Legal Pitfalls in Obstetrics
Interprofessional Perspectives

Objectives

<table>
<thead>
<tr>
<th>Discuss</th>
<th>Discuss current issues in obstetric litigation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review</td>
<td>Review pitfalls of normalizing abnormal findings and failure to recognize a change in maternal or fetal status</td>
</tr>
<tr>
<td>Illustrate</td>
<td>Illustrate concepts in case studies</td>
</tr>
</tbody>
</table>

Williams Obstetrics
Chemotherapy. See Antibiotics
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hydatidiform mole and, 565, 567–68
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Chemotherapy. See Antibiotics
choriocarcinoma and, 570–71
hydatidiform mole and, 565, 567–68
Chiari-Frommel syndrome, 921

Legal Perspective

Healthcare lawyer
100% bad outcomes...
But not all bad care
Legal Perspective

29 Nurses
22 Obstetricians
16 Neonatologists
2 Psychiatrists

Legal Perspective

Brain damage
Brachial plexus injury
Infant infection or death
Maternal death

Legal Perspective

Bad outcome
Charting deficiencies
Communication issues
No critical thinking
Legal Perspective

- Competent
- Caring
- Attentive
- Critically thinking

What we’ll discuss:

- Primary drivers of claims
- Progression of a typical lawsuit
- The discovery process
- Obstetric defense strategies

Case study:

38 week female infant
Admitted to L&D at 10:30am
SROM at 12:45pm, thick meconium
Case study:
NSVD at 9:17pm
APGARs of 3 and 5
Nuchal cord x1, easily reduced

Case study:
2cc meconium suctioned
PPHN diagnosed
ECMO treatment x5 days

So...why do patients sue?
Unexpected or untoward outcome

Inadequate explanation

Jousting or team bickering
System failures

Bad medicine

Case study:
38 week female infant
Admitted to L&D at 10:30am
Is this fetus healthy?

A prospective study of 2,200 consecutive deliveries found that 80% of cases with adverse outcome exhibited good FHR variability.

“A 38-week term infant, healthy prenatally, delivered with APGARs of 3 and 5, and developed PPHN requiring intubation and eventually ECMO…”

Case study:

- 38 week female infant
- Admitted to L&D at 10:30am
- SROM at 12:45pm
- Amnioinfusion for thick meconium
Is this fetus compromised?

FHR abnormalities have a low predictive value for acidemia and a high false-positive rate for fetal neurologic injury.


Case study:
NSVD at 9:17pm
APGARs of 3 and 5
Nuchal cord x1, easily reduced
Fetal distress.

What is it?
The Committee reaffirms that the term fetal distress is imprecise and nonspecific.

Inappropriate use of the terms fetal distress and birth asphyxia.


If you were called to the bedside to assist... would “fetal distress” tell you everything you need to know?

Case study:
- 2cc meconium suctioned
- PPHN diagnosed
- ECMO treatment x5 days
Hypoxic-Ischemic Encephalopathy
Using the term neonatal encephalopathy rather than HIE or “birth asphyxia” is important for families, clinicians, and researchers because it permits identification of infants on the basis of clinically-observable data and imposes no assumptions about etiology of the disorder.


Although HIE composes a cause-specific subset of all neonatal encephalopathy, neonatal encephalopathy often is mislabeled HIE.

Hypoxic-ischemic encephalopathy is diagnosed by:

- Serial brain ultrasonography
- Computed tomography of the brain
- Magnetic resonance imaging
- Neonatal EEG
- Clinical examination

- Cranial ultrasonography lacks sensitivity, but echodensity or echogenicity may be detected **48 hours or longer** after injury.

- Computed tomography will often not reveal abnormalities in the first **24-48 hours**.

- MRI is the most-sensitive, and should be used between **24 and 96 hours** of life.


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**Can you really admit for HIE when you cannot yet know the cause?**

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**Case study:**

Cerebral palsy
Spastic quadriplegia

Lawsuit filed seeking +$60 million
Duty Breach Causation Damages

Standard of care

What a reasonable nurse or physician would do in similar circumstances.
Standard of care is established by

- Expert testimony
- ACOG Bulletins
- Authoritative texts
- Hospital policies and bylaws

Medical literature

Challenging the 4- to 5-minute Rule: From Perimortem Cesarean to Resuscitative Hysterectomy

Hawe, C.W.; Fekete, A.; Haycer, R.O.; Camrano, D.; Appel, K.W.; Best, B.C.

Obstet Gynecol Surv. 2016; Volume 36 - Issue 4 - p. 171

[Abstract]

About 114,000 deliveries are complicated by antepartum maternal cardiac arrest, causative factors of which include hemorrhage, cardiac and respiratory arrest, preeclampsia, anesthesia complications, and trauma. The maternal survival rate ranges from 17% to 69% and fetal survival rates from 87% to 90%. This article is a review of current practices for maternal cardiopulmonary arrest (MCA) management and also proposes a multifaceted management strategy that differs from the current 4 to 5 minute rule for perimortem cesarean delivery (PMCC).
The American College of Radiology recommends annual mammograms for asymptomatic women 40 and over.

The US Preventative Services Task Force recommends biannual mammography for women 50-74 and believes that there is insufficient evidence to support clinical breast exam.
The American Cancer Society recommends annual clinical breast exams.

ACOG recommends annual clinical breast exams and mammograms but states "biannual mammography may be more appropriate and acceptable."

Which standard of care is right?
It is plaintiff’s burden to show that, had she known of a possible adverse outcome, she would not have gone forward with the procedure.

This is a subjective standard.
Amniocentesis is not discussed and a baby is born with Down’s Syndrome. The patient claims she would have terminated the pregnancy.

A macrosomic baby is born with Erb’s Palsy. The patient claims she would have had a cesarean section if one was offered.

Can a resident give informed consent after a detailed discussion with the attending physician? Can a nurse?
Res ipsa loquitur...huh?

This is a “FISH” abdominal retainer.

This is what a “FISH” looks like during closure.
This is a lawsuit.

Vicarious Liability

Hospitals are responsible for the conduct of employees and agents, including nurses, who are employees, and residents, who are agents.
Your brain is not wired for the deposition room.
Case study:
32 weeks pregnant (G1P0)
FHR on prior visits 160, 165, 160, and 160
In for her fifth office visit, and the FHR is 135

Q

Is my baby __________?
Forced cognition

Q → LISTEN → THINK → A.

Forced cognition

45 minutes
Your brain has a 20 minute power reserve.

Factual Questions

Know the chart.
Do no be scared of factual questions.

Factual Questions

“Isn’t it true, nobody examined the plaintiff for two hours.”
Hypothetical Questions

“I’m not talking about this case...”

Hypothetical Questions

“If a patient called in complaining of leg swelling and intense headaches that would not go away with Tylenol...”

Hypothetical Questions

Your brain enjoys problem solving.

The attorney knows this.
Labeled Questions

What is a “labeled question?”

Is patient safety important?

Is documentation important?
Is documentation important?

The issues are timing and completeness.

Our response: Patient care comes before paper charting.

Labeled Questions

Labeled questions give the attorney control over the words.
The attorney already knows the answer to every question she plans to ask you.

Know and accept the facts.

Do not be trapped by “labeled” questions.

There are no hypothetical questions.

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Stick with the process.

Do not let be fooled by patterns.

Take breaks every 45 minutes or sooner.

Listen, and do not teach.

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Case study:

“Pitocin must be stopped if one of the following occurs... hyperstimulation.

...and delivery should be considered and the discussion documented.”
How do you win a case when you lose on standard of care?
Physicians Perspective

Normalizing the Abnormal Assessment

**Hypoxemia**

- "She is sleeping"
- "I just gave her some IV pain medicine. This is expected"
- "She is relaxed"
- Inability to obtain SpO2 - due to faulty equipment
- Increased respiratory rate - explained as anxiety

Pregnant woman with pulmonary edema

No recognition of abnormal SpO2

No intervention documented
Oxygen Content

- Oxygen dissolved in the blood plasma ($\text{PaO}_2)$
- Oxygen combined with hemoglobin (saturated) ($\text{SaO}_2$)

Quick Reference: Oxyhemoglobin Curve

<table>
<thead>
<tr>
<th>$\text{pO}_2$ mmHg</th>
<th>$\text{SpO}_2$ %</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>70</td>
</tr>
<tr>
<td>50</td>
<td>80</td>
</tr>
<tr>
<td>60</td>
<td>90</td>
</tr>
</tbody>
</table>
Hypoxemia: Reduced oxygen in blood (PaO$_2$)

- Low Alveolar Oxygen (reduced PAO$_2$)
  - Altitude
  - Hypoventilation (increased PACO$_2$
  - Breathing of gas mixtures less than 21%
- Diffusion Impairment (pulmonary edema)
- Intrapulmonary Shunt (pneumonia)
- Ventilation/Perfusion Mismatch (PE)

Aerobic Metabolism

- Decreased pH
- Metabolic Acidosis

Hypoxemia

- Production of lactic acid

Tissue Hypoxia

- Anaerobic Metabolism

Depletion of Oxygen Delivery

Tachycardia

- “She is in pain”
- “She has a history of anxiety”
- “Cardiac assessment WNL”
- “It’s just sinus tachycardia”
Cardiac output  Heart Rate  Stroke Volume

Tachycardia
Volume depletion
Anemia
Fever
Pulmonary embolism
Hypoxemia

Hypotension

She is hypotensive because she is pregnant
“She runs low blood pressures normally”
“That is expected when you get an epidural”
“The baby looks fine”
Compensatory Mechanisms of Hypotension

- Compensatory Vasoconstriction
- Conserve blood volume
- Maintain left ventricular filling volume
- Blood shunted from non-necessary organs
Hypertension

"But she feels fine"

"She has chronic hypertension. This is her norm"

"She is in pain"

"She just had a fight with her mother"

"She has too many visitors in the room"

"Her preeclampsia labs are normal"

COMMITTEE OPINION

Emergent Therapy for Acute-Onset, Severe Hypertension During Pregnancy and the Postpartum Period

ABSTRACT: Acute-onset, severe systolic hypertension, severe diastolic hypertension, or both can occur in pregnant women or women in the postpartum period. Introducing standardized, evidence-based clinical guidelines for the management of patients with preeclampsia and hypertension has been documented to reduce the incidence of serious maternal and neonatal complications and mortality through the implementation of protocols to establish the patient's blood pressure level.

Blood Pressure Measurement

<table>
<thead>
<tr>
<th>Protocol</th>
<th>Take BP in 10 minutes</th>
<th>After dose 1</th>
<th>After dose 2</th>
<th>After dose 3</th>
<th>After dose 4</th>
<th>After dose 5</th>
<th>After dose 6</th>
<th>After dose 7</th>
<th>After dose 8</th>
<th>After dose 9</th>
<th>After dose 10</th>
<th>After dose 11</th>
<th>After dose 12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hydralazine</td>
<td>Hydralazine 1.5 mg BP over 2 minutes</td>
<td>Hydralazine 1.5 mg BP over 2 minutes</td>
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<tr>
<td>Labetalol</td>
<td>Labetalol 20 mg BP over 2 minutes</td>
<td>Labetalol 20 mg BP over 2 minutes</td>
<td>Labetalol 20 mg BP over 2 minutes</td>
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<td>Nifedipine</td>
<td>Nifedipine 10 mg BP over 2 minutes</td>
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Target BP = systolic BP 140 to 155, diastolic BP 90 to 100 mmHg. If target BP achieved, include BP every 10 minutes X 4, every 15 minutes X 4, every 30 minutes X 2, every hour X 4, every 4 hours thereafter.
The patient has a Category 2 tracing
I need you to evaluate the patient
The baby is fine, I will call if it gets worse
"Her blood pressure is up. Please come evaluate the patient and give me an order for antihypertensive medication. Her pressure is not high enough for you to ask me to come to see the patient - you are just calling because the protocol states call if > 140/90.

"The patient is having some vaginal bleeding." I need you to come evaluate the patient because I think she is having an abruption.

Why is she calling me for bloody show?
Nursing Perspective

Failure to Recognize Complications of Pregnancy and Postpartum

<table>
<thead>
<tr>
<th>Failure to Recognize Common Complications of Pregnancy and Postpartum</th>
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<tbody>
<tr>
<td>Pulmonary Edema</td>
</tr>
<tr>
<td>Sepsis</td>
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<tr>
<td>Preeclampsia</td>
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<tr>
<td>Abruption</td>
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</table>
Case Study: Patient History

- **28 yo**
- **G 5-3-1-0-4**
- **OB History**
  - Vaginal birth at 36 weeks
  - C-section at 40 weeks
  - C-section at 40 weeks
  - C-section at 39 weeks
- **Surgical History**
  - C-section x 3
- **Medical History**
  - Chronic hypertension
  - Superimposed preeclampsia in previous pregnancies
  - Pulmonary embolus
  - Recurrent UTIs
- **Medications**
  - Lovenox
  - Labetalol 100 mg po BID
  - Previous 2 doses of Betamethasone

Case Study: OB Triage

- Patient c/o decreased fetal movement
- EGA 36 1/7 weeks
- EFM placed 35 minutes after arrival to unit
- Urine dip = 3+ proteinuria
- BP 174/111, HR 90, SpO2 97% (note: RR not documented)
- Cervix = closed, high
- Assessment
  - Lungs CTA
  - DTRs 1+
Case Study: QUESTION

• When a woman comes into triage with c/o of decreased fetal movement and has a history of chronic hypertension, what components do you want to focus on in your assessment?
Case Study: RN EFM Assessment

- Baseline 130
- Minimal variability
- Variable decelerations
- Uterine Activity
  - Q 1-4 minutes
  - No intensity or resting tone documented

Question:
Is the assessment of resting tone important - especially in this clinical scenario?
Case Study: Handoff and Reports

• RN to RN shift change report given
• RN to Physician report given
  • 1 hour and 10 minutes after triage
  • Physician is outside of hospital
  • Informed that another c-section is in progress
  • Plan to follow c-section
• RN to Charge RN report given
  • Plan for repeat c-section
• Charge RN report to Anesthesiology

https://encrypted-tbn0.gstatic.com/images?q=tbn:ANd9GcSyUpEaN8T_SfOiuhrL9bm7dIufmBYeTeDqmUewGGqDg4krhMVm7Q

Case Study: Facebook Post

• Timed entries
• Played into the case
Vital signs are VITAL

Oxygen Started at 10L FM

RN Documentation: minimal variability, late decelerations
Case Study: Update

- Labs
  - Hct 37.2 / Hgb 12.7
  - WBCs 17.2
  - Platelets 189,000
  - Uric Acid 9.2

Physician called
- BP reported
- Orders
  - Labetalol 20 mg IVP now
  - Notify Anesthesiology re. management

Anesthesiology notified
- Currently in PACU with other patient
- Orders RN to not give labetalol since patient will be getting a spinal for c-section
Case Study: In OR

- Spinal anesthesia placed
- 400mL preload given
- BP dropped to 120's/60's range after placement
- Neosynephrine 200 mg IV given
- Fetal Assessment:
  - FHR doppler follow spinal = 110 (note: MHR 110 range)
  - No EFM x 27 minutes in OR
- Physician reports to OR
  - Note: Has not seen patient prior to this time
  - 2 hours and 10 minutes after patient arrival to Triage
  - 1 hour after report from RN
- Pre-op Diagnosis: Repeat C-section
- Surgical type documented: Emergency
- Incision

Case Study: Outcome

- Apgars 0(1), 0(5), 0(10), 0(15), 3(20)
- Weight 4lbs, 10 ounces
- Meconium
- Arterial cord gas
  - pH 6.69
  - pCO2 85.2
  - pH2 - not able to report
  - BE -28.9
- NICU called at 3 minutes of life
- Baby transferred for cooling
- Retroplacental abruption
Case Study: Legal Outcome

- Case settled w/o any depositions from experts
- Hospital website: Can handle emergency situations
- Large OB service with more than 1 OB OR
- Several Anesthesiology providers on 24/7
  - CRNA never called Anesthesiologist for assistance
- Level III NICU - not notified to be at birth
- Physician deposition
  - Stated RN never discussed EFM assessment in phone report
  - Surprised at condition of baby

Case Study: Key Points

- Antepartum admission
- Preeclampsia
- Twins
- Abruption
- EFM
- C-section
**Case Study: Patient History**

- 36 yo
- G 1
- IVF Twin pregnancy (Di/Di)
- Serial Ultrasounds - Discordant growth noted
  - Twin B IUGR (< 10th percentile) and intermittent absent end diastolic flow
- Plan of Care
  - Admit to Antepartum Unit
  - R/O preeclampsia

**Case Study: Admission**

- EGA 28 4/7 weeks
- Plan of Care
  - VS every 8 hours
  - NICU consult
  - BPP
  - EFM Q 12 hours

**Case Study: Hospital Day 31**

- EGA 32 6/7 weeks
- BPs have been slightly elevated
- Most recent US and BPP
  - Twin A BPP 8/8; EFW 4-12 (56th percentile)
  - Twin B BPP 8/8; EFW 3-4 (< 3rd percentile)
- Patient wakes and gets up to bathroom - notices bright, red, vaginal bleeding
- Notifies RN
- EFM applied
Case Study: Update

<table>
<thead>
<tr>
<th>Time</th>
<th>Event and Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0508</td>
<td>EFM applied</td>
</tr>
<tr>
<td>0518</td>
<td>EFM off x 29 minutes: Transferred to L&amp;D</td>
</tr>
<tr>
<td>0525</td>
<td>RN Note: patient up to bathroom and had bright red vaginal bleeding with 2 quarter sized clots; patient feeling cramping; called physician; order to transfer patient to L&amp;D</td>
</tr>
<tr>
<td>0532</td>
<td>Arrives in L&amp;D</td>
</tr>
</tbody>
</table>
Case Study

• You are the RN, what can you do?
  • What are your resources?
  • Have you provided intraperitoneal resuscitation?
  • Is the patient ready for the OR?
  • Have you notified Neonatal Team?
  • Can you go on to the OR?
  • Is there another physician who can intervene?
  • Have you notified your Charge RN of the situation?

0543: IV started; Kleihauer-Betke drawn
0545: Physician in OR reviews EFM
0552: NICU notified
Case Study: Outcome

- General anesthesia - difficult intubation with SpO2 low
- Decision to incision time: 23 minutes
- Delivery
  - Twin A: pale, flaccid; Apgars 0(1), 0(5), 5 lbs 1.5 ounces; full resuscitation; pronounced
  - Twin B: Apgars 4(1), 8(5); 2 lbs 10 ounces; to NICU
- Abruptio noted
- EBL 1500 mL
**Chicago Daily Law Bulletin.**

$53M verdict for birth injury

Delaware Judge Awards Over $40 million to Birth Injury Victim and Family

$144.5M Michigan Birth Trauma Verdict Upheld

Thank you!

Thank you!
Additional References
