



# Can a change in practice patterns reduce the number of OB malpractice claims?

**Yes** This descriptive study of 189 closed obstetric claims from a single large liability insurer concluded that **1)** the majority of claims arose from substandard care and **2)** injury could be prevented—and the number of claims lowered—by four changes in practice (see the box on practice recommendations, below).

*Clark SL, Belfort MA, Dildy GA, Meyers JA. Reducing obstetric litigation through alterations in practice patterns. Obstet Gynecol. 2008;112:1279-1283.*

## ▶ EXPERT COMMENTARY

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This article, like any other written about litigation in obstetrics, is sure to spark much discussion and many opinions. And because the article states that most of the cases reviewed for the study involved substandard medical care, emotions will flare and many physicians will disagree. Many readers will ignore the findings because the authors do *not* conclude that tort reform is the major solution to the professional liability crisis.

Most obstetricians have been sued at some point in their career. The cost of these lawsuits can be measured in both financial and human terms—from the expense of mounting a defense to enormous stress and loss of physician productivity. Fear of litigation also leads to the practice of defensive medicine, driving up the cost of health care and further limiting our procedural options.

Suggestions for reform, such as modifying the tort system and reining in medical ex-

perts, have met with limited success. Neither an obstetric practice nor a hospital—let alone an individual obstetrician—can hope to effect these kinds of changes. The best solution for mitigating the cost of obstetric litigation is to make care safer. Safer obstetrics may lower obstetricians' costs while reducing the financial and emotional toll that injury takes on our patients and their families.

## A few caveats

The case series by Clark and colleagues is limited because it does not include a comparison

## WHAT THIS MEANS FOR PRACTICE

The authors offer four practical recommendations to lower the number of obstetric liability claims:

- Deliver in a facility with 24-hour in-house obstetric coverage
- Adhere to published high-risk medication protocols, especially for oxytocin, misoprostol, and magnesium sulfate
- Limit vaginal birth after cesarean (VBAC) to spontaneous labors progressing without augmentation and without repetitive moderate or severe variable decelerations
- Use a comprehensive, standardized procedure note in cases of shoulder dystocia.

Although this study does not provide proof, it does suggest that it will cost obstetricians much more if they do not follow these four simple recommendations.

» JASON K. BAXTER, MD, MSCP,  
AND LOUIS WEINSTEIN, MD

## FAST TRACK

Most of the claims in this descriptive study arose from substandard care. According to the authors, four practice changes can prevent injury and lower the number of claims.

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## Examining the EVIDENCE

group or address cases that were dropped, defended successfully, or filed despite good care. Nor do the authors fully explain how “substandard” care is defined or the evidence on which this finding is based.

In obstetric liability cases, decades may pass between the delivery of an infant and the delivery of a jury verdict, which limits the applicability of these findings to modern obstetric care.

As a case series, this study is hypothesis-generating. It offers four practice- or hospital-level solutions without proving that they work. The authors' expert opinion should stimulate analytic research that utilizes a comparison group so that associations can be made.

Despite these weaknesses, the conclusions that:

- most cases were a result of substandard care
- documentation is often lacking or inadequate
- use of oxytocin should be standardized
- obstetric coverage should be 24/7

are all correct, and have been described in other articles dating back to 1988.<sup>1,2</sup>

### The blame game can be destructive

We live in a blame-based society, exemplified by the obstetric-litigation environment. The study by Clark and colleagues is a welcome step toward realigning our priorities and lowering costs by eliminating preventable errors.

#### References

1. Weinstein L. Malpractice—the syndrome of the 80s. *Obstet Gynecol.* 1988;72:130-135.
2. Hayes EJ, Weinstein L. Improving patient safety and uniformity of care by a standardized regimen for the use of oxytocin. *Am J Obstet Gynecol.* 2008;198:622.e1-622.e7.

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# What is the optimal timing of elective cesarean delivery at term?

**39 weeks** This multicenter cohort study found that, when elective cesarean delivery was performed at term (37 weeks or more) but before 39 weeks' gestation, the likelihood of respiratory complications, newborn sepsis, NICU admission, and other adverse outcomes increased by a factor of 1.8 to 4.2 for births at 37 weeks, and by a factor of 1.3 to 2.1 for births at 38 weeks, compared with delivery at 39 weeks. However, the only death in the study involved an infant delivered at 39 weeks' gestation.

*Tita ATN, Landon MB, Spong CY, et al, for the Eunice Kennedy Shriver NICHD Maternal-Fetal Medicine Units Network. Timing of elective repeat cesarean delivery at term and neonatal outcomes. N Engl J Med. 2009;360:111-120.*

## ► EXPERT COMMENTARY

**Andrew M. Kaunitz, MD**, Professor and Associate Chairman, Department of Obstetrics and Gynecology, University of Florida College of Medicine—Jacksonville. Dr. Kaunitz serves on the OBG MANAGEMENT Board of Editors.

Approximately 1.3 million cesarean deliveries are performed each year in the United States—40% of them repeat procedures. As the number of cesarean deliveries continues to rise, the timing of elective cesarean delivery—including the increasing percentage of repeat cesareans—gains even more importance. The study by Tita and colleagues focuses on this population.

Unless fetal lung maturity has been confirmed, elective cesarean delivery before 39 weeks' gestation is associated with a higher rate of neonatal respiratory problems. In this observational study, performed at 19 US centers from 1999 to 2002, and funded by the National Institutes of Health, infants of women who underwent elective cesarean delivery at 37 or more weeks' gestation were assessed for the primary outcome—a composite neonatal outcome that included the occurrence

of any of the following:

- death
- respiratory distress syndrome
- transient tachypnea of the newborn
- hypoglycemia
- newborn sepsis
- confirmed seizures
- necrotizing enterocolitis
- hypoxic-ischemic encephalopathy
- cardiopulmonary resuscitation or ventilator support within 24 hours of birth
- umbilical cord-blood arterial pH <7.0
- 5-minute Apgar score of 3 or below
- admission to NICU
- hospitalization for 5 or more days.

Of 13,258 elective cesarean deliveries performed at term, 35.8% occurred before 39 completed weeks of gestation (6.3% at 37 weeks, 29.5% at 38 weeks) and 49.1% at 39 weeks. Women who delivered before 39 weeks were more likely to be married, white, and to have initiated prenatal care early.

Compared with infants delivered at 39 weeks, those born at 37 to 38 weeks' gestation had a greater risk of the primary (composite) outcome. At 37 weeks, the adjusted odds ratio (OR) was 2.1 (95% confidence interval [CI], 1.7-2.5). At 38 weeks, the adjusted OR was 1.5 (1.3-1.7).

## WHAT THIS MEANS FOR PRACTICE

Obstetricians and their patients should weigh the known risks of elective cesarean delivery before 39 weeks' gestation against the small risk of late stillbirth. At the same time, it is important to factor in the patient's preferences about when delivery occurs and who performs it.

» ANDREW M. KAUNITZ, MD

## FAST TRACK

**Elective cesarean delivery between 37 and 39 weeks' gestation carried a greater risk of respiratory complications and other adverse outcomes than did delivery at 39 weeks**

The authors estimated that, at 37 weeks' gestation, postponing elective delivery until 39 weeks might prevent 48% of cases of the primary outcome; this percentage was estimated to be 27% at 38 weeks' gestation.

### **Patient preference determines timing in some cases**

Cesarean delivery accounts for almost one third of US births, and most women who have had such a delivery opt to repeat it in their next pregnancy. As an editorial accompanying this article points out, women in this study who delivered before 39 weeks were more likely to be private patients and had likely asked their own obstetrician to perform the delivery.<sup>1</sup> Obstetricians who wish to promote patient satisfaction are likely to honor such a request, recognizing that waiting until later would increase the likelihood of labor, which would exclude the possibility of an elective procedure.

### **Limitations of the study**

Because this study lacked data about testing for fetal lung maturity, it is unclear whether the higher rate of adverse outcomes with elective cesarean delivery before 39 weeks could be explained by failure to assess for fetal lung maturity.

It also appears that the delay of delivery to 39 weeks or beyond may be associated with an increased risk of stillbirth. In other populations, this risk has been estimated to be roughly 0.5 of every 1,000 births for each advancing week of gestation. 

#### **References**

1. Greene MF. Making small risks even smaller [editorial]. *N Engl J Med.* 2009;360:183-184.

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