Statement by
The American College of Obstetricians and Gynecologists, District II
Regarding Patient Safety and Improving Reporting of Adverse Events

The American College of Obstetricians and Gynecologists, District II (ACOG) represents nearly 4,200 board-certified obstetrician-gynecologists in New York State who deliver quality health care to New York’s women and are dedicated to advancing women’s health through education, advocacy, practice, and research. ACOG is a private, voluntary, non-profit organization with an office in Albany and a national headquarters in Washington, D.C.

Adverse Events

Although advances in obstetrical care have resulted in striking improvements in maternal outcomes over time, studies suggest that a substantial number of quality improvements can still be made. Because of this, ACOG is committed to finding viable and long-term solutions to medical errors in the field of obstetrics and gynecology. As part of its patient safety efforts, ACOG has initiated numerous measures to decrease the occurrence of adverse perinatal events.

Adverse events, preventable or otherwise, are an uncomfortable reality of medical care. The Institute of Medicine has proposed a multifaceted approach toward reducing and managing adverse events, including the establishment of a national focus on patient safety, the creation of a mandatory reporting system, raising standards and expectations for safety improvements at the national level, and creating safety systems in health care organizations. Despite continuing efforts to prevent their occurrence, adverse events may happen even in the absence of medical error. Thus, there is a need for health care providers and institutions to understand how to best disclose and discuss these adverse events with patients and their families. ACOG supports these efforts and seeks to assist its ob-gyns in understanding the value of disclosure and discussion in the face of preventable and non-preventable adverse events and to provide guidance for such conversations.1

Additionally, physicians have an ethical obligation to communicate honestly with their patients. Disclosing information about unanticipated adverse events likely has benefits for both parties through a strengthened physician-patient relationship and a promotion of trust. Studies show that in the event of an adverse outcome, patients expect and want full disclosure of the event(s), an acknowledgement of responsibility, an understanding of what happened, expressions of sympathy, and discussion of what is being done to prevent recurrence(s). Additionally, disclosure of adverse events can be important for the physician’s personal healing.2

Patient Safety

Patient safety is an explicit principle that must be embraced as a core value in patient care. This is an on-going process that requires health care professionals to continually strive to learn from problems, identify system deficiencies, redesign processes, and implement change in their daily practice. Patient-centered care, open communication, and teamwork provide the foundation for optimal patient care and safety.

2 Ibid.
Adverse events in the health care setting directly affect patient safety and quality improvement, particularly in the field of obstetrics and gynecology. Patient safety emphasizes a systems analysis of medical errors and minimizes individual blame and retribution. To improve patient care and reduce medical errors, ACOG encourages all health care providers to commit to a culture of patient safety; to implement safe medication practices; to reduce the likelihood of surgical errors; and to improve communication.  

To fulfill its mission to decrease adverse perinatal events by promoting patient safety and quality improvement initiatives for New York State ob-gyns, in July 2009 ACOG hosted a one and one-half daylong conference entitled, “Implementing Patient Safety Systems in Obstetrics.” This conference was designed to provide introductory patient safety education to obstetric providers across the state. Best practices were discussed and tools (i.e. ways to improve outcomes and reduce risk, and perinatal bundles/processes) necessary to develop a successful and sustainable quality improvement and patient safety program were provided. ACOG plans to host two similar courses in 2010.

Fetal Heart Rate (FHR) Monitoring and Electronic Fetal Monitoring (EFM)  

Ob-gyns and their obstetrical teams utilize fetal heart rate (FHR) monitoring to oversee the progression of labor and its impact upon the fetus, intervening when necessary. Electronic fetal monitoring (EFM) is one of the primary and most commonly used FHR monitoring methods to prevent fetal injury that might result from disrupted fetal oxygenation during or prior to labor. Approximately 3.4 million fetuses or 85 percent of approximately four million live births, in the United States were assessed with EFM in the most recent year for which data is available. FHR has become increasingly more widespread and used among 85 percent of laboring women in 2002. In June 2009, ACOG announced its refinement of the definitions, classifications, and interpretations of FHR monitoring methods in order to reduce the inconsistent use of common terminology and the wide variability that sometimes occurs in FHR interpretations.  

ACOG remains committed to improving the way in which EFM data are interpreted as a means to increase patient safety as proper analysis poses a challenge to many obstetrical teams. Over a three month period, ACOG collaborated with the Healthcare Association of New York State (HANYS) and the New York State Department of Health (NYSDOH) and held six train-the-trainer courses across the state to address electronic fetal monitoring (EFM) inaccuracies. Those who attended the courses learned how to standardize the way obstetric teams define, discuss, interpret, and manage EFM tracings. The conference attendees are now training their hospital peers and participate in bi-monthly web-conferences and data collection to monitor their progress.

Further, ACOG is currently offering online EFM courses to familiarize clinicians with standardized definitions for visual interpretation of FHR monitoring patterns as proposed by the National Institute of Child Health and Human Development (NICHD). These online courses are beneficial to clinicians who take part in that they enhance interdisciplinary education and provide clear paths to better communication and satisfaction.

To better understand the widespread nature of EFM interpretation patterns and how inconsistent readings are continually used against ob-gyns and their teams in New York’s fractured tort system, over the next several months ACOG will conduct a closed claim analysis of Medical Liability Mutual Insurance Company’s (MLMIC) insured physicians to gain a focused understanding of the failure by providers to use a standardized EFM nomenclature. This analysis

will enhance ACOG’s patient safety initiatives by guiding further efforts to create a consistent, safe practice environment in which education, training, and certification for obstetric team members is improved and ultimately required. Currently, there is no requirement for ob-gyns and their teams to take part in mandatory EFM training. ACOG seeks to correct this practice.

**Obstetrical Emergency Simulation**

There is no question that problems can arise when physicians or staff perform procedures or use equipment for which they are not trained. To increase the understanding of potentially dangerous outcomes during labor, obstetrical emergency simulation technology can be used to improve clinical performance and decrease the incidence of medical negligence.

Over the past two years, ACOG District II has offered obstetrical emergency simulation training to its annual meeting attendees to practice obstetric emergencies such as shoulder dystocia, breech vaginal delivery, and postpartum hemorrhage through hands-on training. This unique educational tool offers teams the opportunity to work closely with each other to develop clinical skills, effective communication and teamwork skill sets, all of which set the foundation to foster a culture of safety in obstetrics.

Continuous quality improvement starts from the premise that although most medical care is good, it always can be better. The goal is to reduce variations in care and improve performance. Continuous quality improvement accepts that good care depends upon more than just the judgment of the individual. ACOG continues to develop education and curricula to enhance patient safety among obstetricians and gynecologists. The development of common terminologies and the utilization of simulation tools are just two avenues by which to achieve this and to help reduce communication errors thereby reducing adverse perinatal events. Error prevention is not only the removal or retraining of an individual, but must also include a restructuring of the system that created the condition under which the error became apparent. ACOG strongly supports and encourages efforts to improve patient safety in hospitals across New York State and to make health care for all women safer.

To learn more about ACOG District II’s patient safety and quality improvement initiatives, visit [www.acogny.org](http://www.acogny.org).

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5 The American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care, Sixth Edition*, p. 36.