Ethical and Legal Liability Issues in Treating the Pregnant Client

Review of Ethics
Ethics, Liability, and Risk Management Related to Physical Therapy Practice
Practice Management in Obstetrics and Gynecology
Considerations for Specific Prenatal Situations in the Scope of Physical Therapy

Review of Ethics (Gambone 2004)

- Areas of ethical concern within obstetrics and gynecology practice fall into two main categories:
  - Those of high ethical/moral concern, such as in vitro fertilization (IVF), other assisted reproductive technologies (ART), abortion, use of aborted tissue for research or treatment, surrogacy, contraception for minors, and sterilization of the mentally retarded.
  - Those presenting no moral problem; relating to the competence and beneficence of the provider. The majority of day-to-day practice ethical concerns fall into this category.
    - Current areas of ethical concern should include goals, values, ambitions, and preferences of the patient and community at large. (Gambone 2004 a)
- Brief definition and principles regarding ethics:
  - Ethics was derived from a Greek word meaning “pertaining to custom or habit”; morality was the Latin equivalent.
  - Today: morality refers to concepts of right and wrong, and ethics refers to the systematic study of moral behavior.
  - In considering day-to-day practice, four ethical principles are commonly accepted:
    - Nonmaleficence: “first do no harm.”
      - Too stringent an application of this principle could prevent needed treatment. (E.g. radiation will harm good tissue as well as cancerous)
      - Ethical obligation to be certain that recommended medical treatment or testing is not likely to cause more harm than benefit.
    - Beneficence: Promote the welfare of others when in a position to do so.
      - This is a duty when encountering a patient.
    - Autonomy: The right of self-determination. To exercise autonomy, the individual must be capable of effective deliberation and neither be coerced into a particular course of action, nor limited in his or her choices by external constraints. Autonomy may be reasonably limited in certain situations:
      - Prevent harm to others.
      - Prevent self-harm.
      - Prevent immoral acts.
      - Benefit others.
      - Prevent offense to others.
    - Justice: Rational rationing of healthcare resources. Justice becomes more of an issue when resources are limited or scarce.
Ethics, Liability, and Risk Management Related to Physical Therapy Practice

- **Therapist Qualifications:** The APTA Guide for Professional Conduct (Guide) (APTA 2008 a) provides interpretations of its Code of Ethics for applying general ethical principles to specific situations for the physical therapy practitioner.
  - Regardless of practice setting, a physical therapist shall make judgments in care that are consistent with accepted professional standards (Guide 4.1B).
    - Ways to stay abreast of standards of practice: join specialty organizations; read the literature; attend relevant continuing education programs; brush up on high-risk, complex tasks that you perform infrequently (LaDuke 2002).
  - As with all patients, it is pertinent to provide Physical Therapy services within your scope of knowledge, skill, education, training, and experience (Guide 4.1D).
  - If the diagnostic process reveals findings that are outside the therapist’s skills or experience, the physical therapist shall inform the patient and refer to an appropriate practitioner (Guide 4.1F), including (but not limited to) the referring physician or a therapist with advanced training or experience related to the patient’s diagnosis.

- **Informed Consent:** The World Confederation for Physical Therapy (WCPT 2008) expects that therapists will obtain appropriate consent before treatment is begun. In June 2007, they adopted the “Declaration of Principle: Informed Consent.” It states:
  - A competent adult should be provided with adequate, intelligible information about the proposed therapy:
    - A description of the intervention/treatment to be provided.
    - A clear explanation of the risks, which may be associated with the therapy.
    - Expected benefits from the therapy.
    - Anticipated time frames.
    - Anticipated costs.
    - Reasonable alternatives to the recommended therapy.
  - The physical therapist should ascertain the ability of the patient/client to understand the above before seeking consent.
  - When the adult is deemed not competent or when the patient/client is a minor, a legal guardian or advocate may act as a surrogate decision maker.
  - Physical therapists should record in writing in their documentation that informed consent has been obtained.
  - Physical therapists functioning in team situations are responsible for ensuring that appropriate consent arrangements have been made prior to their commencing therapy. Such collective consent, however, does not negate the physical therapist’s responsibility for ensuring that the patient/client is properly informed about the physical therapy.

- **Additional Considerations for Informed Consent:**
  - Informed consent supports patient autonomy and underlies its ethical principles and legal doctrines. (Bennett 2008)
• Informed consent also protects patient and research subjects from harm. (Gambone 2004 a)
• There are no universally accepted rules regarding what a PT should disclose to a patient for informed consent; however, therapists are expected to support patient autonomy and obtain consent for treatment (Guide 2.4) (APTA 2008).
• Each PT should start with following his or her state practice act (Bennett 2008).
• As a general rule, the more information a therapist provides regarding the risks, benefits, and alternatives, the less likely he or she is to be held liable for providing inadequate information. (Bennett 2008)

• “Patients have a right to expect contact with health care providers not to worsen their health.”
• Adequate therapist qualifications and informed consent (as noted above).
  Ensure high quality of care through written plans within the department or practice.
  o Consider that the standard of care may be judged based on a specialist’s level of care.
• Join your professional association and/or specialty associations to shape an informed professional identity.
• Maintain your own professional liability insurance coverage, as your employer’s coverage may not cover you in extensive litigation.
• Foster relationships with colleagues, patients and families. “People who like you are more likely to . . . excuse your errors.” Tips to build rapport with your patients and their family:
  o Never leave patient unattended.
  o Discuss procedures.
  o Always be accessible to your patient (answering service, voicemail, pager, email).
  o Foster realistic expectations (“under-promise” and “over-deliver”).
  o Ensure support personnel are supervised.
  o Maintain equipment.
• Interact with your facility’s risk manager:
  o Report untoward events (any that cause injury or almost cause injury)
  o Follow the risk manager’s advice for improving systems and practices
  o Seek help with medical-legal matters
• Documentation: “If you didn’t document it, you didn’t do it.”
  o Document all of the following:
    • Complaints
    • Medical history
    • Current and past obstetrical history
    • Medications
    • Allergies
• Observations and measurements
• Modifications in evaluation and treatment techniques
• Treatment specifics
• Patient’s response to the treatment
• Instructions to the patient
• refusal of care or non-compliance
• Correspondence with the patient’s other medical providers

• Confidentiality: Confidentiality is a cornerstone in the relationship between provider and patient (Gambone 2004a). This duty arises from considerations of autonomy and promotion of beneficence and patient honesty.
  ▪ HIPAA (Health Insurance Portability and Privacy Act) provides strict rules regarding confidentiality and security of patient health care information and records. (The full act may be downloaded in pdf form from the HIPAA information page on the CMS (Centers for Medicare and Medicaid) website: http://www.cms.hhs.gov/HIPAAGenInfo/)
  ▪ There are concerns that the stringent HIPAA regulations may inhibit flow of information amongst providers and hinder overall performance of care.
  ▪ There are situations that may make confidentiality difficult, such as suspicions of domestic abuse.
    o Follow your state and institutional guidelines for making such reports.
    o However, most situations are more likely to involve the patient’s physician (e.g., woman with a sexually transmitted disease who refuses to have a sexual partner informed, or school-aged children seeking contraceptive devices or abortion)

Practice Management in Obstetrics and Gynecology (Gambone 2004a)
• Practice of medicine becoming more complex and business-like
  ▪ Increased management challenges: rising health care costs, changes in reimbursemens
• Concurrently, patients and employers desires:
  ▪ Health care quality, evidence of value, patient safety
• Specifically, OB/GYN care cost has increased greatly since 1970
  ▪ Rapid development of expensive technology
    o Often improves outcomes only slightly but substantially increases the costs
  ▪ Technology over utilization
    o Lack of agreed upon protocols for its use
  ▪ Extremely costly medical malpractice system
    o “Defensive” practice – needless use of tests and procedures
• OB professional liability insurance premiums – signify legal issues in OB practice
  ▪ In some areas of the United States, obstetricians are paying over $100,000 annually for malpractice insurance
  ▪ Affects every major decision – creates “tunnel vision,” inability to see clear answers to ethical problems
Applicable questions for medical practice:
- Do we sometimes consider liability risk more than research findings?
- Does the weight of liability limit our creativity in the development of evaluation and treatment tools?

Literature Reports related to risk management and liability
- Review of a humanistic risk management policy: (Kraman 1999)
  - Early injury review, steadfast maintenance of the relationship between hospital and patient, proactive full disclosure to patients who have been injured because of accidents or medical negligence, and fair compensation for injuries
  - Looks specifically at one Veterans Affairs medical center using this approach since 1987 and notes encouragingly moderate liability payments
  - Concludes: honest risk management policy may be relatively inexpensive
    - Allows avoidance of lawsuit preparation, litigation, court judgments and settlements at trial
    - Also offers goodwill and maintenance of the caregiver role
- Professional liability payment data from the Massachusetts Board of Registration in Medicine: (Barbieri 2006)
  - 1995 to 2005, up to 38.6% of obstetrician-gynecologists made at least 1 professional liability payment.
  - Fewer subspecialists made a payment: gynecologic oncologists 10%, maternal-fetal medicine 3.7%, reproductive endocrinologists 11.9%.
  - However, subspecialist payments make were significantly greater (average of up to $1,950,000) compared with non-specialists (average of up to $447,983).
  - Impact on decision for professional path?
- Mean liability insurance premiums for obstetric providers increased between 34%-84% (midwives, obstetrician-gynecologists, and family physicians) from 2002 to 2004 in Washington state (Bendetti 2006)
  - Providers’ monetary response: reduce compensation, raise cash through loans and liquidating assets
  - Ob-gyn response: increase cesarean rates, obstetric consultation rates, and number of deliveries; decrease high-risk obstetric procedures
  - Family physicians response: less offering of obstetric care in rural settings
  - Many practitioners reported their liability insurance imposed practice restrictions; most common related to vaginal delivery after cesarean (VBAC)
  - All providers reported increase in on-call hours due to changes in obstetric provider supply, most markedly amongst physicians
  - ~10% of physician providers reported plans to stop accepting obstetric patients within the next year
- A look at the decision of future practice of near-graduating medical residents of Pennsylvania in anesthesiology, general surgery, emergency medicine, obstetrics and gynecology, orthopedics, and radiology: (Mello 2005)
Large increases in medical professional liability insurance premiums and decreasing availability of insurance (referred to as a “professional liability crisis”) has deepened to extreme levels in Pennsylvania, West Virginia, Nevada and Florida.

One third of medical residents in final or next-to-last year of residency planned to leave Pennsylvania because of the lack of availability of affordable malpractice coverage

May lead to decreased specialist availability serving high-cost states

Considerations for Specific Prenatal Situations in the Scope of Physical Therapy

This section highlights a few categories of pregnant patients that PT’s will work with; some of these and additional others are covered more in-depth later in OBA: **high-risk pregnant patient, teen pregnancy, prenatal/postnatal fitness classes, intimate partner violence or domestic violence victims**

- **High-Risk Pregnant Patient (adapted from Stephenson 2000)**
  - A high-risk pregnancy is one in which maternal or fetal factors may adversely affect the outcome – a very broad definition into which many pregnancies will fall.
  - Factors may be pre-existing in the mother or develop during the pregnancy.
  - It is important for the therapist treating a patient in a high-risk pregnancy to obtain further education through reading and communication with the patient’s health care team regarding the patient’s diagnosis and condition.
  - Caring for a pregnant woman creates a unique relationship because the management of the mother has an effect on her baby. (Gambone 2004 b)
  - Treatments offered to promote the welfare of the fetus may violate the mother’s autonomy.
  - However, most “conflicts” are resolved due to the mother’s willingness to undergo considerable self-sacrifice to benefit the fetus.
  - For example, placement on activity restriction, including prolonged bedrest.
  - Activity levels or restrictions, are determined by the patient’s obstetrician or midwife. The PT is to assess the patient and offer treatment that stays within these restrictions. The evaluation and treatment must be tailored to the patient’s prescribed activity levels and positions in order to prevent premature labor.
  - For example, if a patient is on strict bedrest, this may mean that the entire evaluation is performed with the patient in sidelying or even in Trendelenburg. It may also mean that certain measurements are not taken (such as manual muscle testing) in order to follow precautions/restrictions.

- **Home Health Pregnant Patient**
  - As insurance pays less for hospital stays, more high-risk pregnancies will be managed through home care. (Stephenson 2000)
  - Home health practitioners face unique risks because they practice in an independent environment.
Therefore, their evaluation skills, judgment, and technical skills must be especially well-developed as they lack the benefits of a structured health care delivery system.

Tips for risk management in the care of home health patients: (Adapted from Young 1993 a)

- The therapist in the home may be the one to detect a medical complication, infection or other problem. Report any concerns to the patient’s physician and rehabilitation coordinator, thus preventing loss and promoting proactive care.
- The therapist’s differential diagnosis skills are important to assist in detecting such problems that may require further medical management.
- Periodic assignment of different therapists or therapy assistants to a patient is a helpful risk management tool when communication problems exist and when the patient has unrealistic expectations.
- The therapist should document all examination findings, interventions and instructions thoroughly, as well as communication with other practitioners regarding the patient’s care or observations.
- Home exercises and instructions should be taught not only verbally, but issued in written format. Pictures of exercises and instructions are also desirable.
- Having the patient sign that she understands the plan of care and is willing to comply with the plan and interventions is another risk management tool. Whether a patient actually complies with the home program should always be documented.
- Maintain positive communication with the patient and family; establish rapport with them. Document the family’s involvement.
- Include the patient and family in goal-setting.
- Social workers are common providers in the home health setting that can help to reduce/resolve some other common risks: entering crime-infested neighborhoods, entering homes in which illegal substances are being used, cluttered rooms, lack of needed handrails, unfriendly pets, allergies to pets, lack of compliance of the patient or family members.
- Durable medical equipment suppliers may also be of assistance.
  - Therapists providing home health care may want to join the Home Health Section of APTA for additional member benefits and resources: http://www.homehealthsection.org
  - Pelvic Floor Treatment for the Pregnant Patient
    - As noted previously, a Physical Therapist should only provide care that is within her scope of knowledge, training and experience (APTA 2008 a).
    - Inadequate training on the part of the physical therapist is a contraindication to perform a perineum and pelvic muscle exam. Therefore, a PT treating pelvic floor dysfunction should have adequate, specific training at courses
sponsored or recommended by the APTA Section on Women’s Health (Kotarinos 2000).

- Visit the Section on Women’s Health website for their sponsored pelvic courses: http://www.womenshealthapta.org

- Internal pelvic muscle exams are contraindicated for patients who are less than 6 weeks postpartum to allow tissue healing.

- Internal pelvic muscle exams are precautioned for patients who are pregnant (Kotarinos 2000). This is due to the possibility of introducing infection to the mother and/or baby (Stephenson 2000). It is recommended to first obtain written clearance from the patient’s physician prior to performing an internal examination.

- Food for Thought:
  - Obstetricians perform internal vaginal examinations during pregnancy. However, these exams are generally infrequent and toward the end of gestation. (Stephenson 2000)
  - In addition, women participate in sexual intercourse during pregnancy, which is certainly more invasive and less hygienic than a pelvic muscle exam that would be administered by a physical therapist.
  - So why caution with PT internal exams? Exam and intervention techniques provided must be consistent with current physical therapy practice (APTA BOD S03 2008 b). Current practice involves caution/written MD clearance for internal exam in pregnancy.

- Alternative methods for evaluating pelvic muscle dysfunction in pregnant clients includes: (Kotarinos 2000)
  - External observation of the perineum for skin condition, color, scars, symmetry of anatomy, swelling, gland enlargement, condition of the introitus, and location of structures at rest.
  - External observation of the perineum from the resting position, contracted position, with Valsalva maneuver, and position with coughing.
  - External palpation of the perineal body with same positions as observation.
  - Surface EMG biofeedback with use of external surface electrodes (internal electrodes are contraindicated) placed perianally (2-3 o’clock and 8-9 o’clock positions). (Wallace 2000)
  - External palpation of levator ani muscle contraction with patient in sidelying, slight hip and knee flexion. Palpate just medially to the ischial tuberosity and instruct patient to contract. A proper contraction will push the therapist’s palpating fingers out of the space.

- The Worker’s Compensation (WC) Pregnant Patient (APTA BOD G02 2008 c)
  - Challenge in caring for WC patients is that the therapist has an obligation or relationship with the patient and the patient’s employer. These concurrent relationships may have competing responsibilities.
  - Legal consideration: Recognize that individuals who file claims for one purpose (work injury claim) may file claims for other purposes (medical malpractice claim).
- Reducing risk:
  - Work within your scope of practice and professional competence.
  - Document only observable behaviors and avoid disparaging remarks or clinical labels that you are not qualified to make. Document the interventions.
  - Do not expand the interventions at the request of the patient unless directed by appropriate referral source and only after additional examination/assessment.
- Physical therapists may be called on as a witness in an occupational health case and should be aware of the workers’ compensation law within their states regarding documentation and definitions of terminology (such as “impairment” and “disability” – these can vary state to state).
- A physical therapist should only make recommendations regarding return to work or work environment that pertain to the therapist’s scope of practice. In written recommendations, therapists may even want to consider a disclaimer statement.
- Group Education / Prevention Services:
  - Know your state practice act regarding allowance of prevention services without a referral.
  - Ensure activities provided fall within your state’s practice act.
  - Develop policies and procedures for the program.
  - Document objectively services provided and time spent.
  - Ensure you have the requisite knowledge base to provide the education/services.
  - Do not provide individual therapeutic interventions without first performing a screening examination; refer to your state practice act whether you may provide such intervention without a referral.
- Therapists should be aware of the differences between consultative services and those that introduce a provider/patient relationship.
- Conducting Instructional & Exercise Classes (Stephenson 2000)
  - Depending upon the therapist’s training, a PT may conduct a variety of instructional classes:
    - Prenatal / postpartum exercise (discussed more in OB3)
    - Early pregnancy
    - Childbirth preparation
    - Breastfeeding
    - Prenatal
    - Post-natal (with or without baby) or post-Cesarean exercise classes
    - Prenatal or postpartum back care
  - Additional continuing education and certification is recommended for someone desiring to become an instructor in these areas.
  - Care must be taken to provide adequate waivers, liability forms etc. (discussed more in OB3); work with your facility’s legal & risk management departments.
Depending on the class being taught, certification may be required to become an instructor. A few examples of certifications:

- Lamaze
- Bradley birth method
- Hypnobirthing
- Yoga
- Pilates
- Lactation Consultant
- Childbirth Educator

References


Mello MM, Kelly CN. Effects of a Professional Liability Crisis on Residents’ Practice Decisions. ACOG. 2005:105(6);1287-1295.


