigious country in the world. A medical malpractice lawsuit is a civil action taken by the patient (or an authorized representative of behalf of the patient) seeking monetary damages for injuries claimed to have resulted from negligent treatment. Medical negligence is the most common threat of liability faced by physicians (including anesthesiologists) in the United States. The medical malpractice crisis is one of the main factors responsible for the rising cost of healthcare [1,2].

Obstetric anesthesia: a subspecialty of anesthesiology

Obstetric anesthesia has become a recognized subspecialty of anesthesiology and an integral part of practice of most anesthesiologists. Perhaps no other subspecialty of anesthesiology provides more personal gratification than the practice of obstetric anesthesia [3]. An obstetric anesthesiologist has become an essential member of the obstetric care team, who closely works with the obstetrician, midwife, neonatologist and Labor and Delivery nurse to ensure the highest quality care for the parturient and her baby.

Communication skills and exchange of information in ever changing environment of Labor and

Delivery is essential for perfect outcome, which is always expected when providing safe passage for both the mother and her fetus from antepartum to postpartum period. The anesthesiologist's unique skills in acute resuscitation combined with experience in critical care make members of this subspecialty of anesthesiology particularly valuable in peripartum care of the high-risk patients, extending our role well beyond the routine provision of intrapartum anesthesia or analgesia [3]. However, in addition to clinical challenges [3-7] obstetric anesthesia is laden with medico-legal liability [1,2,8-24]. Obstetric anesthesiologists are frequently named (besides obstetricians) in claims involving bad fetal/neonatal outcomes [1,2,4,11,12]. This review article reflects on the tense medico-legal climate in obstetrics and obstetric anesthesia in the United States [1,2,4,6] and several other countries [4,8,18,22-24].

Obstetric anesthesia and law: international perspective

Beckmann [8] studied (posted survey with a 78% response rate) the influence of the current medico-legal climate in Australia and New Zealand on anesthetic practice. Information collected by the author included demographics, opinions regarding the current medico-legal climate, medical defense organizations, and the implications for anesthetic practice. Nearly all (95.3%) members of the Australian and New Zealand College of Anaesthetists were concerned about the current medical indemnity crisis and 80.5% felt concerned about the financial security of medical insurers. Of all these respondents 23.6% had personal experience of litigation and 73.6% expected to have a claim made against them during their career. Responding anesthesiologist spent an average of 8.3% of their gross annual income on medical insurance premiums and 47.2% were concerned about the viability of their practice given the rising costs of medical insurance [8]. Obstetric anesthesia was the most common area (subspecialty) of practice to be ceased due to medico-legal concerns. In the next two years, 20.2% of obstetric anesthesiologists who responded intended to cease practice. In the past two years, 3.1% of respondents retired due to their litigation concerns, while 12.8% (average age of 56.7 years) were intending to retire in the next two years for the same reasons [8]. Changes to the conduct of the preoperative consultation were common. Other changes to practice of anesthesia included more thorough documentation of complications (50.8%) and a strong reluctance to perform neuraxial blocks (54%). This study strongly suggests that anesthesiologists are increasingly concerned about the current medico-legal climate and as a result, some might be retiring earlier and giving up high-risk areas of practice (e.g., obstetric anesthesia) [8].

Lee et al. [1] used the American Society of Anesthesiologists (ASA) Closed Claims Project database *[The database does not contain claims on all adverse anesthetic events, nor does it have any denominator data on how many anesthetics are performed per year. Consequently, estimates of risk for specific regional anesthesia procedures or populations cannot be made. Other limitations include the nonrandom, retrospective collection of data provided partially by direct participants instead of impartial observers; the bias toward substandard care designations for poor outcomes; and changing anesthetic practice and standards during the 20-year time span for this data. Despite these limitations, the ASA Closed Claims database provides useful information on large numbers of rare adverse events that are not amenable to prospective study from single centers.]* to identify specific patterns of injury and legal liability associated with regional anesthesia in the USA. Because obstetrics represents a unique subset of patients, claims with neuraxial blockade were divided into obstetric and nonobstetric groups for comparison. An in-depth analysis of 1980-1999 regional anesthesia claims was performed with a subset comparison between obstetric and nonobstetric neuraxial anesthesia claims. Of the total 1,005 regional anesthesia claims, neuraxial blockade was used in 368 obstetric claims and 453 of 637 nonobstetric claims (71%). Damaging events in 51% of obstetric and 41% of nonobstetric neuraxial anesthesia claims were block related. Obstetrics had a higher proportion of neuraxial anesthesia claims with temporary and low-severity injuries (71%) compared with the nonobstetric group (38%; P <or=0.01) and a lower proportion of claims with death or brain damage and permanent nerve injury compared with the nonobstetric group (P <or= 0.01). Cardiac arrest associated with neuraxial block was the primary damaging event in 32% of obstetric and 38% of nonobstetric neuraxial anesthesia claims involving death or brain damage. The authors concluded that obstetric claims were predominately associated with minor injuries (e.g., back pain, headache, pain during

anesthesia and emotional distress) [1].

Ross [2] pointed out that detailed analysis of statements made in the ASA files revealed that a substantial number of obstetric patients were unhappy with the peripartum care provided and felt themselves mistreated and/or ignored. It is possible that malpractice litigation might serve the purpose not only of reparation of injury for substandard care but also one of emotional vindication. Obstetric anesthesiologists are frequently named in claims involving bad fetal/neonatal outcomes. Most of these claims, for whatever reason, do not result in payments to the litigant. Problems involving airway management (e.g., difficult intubation and/or pulmonary aspiration of gastric contents) continue to be well represented in the obstetrical files. Another cause of adverse outcomes with regional anesthesia is local anesthetic toxicity.

The fact that a lawsuit suit has been filed does not necessarily indicate injury. It has been suggested that the number of patients harmed by negligent care who actually file a claim is less than 2% [2]. In contrast, lawsuits are usually not filed unless people perceive that they or a family member have been wronged by the system. The unique feature of the ASA Closed Claims database is that it reflects the patient's (consumer's) perspective on quality of care received [2,4,9].

Crawforth [9] evaluated the anesthesia care provided during obstetric adverse events. Malpractice claims filed against nurse anesthetists for care involving obstetric anesthesia (n = 41) were extracted from the American Association of Nurse Anesthetists (AANA) Foundation Closed Claim database. The events represented in the claims occurred from 1990 to 1996 and represented anesthetics provided by both nurse anesthetists and anesthesiologists. Risk factors for adverse outcomes identified in this study included advanced maternal age, obesity and ethnicity. Patients requiring emergency cesarean deliveries under general anesthesia were found to be at considerable risk for sentinel events. The most common adverse outcome in the obstetric closed claim database was neonatal death (n = 11 [27%]), followed by maternal death (n = 9 [22%]) and complications resulting from neuraxial blocks (n = 8 [20%]). The leading cause of maternal death and brain damage was a failure to secure a patient airway. The mode of delivery in 95% (n = 19) of the 20 claims in which death was the outcome was surgical (Cesarean section). In the claims representing maternal death, 89% [8] of the 9 claims represented surgical deliveries under general anesthesia. These maternal death cases were designated emergent in 56% [5] of the claims. The anesthetic care was deemed appropriate in 56% [23] of the claims. The median payment for appropriate care ($2,866.00) was less than for care determined to be inappropriate ($45,000.00) [9].

Alsaddique [23] analyzed a total number of 2,223 medical malpractice cases submitted to the Medico-legal committee of the Ministry of Health, Riyadh, Saudi Arabia for the period of 4 years (from 1999 to 2003). The author concluded that the practice of obstetrics lead the way in being the most litigation-prone medical specialty. Surgery took the second place followed by internal medicine. Pediatrics was the fourth in order of frequency. Least number of malpractice lawsuits in Saudi Arabia was filed against the dentists. Most (if not all) of the physicians involved in these claims were ill prepared to face a medical malpractice and litigation [23].

Mavroforou et al. [24] conducted a search of medical literature on the subject of the most common reasons/causes for litigation in the practice of obstetrics and gynecology in Greece. The four most common causes of medical litigation in obstetrics and gynecology in Greece were fetal distress, uterine rupture after a vaginal birth in a parturient with history of previous Cesarean section, shoulder dystocia, and misdiagnosis of breast cancer. The authors pointed out that in obstetrics both the jury and the public often expect perfect outcome (as the natural result of uneventful pregnancy) and any deviation from this expectation has to be the result of someone's "negligence". The authors concluded that maintenance of high standards in daily practice with continuous medical training, clear communication and a signed Patient's Informed Consent Form (along with the appropriate documentation of any procedure carried out) may offer some professional safety to practicing obstetricians and gynecologists in case of litigation [24].

Obstetric anesthesia and lawsuits: lessons learned

Lessons learned [1,2,4,8-24], which may reduce medico-legal complications (litigations) and increase patient safety;

* First, careful professional and personal conduct,
* Second, good rapport with the patient,
* Third, good/detailed perioperative evaluation of

all patients (preoperative evaluation is often the first point of attack by the plaintiff and the first barrier of defense for the defendant),
* Fourth, detailed review of patient's medical records (the old chart can be the tiebreaker between uncertain choices),
* Fifth, provision of realistic expectations,
* Sixth, adequate review of potential minor and major risks of anesthesia,
* Seventh, involvement in the prenatal education,
* Eight, in case of the bad outcome the defendant stands alone,
* Ninth, "vigilance" (or lack thereof) really matters ("Vigilance is the motto of the American Society of Anesthesiologists),
* Tenth, denial that a complication could/did occur (and/or delay of actions) may (and often will) convert a small complication to a big complication.

Medical malpractice: the expert witnesses

The anesthesiologist (obstetric anesthesiologist) who provides expert witness testimony is recognized as an important participant in the medical liability system. She or he must first, define a standard of care and second, opine whether the standard has been breached and third, whether any perceived injury was caused by the breach.

The American Society of Anesthesiologists (ASA) has published guidelines for expert witnesses (expert reviewers) qualifications and testimony. The ethical and professional boundaries of appropriate expert testimony as delineated by the ASA seem more restrictive than the legal boundaries. Even with adherence to these guidelines, genuine disagreements and differences of opinions between expert witnesses are expected [4].

Anesthesiologists who testify as expert witnesses should:
1. posses a current, valid and unrestricted license to practice medicine,
2. be board certified by the American Board of Anesthesiology (ABA), or the equivalent,
3. be familiar with the practice, and be in the clinical practice at the time of the event.

The guidelines for expert testimony are:
1. be accurate and impartial,
2. evaluate the performance in light of generally accepted standards,
3. clearly distinguish between medical malpractice and adverse outcomes not related to negligence,
4. access the relation of the alleged deviation from the standard to the patient's outcome,
5. charge fees on a time basis and never contingent on the outcome,
6. be willing to submit the testimony for peer review.

The expert witnesses (expert reviewers) are influenced by several factors. These may include economics (becoming an expert witness may be a lucrative avocation), affinity for the defendant or plaintiff, antipathy for the attorneys involved in the litigation process, and/or the severity of injury sustained by the plaintiff. Expert witnesses use their own, often unstated, subjective and poorly defined, criteria as basis for their "standard-of-care" and causation decisions [4].

Characteristics of physicians who frequently act as expert witnesses:
- only a small cadre of physicians frequently testifies in medical malpractice litigations
- the expert witnesses tend to act consistently for one side (e.g., the plaintiff or the defendant)
- plaintiff witnesses have fewer markers of expertise (e.g., subspecialty training) than defendant witnesses
- The above descriptive and analytical findings may reflect suboptimal expertise or bias in physician expert testimony

Medical malpractice: a difference in perspectives

Physician's perspective;
1. being an incompetent doctor
2. harming the patient
3. an act of persecution and vindication
4. a reason to cease to practice medicine

Attorney's perspective;
1. a health care provider (e.g., a doctor) has run a professional "red light"
2. there is liability for negligence if it causes unintended, yet adverse results/outcomes
3. the expert reviewers/witnesses often disagree as to whether an adverse event is negligence
4. Permanent injury more often leads the expert witnesses to conclude that medical care provided was inappropriate or impossible to judge

Legal perspective;

1. an allegation that the doctor (or other health care provider) acted or failed to act in a manner other doctors (other health care providers) would have under similar/same circumstances
2. an act of professional negligence
3. medical malpractice is not uncommon
4. in the United States medical malpractice is an industry with a "healthy" and steady annual growth rate

Patient's perspective;

1. most patients subjected to adverse outcome do not take legal actions (do not sue)
2. the vast majority of patients injured as a result of substandard care do not file a claim
3. many injured patients complain they cannot find an attorney to represent them in medical malpractice claim

Conclusion: a take home message

Good preoperative evaluation of all patients, detailed review of each patient's medical records and constant vigilance can decrease the incidence of complications and subsequently litigations [4].

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