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NACPM

Webinar

"Best Practices for Risk Management for the CPM Practice"

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What it's all about…

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Many state statues and rules specifically address home birth. This presentation contains generally accepted practices including liability issues but is not meant to be a replacement for your own legal counsel.

DISCLAIMER: The risk management advice presented in this program is intended as general information of interest to physicians, midwives, administrators and other healthcare professionals. It is not intended to constitute legal or medical advice. For advice in those areas, please consult an appropriate professional. The recommendations and advice presented in this program do not reflect or establish a standard of care and do not establish rules for the practice of medicine or midwifery. This guideline is not intended to establish a policy or procedure nor to create a mandated course of action for any physician, midwife or medical practice.

Note: remember, this presentation is from the perspective of the insurance industry that specializes in handling the unique needs of midwives.

Criminal vs. Civil Liability

Criminal Matters

- State/Government vs Defendant
- Burden of proof is on state – must prove defendant is guilty
- Innocent until proven guilty
- Fines and/or prison time

Civil Liability

- Plaintiff (person/entity) vs Defendant
- Burden of proof is on defendant – must prove s/he is not negligent
- Monetary awards are usually the end result of civil matters

Insurance

- Cannot cover criminal matters
- Covers civil liability or negligence

Negligence

- Involves harm caused by carelessness rather than intentional harm
- Elements of Negligence:
  1. Duty of care
  2. Breach of duty
  3. Injury/Harm
     - Property/Physical Damage
     - Bodily Injury
  4. Factual Causation/Direct Cause
- Duty = Standard of Care
  1. For non-professionals, "reasonable person" standard
  2. For midwives, professional standard is the yardstick

What is the Standard?

- Reasonable Person Standard
- Professional Standard of Care
  1. Expert (Peer) Review
  2. Plaintiff and Defendant's Experts
  3. License/Legal Requirements
  4. Professional Association/Accreditation Standards
  5. Ethical codes of conduct

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How will they know?

- Documentation!
- If it's not documented, it didn't happen!
- Documentation vs Your word = Credibility Concerns
- Witnesses
- Proper documentation is the best way for a midwife to prove the care she provided was appropriate

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What the plaintiff attorneys are saying:

"In our experience, birth injuries caused by midwives usually result from one or more of the following:

Patient criteria: midwives must screen their patients very carefully. Not all women are candidates for home births or midwife-assisted births, particularly those who are high risk. In particular, midwives are more likely to ignore the dangers of vaginal birth after cesarean (VBAC)

Informed consent: midwives must clearly and openly disclose all significant risks to a midwife-assisted delivery.

Negligent credentials: some midwives do not meet minimum state standards or licensing requirements.

Failure to assess the baby's condition: midwives may ignore warning signs in an effort to provide a natural birth, at significant risk to the baby or delivering mother.

Failure to have in place and/or follow adequate policies and/or procedures regarding emergency delivery of babies."

Administrative Actions

- Action by the state licensing authority
- This is not a Yelp! review looking for patient satisfaction
- All about state laws, rules and regulations of midwifery
- Reprimands, revocations, probations and lots of headaches!

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Patient Safety Work Product

- Data or reports that are provided to a Patient Safety Organization (PSO)
- Privileged information, not subject to discovery in a lawsuit

Adverse Outcomes

Following are examples of the types of events that should be reported to OneBeacon:

- Medication errors resulting in injury and/or requiring further treatment (including patient not receiving medication; receiving incorrect dosage of medication; or receiving wrong medication)
- Falls, resulting in injury
- Family/Patient complaints of inadequate care resulting in injury
- Events reported to the state Dept. of Health, other regulatory body or police
- Visitor injuries
- Unexpected death
- Serious injury (including, but not limited to, paraplegia; quadriplegia; or severe neurological impairment)
- Elopement
- Allegations of physical or sexual abuse
- Sentinel events
- Oral or written demand for damages
- Lawsuits
- Communication from an attorney regarding any of the events noted above
- Request from an attorney for medical records
- Any other event the Insured reasonably believes could result in a Claim under the policy

The above list of events is not meant to be exhaustive or exclusive. Nothing contained in or omitted from this document should be deemed a waiver of any terms or conditions of any applicable policy. These guidelines are provided for general informational purposes only and should not be considered or relied upon as coverage, legal or risk-management advice. Readers should consult the specific terms of their policy and their own legal counsel for advice.

Note: Future presentations could deal with preventing obstetrical adverse events. For more information, the Institute for Healthcare Improvement has an excellent How-to guide as well as Birthtools.org tools for optimizing the outcomes of labor safety.

Business owners perspective…

- Vicarious liability
- Respondeat superior
  - "Let the master answer"
  - Imputed liability
- Agency law
  - Employee relationship
  - Scope of employment
  - Independent Contractors

Enough theory, what about data?

- 2015 Study, Journal of Midwifery & Women's Health, Analysis of 162 malpractice claims from 2002-2011

- 7 Major categories of allegations:
  1. Fetal/newborn complication or death (62/162)
  2. Alleged provider negligence related to pregnancy care (50/162)
  3. Shoulder dystocia (18/162)
  4. Alleged negligence related to gynecologic care (12/162)
  5. Failure to assess need for cesarean (12/162)
  6. Genetics (3/162)
  7. VBAC (1/162)

  4 other claims could not be categorized due to insufficient information.

- 5 had values (indemnity – judgment or settlement) of $1 million or more with largest above $5 million

Risk Management Conclusions from this Study

- Malpractice (negligence) vs bad outcomes with little or no negligence
- Documentation omissions contributed to poor credibility
- Perception of negligence
- Failure to consult and/or refer leads to conclusion of not meeting standard of care
- What do the notes say when a pregnancy doesn't follow normal physiologic course?

Shoulder Dystocia/Maternal Hemorrhage

- Due to nature of injury, these are expensive with ongoing medical costs
- Review and recognize signs and symptoms of shoulder dystocia and maternal hemorrhage
- Ensure that all necessary providers for handling these situations have been consulted and are present at delivery
- Simulate these situations with all members of your birth team

Other Risk Management Practices

- As midwifery scope of practice expands into more gynecologic care, duties expand
- Make sure your skills are up to speed
- C-sections and genetic testing – Refer!
- For VBACs, TOLACs have been shown to be acceptable especially in situations with prior vaginal births. Make sure you collaborate and have a lower risk tolerance.
- At the MANA conference in 2015, it was noted that 25% of mothers did not receive ultrasound with VBAC

Care for the Patient

1. Triage - identify and prioritize mother's and/or baby's health and safety needs
2. Address these needs immediately
3. Arrange for safe transport via 911
4. Give report to receiving facility or back up physician (NNEPQIN has a good transfer form)
5. Accompany your client and provide information and support until the situation is resolved
6. Follow up on any problems with the family and medical facility

Case Study

- Midwife M performed a home delivery for Patient P
- VBAC birth, P had a history of gestational hypertension which led to pre-eclampsia during last pregnancy
- Patient P was markedly obese and asthmatic
- Midwife M had a good relationship with Doctor D and most communication occurred via email
- Collaborative agreement identified three levels for assessing the appropriateness for taking on a patient
- M contended this patient was level 2 while the state licensing board concluded this patient was level 3

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Case Study, continued

- P's home in a rural setting (3+ hrs from hospital), so rental home was used
- Normal FHTs via Doppler until crowning, head turned dark, EMS called
- Baby born with APGAR of 0
- Home was taped as crime scene, M interviewed by police but not detained and no charges filed
- Strong expert testimony in defense of Midwife M
- Family 100% supportive
- M felt "emotionally blackmailed" because the family wanted a home birth and threatened an unassisted home birth if M did not cooperate

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Case Study, continued

- M admitted to the state licensing board that she should not have kept P as patient, given her history
- This is YOUR reputation, YOUR career, YOUR livelihood – do the right thing even if it isn't always the easy thing
- If you advise a certain course of action and the patient refuses, document that with the patient's acknowledgement including why they refuse
- Your patient's decisions are theirs, do not let their consequences become your own
- This particular case ended in a reprimand of M's license, thousands of $ spent with an attorney, and countless hours of worry, stress and frustration

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Support the Family

1. Explain to the client and her family what is happening and why you are transporting.
2. Provide follow-up information and support in the days and weeks postpartum.
3. Act professionally with the client and her family at all times.
4. A word about apology and expressions of empathy.

Communicate About the Unanticipated Adverse Outcome

1. ***Who?*** This will depend to some extent on the nature of the outcome and the relationship of the midwife with other healthcare providers BUT the midwife should make every effort to be present at the initial disclosure discussion.

2. ***When?*** As soon as practical after the immediate healthcare needs of the mother and baby have been addressed.

3. ***Where?*** This will also depend on the circumstances but privacy is key.

4. ***What?*** Only the facts as they are known at the time of communicating. Speculation should be avoided. Expressions of compassion and empathy are most important. Avoid blaming and defensiveness.

Data on Patient/Family Communication

- BMJ Quality & Safety report in June 2015, survey of 700 patients
- Higher likelihood of litigation when patients do not feel their providers are holding themselves accountable for negative outcomes
- Danger areas for higher liability risk:
  1. Disrespectful
  2. Communicates poorly
  3. Failure to listen
  4. Tries to hide fault
- Communicate honestly and with empathy but without admitting guilt
- Many claims are about seeking answers, not $

Communicate with sensitivity

- Consider your audience
  Culture
  Language
  Philosophy
- Match your framing with your audience
- Know your patients and family members
- Bedside manner

Objectively Document the Medical Record

1. First three rule of documentation: Document, Document, Document
2. Review all documentation.
3. If any information is missing, add it – but only as an amendment! Altering medical records is a cardinal, unforgiveable sin!
4. Document the facts regarding what occurred and the care that was provided.
5. Avoid speculation about the cause of the event.
6. Explain rationale for your decisions. Paint a picture of the circumstances to provide a frame of reference for your actions.
7. The medical record can be an extremely valuable tool for a lawsuit, both defensively and offensively. In many cases, the medical record is what makes or breaks the case.
8. Without good documentation, the jury can have "adverse inference instruction."

Support the Provider or Care Team

1. Provide emotional and psychological support to all attendees.
2. Seek emotional and psychological support from trusted peers.
3. Meet with the attending physician, hospital risk manager, others as indicated for political support.

Peer Review Processes & Action Plans

1. Debrief and review the event with all staff present, including doulas. *(Root Cause Analysis)*
2. Learn from the situation and improve care processes as indicated.
3. Take note: Data indicate that if you've had one claim, you're more likely to have another, so learn what you can and make proactive changes; your career, your reputation, your livelihood depend on it!

Report the Event to the Appropriate Parties

1. ***Contact your liability insurance carrier***

2. Report to your state, Medicaid, applicable health care association (NARM, MANA, NACPM) or other appropriate agency as required

3. Meet with the facility risk manager, medical director, supervisor or other staff as indicated

Prepare for Possible Future Lawsuit or Action by State

1. Write down everything you remember in detail: what happened, who was there, what each person was doing, what care you gave and why.
2. Ask all who attended to write down everything they remember and provide it to their carrier.
3. Keep all in a separate file, not part of the patient's medical record.
4. *Debrief and conduct peer review with trusted peers.*

e-Discovery

1. Involves anything stored electronically
   - EMR
   - Biometric info
   - Activity and access logs
   - Billing systems
   - Smartphones and tablets
   - e-mail
2. Discoverable in its entirety, including metadata
3. Must be done in a manner that preserves metadata
4. Includes vendors, business associates
5. NOTHING should be altered in any way (editing, deleting, additions). EVER!

e-Discovery, continued

1. Where does the data reside?
   - Hard drives, the Cloud
   - Back-up Servers
   - Social Media
   - E-mail and voice mail
   - EMR, Paper Files
   - Medical devices (ultrasound equipment, other DME)
   - Surveillance and access systems
   - Employees, volunteers, students, vendors, business associates

2. How do we get it all?

3. Working with the right people: Legal department (at other facilities), IT, Compliance, Records management, Medical Personnel, Risk Management

e-Discovery Gone Wrong

1. Dismissal of suit
2. Adverse inference instruction
3. Monetary sanctions
4. Award of costs for discovery dispute
5. Re-opening of discovery

e-Discovery Best Practices

1. Normal course of action – deleted "stuff"
   "One person's trash is another person's treasure"

2. Issue litigation hold at earliest trigger

3. Avoid self-collection

4. When you do things right, document it! Ensure defensibility.

5. Attention to privacy considerations

6. Consideration of all possible repositories, including cloud and personal devices

Transfer Issues

- Recommend adopting the Home Birth Summit Best Practices Guidelines: Transfer from Planned Home Birth to Hospital.
- OneBeacon and other liability carriers want to have claims where the proper standard of care is followed.

Thoughts on Malpractice

"A malpractice suit is not an indictment of one's professional competence, nor is it a condemnation of one's personal integrity."

Now, YOUR thoughts!

<u>References and Resources:</u>

ACNM Home Birth Practice Handbook

ACNM http://birthtools.org

AHRQ – Perinatal Event Report Form

Catholic Health Partners – Guidelines for responding to serious adverse events

Florida Doctors Insurance Company Risk Management Department, Ginger Kelley, V.P.

Home Birth Summit Best Practices Guidelines: Transfer from Planned Home Birth to Hospital

Kaiser Permanente – Communicating Unanticipated Adverse Outcomes Implementation Guidelines

Institute for Healthcare Improvement – Respectful management of serious clinical adverse events; How-to-guide: Prevent Obstetrical Adverse Events

NNEPQI – Northern New England Perinatal Quality Information Network

OneBeacon Professional Insurance Risk Management Department, Patricia Hughes, BSN, MSN, CPHRM, Risk Control Manager

http://www.birthinjuryjustice.org/what-can-go-wrong-with-the-birth-process/medical-provider-negligence/midwife-negligence/

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