Litigation in obstetric anesthesia

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Litigation

- Ethics
- Claims
- Informed consent
- Standards of Care

Obstetrics : different ?

- 2 (3?) patients : the fetus as a patient ?
  - Neonatal resuscitation
  - Partner : who is responsible ?
- Parent expectations
  - vs Anesthetist preferences & expertise
- Decision taking (mother & doctor)
  - ‘Time’, change of plans, transition to CS

Obstetrics : different ?

- Specific maternal problems
  - Difficult intubation : 1/290
    - *Fiberoptic intubation : a must ???*
- Residents : Supervision at a ‘distance’
- More night-time job for anesthetist ?
- Neonatal care center
  - not always the best for the mother

Delivery options

- **C-section on request**
- **Home delivery**
  - decreasing in Netherlands (29%)
  - increase elsewhere : Belgium 1%
  - 10-15% of ‘normal’ pregnancies may require an ‘intervention’
  - emergency transfer to hospital / CS
  - is the anesthetist to be blamed ?
    - Flat baby : drugs, resuscitation, delay….

Claims

- **Mother :** **unsatisfied or ‘real harm’ ?**
  more minor injuries
  more payment (x 2 à 3)

  Chadwick et al, Anesthesiology 1991
  Ross, Anesth Clin North Am 2003
  Lee et al, Anesthesiology 2004

- **Anesthetist often involved even if it is clear that injury is not related to anesthesia**

Claims : US

- **Closed claims** : 3533 cases up to 1996
  - 12% (n=434) : OB anesthesia related
  - Damaging event : respir. 18%, convulsion 9%
  - Injuries :
    - 19/22% mat. death (airway, GA, urgent)
    - 19/27% newborn brain damage / death
    - 10/20% mat. nerve damage (RA)

IJOA 1996; 5: 258-263

ANAA J 2002; 70: 97-104

Claims : US

- 12% (n=434) : OB anesthesia related
  - Injuries :
    - –15% headache , 8% back pain
    - –9% pain during anesthesia
    - –7% emotional distress
  - *Awareness ??*
  - *Hematoma ?*

IJOA 1996; 5: 258-263

Europe : different…

- Expectations
- Practice
  - LRA for labor : <10%-80%
  - Different within 1 country
- Safety standards
  - One- or more-table system
- Midwife tasks
  - From zero to anesthetic management

Belgium : midwife task

- ***was not allowed to place the epidural, nor to maintain it***
  - **What about CEI / PCEA ?**
  - **Replacement of syringes ?**
  - **Catheter removal ?**
- **actually more tasks allowed**

Claims : Belgium

- 1980-1997 : n=29
- Only 10-15% reaches court, <15-20y>
- Others:
  - Patient claim : no further proceeding
  - Pre-trial settlement
- 7/29 cases : anesthetist sued but no anesthesia-related event : discharged
- But 50% considered as ‘criminal’

Claims : Belgium

- Labor : n=14
  - Anesthesia not involved (4) :
    - NN resusc (2), uterine rupture, nerve damage
  - Catheter fracture (2)
  - Shock (subcl cath, myocardial perforation)
  - Subdural hematoma
  - Minor permanent spinal cord damage(3)
  - Severe permanent damage (3)

Claims : Belgium

- C-section : n=15 (7 deaths)
  - Anesthesia not involved (3) : (postop)
    - Asthma, bleeding, myocard insufficiency
  - Dental (2), ulnar nerve
  - Cauda equina, conus medullaris(2)
  - Severe permanent damage (7)
    - Total spinal (1), GA (6)

–6/7 deaths : organisational problem

Loss of time

- **Question nr 1 :**
  - ***..when did the anesthetist arrive ?***
    - **Mostly time-loss in decision-making**
  - **Survey New Jersey (Kravitz et al,JAMA 1991)**
    - **Claims for time-loss : 31%**
    - **Claims for poor-indication CS : 3%**
- **OR remote from main OR**
    - **Sterility, experience, training, emergency**

Pain during labor/C-section

- **The most common success for claim ?**
- **Reason for a claim ? For not-paying ?**
- **How to avoid a trial in court ?**
  - *Assessment of block pre-incision*
  - *Recording of assessments*
    - *pain, no problems, painfree throughout, ..*
  - *An apology : does not mean ‘fault’*
  - *Informed consent*

Informed consent

- What the patient should be told
- When ?
- Repeated for every delivery ?
- Informed consent for
  - Labor
  - C-section
  - Labor + C-section
  - Studies

Informed consent

- **Should not be considered as a malpractice protection (defense)**

- **Does not prevent claims**
  - *Patient can sue the anesthetist if she can show that there was 'substandard care' (e.g. pain during C-section)*

Informed Consent : when ?

- **Long enough before delivery (for all) ?**
  - **Can she judge when there is no pain?**
  - **Dissuade 'Informed refusal'**

    'I don't want regional anesthesia (even if….)'
- **During labor / pain / fatigue / pressure**
  - **Is she alert enough to understand ?**

    NO : Rolbin CJA 1989, Swan, AIC 1994

    YES : Hoehner / Kuczkowsky, JCA 2003

Informed consent

- Are they able to give consent ?
  - SOAP survey, Saunders et al, IJOA 2006
    - 68% of anesthetists found they could
    - 13% suggested antenatal conults
  - Australian, Black & Cyna, AIC 2006
    - 70% thought they could not
    - recall is poor regardless of info-moment
    - Information best in late pregnancy ?

Midwifery 2007

What women want ?

- They want to take decisions : autonomy
- No paternalism : the doctor should not decide what is good for them
- Individual (rather than a group)
- Anesthetist should not decide what mothers should be told : mothers should
- Comprehensible language (Flesch Kincaid)
- Info varies over time & region

How much information?

- Australia : women overestimate their knowledge, mostly ‘anecdotical’
- The 1% rule ?
- Does ‘knowing all the risk’ prevent them from choosing an epidural ?
- *Chapman & Wolff, Anaesthesia 2002*
  - Minimal : 8.4%
  - Partial : 41.1%
  - Full : 50.4%

What women want ?

- *Jackson et al, Can J Anesth 2000*
  - 60 women in labor
  - Majority : ALL potential complications
  - Understanding rated 4.9/10
  - 95% : 10min. interview + recall
  - Risks do not withhold them from RA

What women want ?

- ***Kelly et al , IJOA 2004; 13: 71-4***
  - **100 parturients (UK)**
    - **>82% : common, less severe compl.**
    - **>70% : also rare, but more severe complications**
      - **neurol. deficit, high spinal, meningitis**
      - **frequently complications that pts would consider important are not discussed**

What women want ?
UK vs US vs Australia

- ***Bush et al , IJOA 1995***
  - **US : more info about risks**
- ***Bethune et al, IJOA 2004; 13: 30-4***
  - **100 Australian vs 100 UK parturients**
    - **UK : more information via media / IV**
    - **Australia : more info from anesthetist / infection**
- ***Black & Cyna, AIC 2006; 34: 254-60***
  - **Top-5 : PDPH, block failure, neurological injury, temporary leg weakness, hypotension**

Informed Consent : issues

- Increasing autonomy of midwives
  - **Home-deliveries :**
    - *are mothers sufficiently informed ?*
  - **Prenatal sessions without anesthetists**
  - **Are we no more than ‘expert technicians’ ?**
  - **Should we be more ‘pro-active’ ?**
- Does it fall to Courts to settle the issue of validity of consent ?

Patient desire vs anesthetist preference

- Anesthetist should document this in patient records
- Ask obstetrician / other colleague to discuss the issue with the patient
- Patient should sign IC which focuses on the specific problem
- Can anesthetist be sued if ‘his/her’ choice is medically justified ?

  – *Patient preference of GA : can it be refused ?*

Informed consent : studies

- **Vulnerable groups / patients**
  - ***Developping countries***
  - ***Bad news : only 20% recall ?***
- **Informed Consent during labor ?**
  - ***Best before, partner, witnessed,….***
- **For ALL patients ?**
  - ***Dural tap and subsequent strategies***

Cohen et al, AAS 1994

N=45

epidural vs CSA alone vs CSA+24h CI

33% **47%** **0%**

PDPH

Ayad et al, RAPM 2003

N=115

epidural vs CSA alone vs CSA+24h

81% **31%** **3%**

PDPH (47%, EBP 36%)

Studies

- **Are some studies ethically justified ?**
  - CSA
  - Epidural vs systemic analgesia
  - PDPH / EBP
    - Quincke needles <27G
      - *Anesth Analg 2002; 94: 233*
  - MLAC studies (comprehensible ?)
    - C-section, VAS<30 ?
      - *Parpaglioni et al, ESRA 2008 (abstr)*

Studies

- **How double-blind are they ?**
  - Epidural vs systemic
    - Unblinded obstetrician
  - Addition of opioid/clonidine to LA
    - Pruritus : 90% ?
    - Hypotension

Informed consent : studies Consenters vs decliners

- ***Dorantes et al, Anesth Analg 2000***
  - **166 consenters vs 109 decliners**
    - **Most important reason for consent :**
      - ***Understanding, perceived importance and benefit for other mothers***
    - **Decline : 41% due to pain…. (pressure?)**
    - **Consent : could read form completely, participated before, not anxious**

How to avoid problems ?

- Information
  - Leaflet (not a booklet), video
- Prenatal visit (possible ? distance ?)
  - Possibility for in-depth information
- Be nice and friendly (apologies)
- Guidelines / Standards of Care

Standards of Care

- Differ from country to country
  - *ASA, ACOG, OAA, …*
- Are not a limitation of freedom
- Standards & guidelines :
  - Concensus by medical authority
  - Standards : to be followed at all times
  - Guideliness : more flexible

Standards & Guidelines

- Evidence based (ref classified A to D)
- Not too rigid
  - *No time intervals, doses, ….*
- Define ‘clinical’ responsibilities of the midwife and other colleagues
  - *For anesthetist : mother’s life prevails*
  - *Obstetrician and neonatologist*

Further reading

- *Scott W, Anaesthesia 1996; 51: 717*
- *Kuczkowski, J Cl An 2003; 15: 573*
- *Roberts, Anaesthesia 2002; 57: 1213*

- **Hoehner, J Cl An 2003; 15: 587-600**
- **Chervenak, A & A 2003; 96: 1480-5**