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Medical Negligence Lawsuits Relating to Labor and Delivery

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Most allegations in obstetric lawsuits against obstetrician-gynecologists relate in some manner to the management of labor and delivery; few solely involve perceived flaws in prenatal or postpartum care. In fact, at least 60% of obstetric medical negligence claims relate to events alleged to have occurred during labor and delivery [1]; these account for more than 80% of the damages awarded in suits against these specialists. Although many of these cases accuse the defendant of not having properly monitored the fetus during labor for signs of oxygen deprivation, there is in most cases an underlying allegation regarding proper decision making about the timing and route of delivery. A perspective on accusations relating to the failure to identify or to act on intrapartum asphyxia has been presented elsewhere in this issue. This article focuses on legal allegations that arise from the conduct of labor and the timing of delivery, independent of those related to fetal monitoring.

Although adverse outcomes from the events of labor and delivery that can be attributed to substandard practice are uncommon, when they do occur, the consequences for the affected mother and child can often be profound and enduring. Most of the preventable complications that lead to litigation arise from violation of a few basic principles of intrapartum care.

It is ironic that during the last three decades, as concerns about the number of lawsuits related to the management of labor and delivery have increased relentlessly, emphasis on teaching the fundamentals of intrapartum obstetrics in training programs has waned, in favor of education in areas involving new electronic or biologic technology (eg, endoscopy, ultrasound, genetics, prenatal diagnosis, and so forth). This relative neglect of

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fundamental obstetric knowledge and practice has had an impact on patient care and the allegations of negligence in the medicolegal arena. That is not to diminish the value of acquiring knowledge and skills based in contemporary biology and technology, because they are important, but they should not be gained at the expense of fundamentals of obstetrics and the building blocks of good clinical judgment. By analogy, a cardiologist who understood the molecular and genetic basis of cardiac ischemia but who had difficulty formulating and carrying out a treatment plan for acute myocardial infarction would be likely to have adverse patient outcomes.

In medicolegal proceedings, the courts expect the defendant obstetricians be familiar with the basic aspects of their specialty. It is indeed distressing in the extreme to hear plaintiff attorneys at trial who have a better grasp of obstetric fundamentals (in the sense of understanding basic terminology and familiarity with relevant medical literature) than the defendant physician. Many defendants are flummoxed by being asked to define, for example, engagement of the fetal head or arrest of dilatation, or to explain the difference between position and presentation, or between engagement and 0 station. Equally telling is the cavalier description of labor as "normal" when the milestones of normal progress have not been met.

The tort system

There are many obstetric malpractice suits that are based on questionable theories of departure from the standard of care or of causation of injuries, and some suits involve frivolous or even ludicrous allegations. This has led many obstetricians to view the plaintiff bar and the tort system as their enemies: the former as venal reprobates and the latter a reliquary of inefficiency and unfairness, both woefully unqualified to pass judgment on the arcane processes of obstetric care. Enormous time, money, and energy have been expended in attempts to reform the tort system, with success in some states and failure in others. Whether the enacted changes (mostly related to capping economic damages for pain and suffering) will have a significant impact on the costs of the system, the number of claims; malpractice premiums; or the level of physician stress, anxiety, and financial risk remains to be seen. These changes have not had any clear impact on perinatal outcome.

It has been argued that the tort system did not create the current malpractice insurance crisis and that we should not, therefore, look to reforms in the tort system to solve the problem [2]. The authors agree. The demon that fuels the core of today's malpractice insurance crisis is poor obstetric practice. Meritless suits, unreasonable allegations, and irrational fears are in many respects the side effects of the disease. Without addressing the core issue of deficient practice, it is unlikely that we ever unburden ourselves of the medicolegal albatross.