Obstetrics Hospitalists

Risk Management Implications

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KEYWORDS

• OB hospitalist • In-house obstetrician • Laborist • Risk management
• Perinatal safety net • Obstetric emergencies

KEY POINTS

- In-house obstetricians provide a safety net for management of obstetric (OB) emergencies that may require expertise and rapid intervention in order to adequately respond to these situations.
- There are emerging data that the presence of OB hospitalists on a perinatal unit improves maternal and newborn outcomes.
- There is a broad spectrum of activities that allows OB hospitalists from any given model to participate in risk management activities at multiple levels in the organization.

RISK MANAGEMENT, CLAIMS, GETTING TO HAVARTI

Risk management has evolved as an independent discipline and profession that is based on the classic concepts of loss prevention and loss reduction.[1] Hospitals generally have an individual designated as a risk manager. This individual may have an independent position or may have other combined duties within the patient safety or quality components of the organization. A significant part of hospital risk management is the management of medical malpractice claims. According the American Society of Healthcare Risk Management, obstetrics (OB) continues to be a leading source of severity of medical malpractice claims.[2] Results of the 2012 Professional Liability Survey conducted by The American College of Obstetricians and Gynecologists (ACOG) showed that neurologically impaired infant claims were the most common claim against obstetricians (28.8% of 2564 claims), stillbirth or neonatal death was the second most common claim (14.4% of 2564 claims), and delays or failure to diagnose were allegations in 11.1% of these claims. The respondents were asked in the survey to identify other factors that applied to OB claims. These factors included

Disclosures: There are no commercial or financial conflicts of interest or funding sources to report.
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Obstet Gynecol Clin N Am 42 (2015) 507–517
http://dx.doi.org/10.1016/j.ogc.2015.05.008 **obgyn.theclinics.com**
0889-8545/15/$ – see front matter

electronic fetal monitoring (20.9%), shoulder dystocia/brachial plexus injury (15.1%), and interactions with OB-gynecology (GYN) residents (11.4%).[3]

Getting to Havarti is a metaphor that this author has advanced for improving safety in the perinatal unit.[4] The Swiss cheese model of James Reason[5] is an important concept describing how accidents occur in complex organizations such as labor and delivery units. Reason's[5] model suggests that when failures in existing defenses and safeguards coincide, the trajectory of a potential accident can penetrate all of these accident protections to cause an injury. The idea of making the holes in the Swiss cheese smaller (ie, getting to Havarti; a Danish cheese with very small holes) is a metaphor for targeting certain areas of a perinatal unit to tighten defenses and safeguards so the chance of penetration by an accident's trajectory is reduced and most often deflected. The idea of placing an obstetrician in house, 24 hours a day, 7 days a week, is one recommendation that theoretically should tighten a perinatal unit's defenses (therefore reducing the size of the holes) and subsequently reduces the chance for patient injury. This safety net offers one of the best risk management loss prevention strategies available to a perinatal unit, particularly to labor and delivery.

Common Obstetric Practices That Can Weaken Defenses

What makes the holes in the Swiss cheese larger?

- The obstetrician may need to be in 3 or 4 places at once. Because of the demands of an OB-GYN practice, an obstetrician can be scheduled in the operating room, the office, and have patients in labor at 1 hospital, and sometimes 2 hospitals, at the same time.
- High-volume practice. Booking a large number of patients that might be delivering at more than 1 hospital puts stress on the practitioner's ability to see all of these patients in the office as well as attend all of the deliveries.
- Poor sign-out practices. Multiple providers caring for 1 patient can sometimes result in confusion about changes in the patient's condition or who is in charge of the patient's care at any given time.
- Inadequate protocols for consultation, referral, or transfer. This situation can result in confusion and, at times, variation in the timing and the nature of consultation between midwives, family physicians, obstetricians, and perinatologists.
- Acquiescing to patient requests that are may be unsafe. There can be the temptation, at times, to yield to pressure from patients; for example, to perform an elective induction earlier than 39 weeks or to allow a trial of vaginal birth after caesarean when there may be inadequate immediately available personnel or operating room space available during a trial of labor after cesarean within the hospital.
- Off-site monitoring of high-risk situations. The demands of an office practice, the operating room, or the need for sleep can sometimes take the physician away from the patient's bedside during a critical situation.
- Operation of hierarchy and the lack of teamwork when it comes to safety issues. OB care has come to be recognized as a team effort and there are occasions when not listening to safety concerns of nurses or house staff can result in failed recognition of a potential problem.
- Backup may be inadequate. Because of the nature of the practice group or the call sharing agreements (or lack of such) within the community, obstetricians may find that they are without backup to care for patients when they are otherwise occupied.