Labor and Delivery

Linda Garrett/Suzanne van Hall

- Defining the legal parent and who can make decisions
- Adoptions and surrogacy issues: consent, baby-friendly visiting, infant security, birth certificates
- Guidance on which obstetric procedures require informed consent or basic consent
- Drug testing and reporting
- Adverse event checklist

Defining the Legal Parent and Who Can Make Decisions

- Birth mother?
- Man married to mother?
- Woman married to mother?
- Man who claims paternity if the mom is unmarried?
- Other?
Basic Rule

- Decisions regarding care of the infant and discharge of the infant will be made by the legal parent or guardian.
- Adoptive parents, including parents in a surrogate birth, may be the legal parent if there is a completed adoption and a court has issued an order confirming the completion of the adoption.
- In all other cases, the birth mother remains the legal parent or guardian unless other circumstances are present (such as DCFS taking custody of a child).
- And father married to birth mother can be a legal parent.

Surrogacy Consent

- Obtain documents on the surrogacy, including any court adoption orders.
- Participation in the labor and delivery process by the surrogate parents may be allowed with joint written consent of physician and birth mother.
  - Participation is limited to that of observer.
  - Birth mother retains all rights to make all medical decisions during delivery.
- Adoption not completed.
  - Contact between the infant and the prospective adoptive parents following delivery, for the purpose of bonding, allowed only with birth mother’s consent.
  - Birth mother’s consent needed for the baby’s care.

Surrogacy: Adoption Completed

- Legal adoptive parents have the right to make decisions regarding contact with the infant and visitation of the infant.
- No rights to make decisions regarding the birth mother’s care.
- No need to complete the Health Facility Minor Release Report Form when the baby is released to the legal adoptive parents.
**Surrogacy: Baby-Friendly Visiting**

- Goal is to have as much time as possible with mom
- In surrogacy situations, consider arrangements for baby-friendly visits
  - If adoption is complete, legal adoptive parents can visit with baby; consider set up
  - If not complete, surrogate parents can still visit, but as visitors with birth mom’s consent
- Birth mother wishes relative to staying on the maternity unit or (condition permitting) transferring to a medical/surgical floor, level of contact with her infant and ultimate adoption planning decisions (including option of reconsideration) should be discussed and honored

**Other Adoptions**

- Birth mothers considering relinquishing their newborns will be interviewed by the clinical social worker to assure the birth mother understands her rights and her baby’s rights
  - If the adoption is unplanned, staff should inform the birth mother who is considering adoption of her options, provide a list of adoption agencies that can be contacted, and help facilitate the connection and coordination with the adoption agency of the birth mother’s choice
  - If an agency adoption has been arranged, the birth mother to provide the documents for the adoption
  - Hospital employees **cannot** act as adoption agent for him/herself or others
- Agents for adoption may **not** have access to the medical records of the mother or the infant without a properly executed “Consent for Release of Information” signed by the birth mother

**Infant Security**

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Banding Mom and Visitors

- Infant security requires each hospital to adopt its own policies to protect infants.
- Birth mom needs to be banded throughout the concurrent stay of birth mom and baby.
- Baby’s dad generally given a parent band and access to baby.
- If an adoption has been completed, the legal adoptive parents can be banded.
  - Baby is double banded then for birth mom and legal adoptive parents.
- Other visitors (grandparents, siblings) are not banded.

Discharge of the Infant

- If the infant is discharged to other than the birth mother, father married to birth mother, or legal adoptive parents, the birth mother will be asked to complete the Health Facility Minor Release Report Form.
  - This form does not grant or affect any legal parental rights.
  - It only allows someone other than a legal parent to take the infant from the Hospital upon discharge.
  - Section of the form can be completed to authorize a person to give consent.

Completion of Health Facility Minor Release Report

Hospitals must complete the “Health Facility Minor Release Report” whenever a minor patient under the age of 16 is discharged to someone other than:
- A parent.
- A person who has legal custody.
- A relative by blood or marriage (such as a step-parent or grandparent).
- An agent of a public welfare, probation, or law enforcement agency if the minor has been adjudged to be a dependent child or ward of the juvenile court.
- For transfer of the minor to another health facility for further care.

Health and Safety Code Section 1283(b).

The form needs to be completed for children on a CPS hold since they have not yet been adjudged to be a dependent child or ward of the juvenile court.
Adoptions and Surrogacy: Birth Certificates

- Birth certificates always have the name of the birth mother.
- If a legal adoption has been completed, the court order may indicate how the birth certificate is to be completed.
- Unmarried parents:
  - California law provides for the voluntary acknowledgment of paternity.
  - Before discharge, the Birth Mother must be provided with oral notice regarding the voluntary declaration of paternity along with written materials provided by the California Department of Social Services.
  - Upon completion of the voluntary acknowledgment, the birth certificate can be amended.

Consent Manual, page 10.16

Consent for Obstetric Procedures

- Ideally patients get excellent education about various procedures as a part of their prenatal care.
  - Discussions about the delivery process and fetal monitoring.
  - Identifying and addressing concerns and preferences patients may have.
  - Going over a birth plan and what can and may not work.

Specific Legal Requirements
Licensed Nurse Midwives

- Licensed Nurse Midwives:
  - Requires nurse midwives to inform patients of their status and limits on the scope of their practice.
  - Must document in writing. Can use “Licensed Nurse Midwives” form suggested by the Medical Board of California, plus a copy of Business and Professions Code Section 2507.
  - Must secure written informed consent for a vaginal birth following cesarean (VBAC).

Consent Manual, page 10.1
CNM VBAC Requirements

- The current statement by the American College of Obstetricians and Gynecologists regarding its recommendations for VBACs
- A description of the licensed midwife’s level of clinical experience and history with VBACs and any advanced training or education in the clinical management of VBACs
- A list of educational materials provided to the client

CNM VBAC Requirements (cont.)

- The client’s agreement to:
  - Provide a copy of the dictated operative report regarding the prior C-section;
  - Permit increased monitoring; and,
  - Upon request of the midwife, transfer to a hospital at any time or if labor does not unfold in a normal manner.
- A detailed description of the material risks and benefits of VBAC and elective repeat C-section
  
  Title 16, California Code of Regulations, Section 1379.19

Specific Legal Requirements

Blood-borne Disease Testing

- Blood-borne disease testing is required
  - Rh blood type
  - Presence Hepatitis B surface Antigen
  - Presence human immunodeficiency virus (HIV)
- Not required
  - If results already known
  - Patient refuses
- Timing
  - As early as possible in prenatal testing

Consent Manual, page 10.1-10.2
Information to Be Provided About Blood-borne Diseases

- Prior to testing, the prenatal care provider must explain:
  - The intent to perform HIV, hepatitis B and Rh blood type testing
  - The routine nature of the test
  - The purpose of the test
  - The risks and benefits of the test
  - A description of the modes of HIV transmission, including the risk of perinatal transmission of HIV
  - A discussion of risk reduction behavior modifications, including methods to reduce the risk of perinatal transmission
  - The approved treatments known to decrease the risk of perinatal transmission
  - That the woman has the right to decline the test.

HIV information and counseling

Informed Consent for OB

- Informed consent appropriate if the procedure involves risks that are not commonly understood
- Informed consent refers to a process in which the doctor discusses with the patient (or a surrogate decision-maker if the patient is not competent), the recommended treatment and its expected benefits and possible risks and the alternatives and their benefits and risks
  - Hospital policy should require confirmation informed consent was given by having the patient sign the Consent for Surgery and Special Procedures
  - Hospital policy should confirm that the doctor is responsible for presenting and discussing the treatment options with the patient

Obstetric Procedures that Warrant “Informed Consent”

- A suggested list for consideration:
  - Epidural
  - Cesarean section
  - Episiotomy or laceration repair that requires surgical repair in the OR (with anesthesia)
  - VBACS
  - Any procedure a doctor specifically decides poses a special risk to his or her patient that the doctor decides warrants the informed consent process and documentation
- Policy should define when “informed consent” is required so doctors and staff can assure the process is fully completed (discussion and documentation)
Basic Consent for OB Procedures

- Basic consent required to avoid “assault and battery.”
- The doctor (not the nurse) should explain to the patient what he or she intends to do (whether to use a vacuum during delivery, or start Pitocin), and answer any questions the patient has about the proposed care.
- As always, the patient does have the right to refuse the recommended care. The doctor should document a refusal:
  - In a progress note, or
  - Refusal of Treatment form

OB Procedures that Require Basic Consent

- Often addressed during prenatal care but good to review at the time.
- Suggested list:
  - Vacuum
  - Forceps
  - Episotomy and repair (except 4th degree)
  - Pitocin
  - IUPC fetal monitoring
- No need to complete forms for consent. Good practice to mention the discussion in the delivery note (e.g., explained to patient and proceeded with …)

No Specific Consent is Required

- Some procedures do not require even basic consent.
- Given their risks and nature, there can be agreement any staff (doctor or nurse) can explains the procedures. Suggested list:
  - Fetal monitoring (except perhaps IUPC)
  - Vaginal delivery
Drug Testing and Reporting

- Positive toxicology screen alone not sufficient indication for child abuse reporting
- Required to complete assessment of risk
  - Risk a mother cannot care for the baby due to substance abuse to be reported to county welfare only and not law enforcement
- Is automatic drug testing OK?
  
  Consent Manual, page 10.2

Labor & Delivery Adverse Event Checklist

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With thanks to Dave Lucchese & Teresa Moran

A Difficult Case

- 33-year old patient with pregnancy complicated by obesity, hyperemesis, poor fetal growth and pregnancy induced hypertension
- During 3rd trimester, baby’s growth dropped from 30 percentile to 10 percentile
- Spontaneous rupture of membranes at 39 weeks, 2 days
### A Difficult Case

- Mother with severe hypertension
- Normal spontaneous vaginal delivery
- Fetal heart monitoring—tracing during 2nd stage of labor reassuring but also areas of minimal to moderate variability with occasional late decelerations with no signs of abruption

### A Difficult Case

- Apgars 1, 6, & 7; no blood gases
- Baby limp and thick particulate terminal meconium was noted.
- Cord wrapped around the shoulders
- In the ICN, the baby’s condition was characterized as “secondary to hypoxic-ischemic perinatal injury”
- The parents are claiming that there should have been an early C-section

### First Question: Did You Get a Call About this Event?

- Key to strong relationship between Quality, Risk and Perinatal group:
  - Trust
  - Incident reporting – Insurance and Excess insurance
  - Regular educational programs, including orientation
  - Attendance at departmental meetings
  - Input into policies and procedures — do we have policies we can follow?
First Question: What Should be Reported?

- Precautionary Incident Notification (PIN) is (1) an adverse event or complication resulting in death, brain damage, permanent paralysis, sensory deficits, partial or complete loss of hearing or sight, birth injury or disability, or other catastrophic damage or permanent disability; (2) an incident anticipated to result in potential liability exposure or a claim
- Put this definition in your M & M form

Why More Adverse Events in OB?

- Even though the clinician’s role is to assist with a natural process, when there is high risk or Mother Nature does not cooperate, the damages can be large
- Have we created unrealistic expectations in OB?
- Is our care really too “patient centered”?

Why More Adverse Events in OB? (cont.)

- Clear high risk patients – acuity
- Presence of multiple providers from different disciplines
- Unpredictable timing of events over a long period of time and across several shifts
- Some people have not worked together before
- Outside interference by patient, doula, midwife?
The Importance of an Adverse Event Checklist

• Need to sort through known fact from speculation
• Review whether there is timely, accurate and objective documentation of the timing of labor, delivery and immediate post-delivery care
• Help clinicians communicate with patient and family
• Document in an objective manner

Checklist Objective

• To develop a more systemized way to respond to an adverse event — goal is that the clinicians are as much aware of the checklist as risk management, nursing and administration
• Real-time or close to real-time documentation will reduce the chance that the facts will be “reconstructed” by patient or attorney

The Placenta

• The placenta can provide a fetal history of gestation
• It can tell you information about:
  • The mother
  • The child
  • Prediction of problems with future pregnancies
  • Causes or contributing factors to an adverse event
The Placenta

- Important to determine chorioamnionitis, abruption and cord anomalies associated with congenital defects
- If there is an obvious anomaly noted at delivery — such as a true knot — photograph before it is sectioned
- Consider that providers can be lulled into a false sense of security because a delivery seems normal

The Placenta

- Do you have a policy for when the placenta is sent to Pathology for a gross and microscopic evaluation? Address triage, storage and release
- Most hospitals do not send all placentas for detailed path review — but consider a retention period to decide
- Develop a list of indicators for study and retention

The Placenta: Some Indicators for Exam

- Diabetes
- Hypertension
- Prematurity
- Post-maturity
- Maternal hx
- Fever or infections
- Drug use
- Abruptio
- Intrauterine death
- Congenital anomalies
- Fetal growth retardation
- Hydrops
- Meconium
- Neonatal ICN admit
- Apgars of 3 or less at 5 minutes
- Neuro issues
- Gross abnormality
The Placenta — What Does it Tell Us?

- Examples:
  - Umbilical cord: tells us the function of fetal activity — the delivery of oxygen and nutrients
  - Thickness can indicate the amount of amniotic fluid
  - The cord can tell us the gestational age
  - The placental disk, extra placental membranes, fetal surface, and maternal surface can tell us many more things

A Checklist

- Manage documentation issues — is there a labor note?; notes during labor process?
- Obtain cord gases and manage placenta
- Sequester medical records and fetal strips (with patient ID) (make sure you have a system to retrieve after departmental M & M)
- Sequester the equipment and maintain any settings or readings as they were at the time of the event

A Checklist

- What lab work will be done?: toxicology, work up for thrombophilia, thyroid, infection
- Interaction with neonatologists, pediatricians, pediatric neurologists, radiologist, pathologist
- Avoid speculative causation statements, e.g., “asphyxia,” “birth trauma,” “secondary to hypoxic-ischemic perinatal injury” — to them it is an interesting case, but speculative root cause should not be in the record
Checklist: Documentation

- Timely H & P
- Contemporaneous, frequent and *timed* progress notes — charting at the end of shift does not work
- Note evidencing intervention and rationale, especially if there is planned deviation from a policy — why oxytocin, amnio-infusion, instrumental delivery, C-section
- BUT, no late entries — days and days later — don’t assume common sense

Checklist: Documentation

- Look at original strip for handwritten notes — keep
- Notes about patient refusal for C-section or other care — often not noted. Informed refusal language is key — notes that family was involved
- Note external interference with care
- Delivery note commenting on placenta and cord

Checklist

- Consider genetic testing or body or head cooling — does the baby need to be transferred for cooling?
- Policies: Did we follow them; is there still time to follow policy?
- Quality Reviews: Make sure this is conducted consistent with Evidence Code section 1157
- Do key interviews close to real time
**Additional Questions to Ask**

- What was the census that day — how many deliveries?
- Were there staffing issues?
- How many hand-offs occurred during the labor and delivery period? Quality?
- System for the team to become oriented to the strip over time, especially at hand-off?
- Trainee supervision?
- Midwife — any scope issues?

**Additional Questions to Ask**

- If there was a C-section, was it done timely? Is there a difference in philosophy on C-section rate?
- Opinions about stages of labor?
- What training do your trainees have at other hospitals?
- Were there notes written with red flag language: “fetal distress,” “inadvertent,” “accidentally,” “erroneously”

**Additional Questions to Ask**

- Was there a delay for anesthesia, IV placement, physician response?
- Was the “Chain of Command” followed in response to delays?
- Did staff allow external forces to interfere with interventions? What is the culture in the unit?
Evidence Code Section 1160

- Statements, writings or “benevolent gestures” expressing sympathy made to a person or his/her family are not admissions of liability
- “Benevolent gestures” are actions that convey a sense of compassion or commiseration
- A statement of fault is admissible, though
  
  *Consent Manual, page 21.5*

Disclosure of Adverse Events

Outcomes may be unanticipated due to:

- Uncorrected “unreasonable” expectations
  — NOTE: Consent discussion is important
- Biological variability
- Low probability risks and side effects
- Wrong judgments without negligence
- Medical or systems errors

To Complicate Matters: Jury Instructions

Alternative Methods of Care:
- “A physician is not necessarily negligent just because he chooses one medically accepted method of treatment or diagnosis and it turns out that another medically accepted method would have been a better choice”

Success Not Required
- “A physician is not necessarily negligent just because his/her efforts are unsuccessful or he/she makes an error that was reasonable under the circumstances. A physician is negligent only if he/she was not as skillful, knowledgeable, or careful as other reasonable physicians would have been in similar circumstances”
- These are difficult to explain to patients after an event
How to Disclose — After the Event

- Talk about how the patient’s care will be managed
- Arrange for appropriate consultants
- Advise family of identity of contact person
- Inform risk management and preserve equipment/relevant information
- Ensure follow-up — disclosure may be an ongoing process, don’t think you have to have an immediate answer
- Document the event and the disclosure
- Advise other staff e.g., nurses, of the plan for disclosure so message to patient/family can be consistent

After the Event

- Remember, the people taking care of the baby after the delivery are not the ones responsible for the labor and delivery
- Make sure the ICN staff is knowledgeable about discussion and to avoid speculation on causation or gossip

How to Disclose — Before the Meeting

- Decide time and place to disclose
- Decide who should disclose (attending physician or designee)
- Decide who should attend — consider whether the family will feel overwhelmed
- Obtain permission from patient to speak to the family as needed
- Consider patient/family’s emotional state/need for privacy
How to Disclose — The Meeting

• Empathize and make eye contact and open posture
• Consider health literacy of the patient/family
• Verify patient’s/family’s understanding of the outcome and prognosis
• Discuss objective information contained in medical record
• Do not discuss confidential protected discussions with risk management or peer review process
• Turn off your pager and phone

How to Disclose — Do Not Communicate the Following:

• Subjective information
• Conjecture or beliefs
• Confidential information (peer review, incident reports, risk management)
• Speculation or blame

Grief and Mourning Strategies

• Seeing, holding baby
• Mementos
• Naming, blessing or other religious traditions
• Funeral plans
• Social work and pastoral referral
• Mental health
• Cultural support groups
Questions?

Thank you

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