
Legally Speaking: Can you win a case involving premature twins?

By Andrew I. Kaplan, Esq.

Apr 1, 2008

Brain-damaged baby cases often pose the most significant challenges to defendant physicians and defense attorneys alike. With that in mind, sometimes the most we can hope to achieve is a palatable resolution of the case.

THE FACTS

The patient was a G3, P2 who had been considered high-risk by the hospital's prenatal clinic because she had experienced fetal distress and a subsequent cesarean section during her second delivery. In addition, for the current pregnancy, she was carrying twins.

AT THE TIME OF HER INITIAL prenatal visit on March 8, the 29-year-old patient was given an estimated delivery date of October 19. On June 30, 24 weeks by dates and 25 weeks by ultrasound, she complained of "tightening in her abdomen" that persisted through July 11. At that time, she was referred for nonstress testing, which demonstrated uterine "irritability," so she was referred to the hospital center for admission. She was managed on the Labor and Delivery unit for a few hours with subcutaneous terbutaline injections, which resolved the irritability and contractions. There were no cervical changes and the membranes remained intact. The patient was kept on bed rest in the hospital center for the week, and repeat tocodynamometry revealed no contraction pattern. The plan was for her to continue on bed rest at home and take oral terbutaline every 3 hours.

On the evening of July 27, the patient was again admitted to the defendant hospital center with a 4- or 5-day history of pruritus, elevated liver function tests, and "mild contractions." She was diagnosed with cholestasis of pregnancy but because of increased contractions she was moved to the Labor and Delivery unit the following day and treated with subcutaneous terbutaline. Daily nonstress tests were done and there was good fetal movement, fetal heart rate (FHR) within normal limits, and good variability. On August 7, IV magnesium sulfate was commenced because of headaches and visual blurring, and she continued to have increased uterine contractions and irritability. (While the woman did have elevated liver function tests, the MgSO₄ was given primarily as a tocolytic.) An August 9 U/S

revealed twin "A" to have an estimated fetal weight of 1,533 g with an estimated gestational age (EGA) of 29.8 weeks, and twin "B" weighed 1,352 g with an EGA of 29.6 weeks. There was no mention of anomalies in either fetus.

At 7:30 AM on the morning of August 15, "spontaneous variables" were noted on fetal monitoring. Fetal heart rate was 110 to 140, and the contractions were mild and irregular. At 9:15 AM, occasional variable decelerations were noted with good return to baseline and good variability. More frequent, stronger contractions (every 2–3 minutes) were noted, and an examination of the cervix revealed 2 cm of dilation and 80% effacement with intact fetal membranes. The rate of MgSO₄ infusion was increased from 0.5 to 2.0 g per hour.

At 2:20 PM, the covering nurse reported a decrease in the FHR (the report did not specify twin "A" or twin "B") to 90 to 100 bpm for at least 2 minutes. The chief resident arrived shortly thereafter and undertook an U/S that reflected two viable FHRs. Thereafter, there was a 6-minute drop in the FHR (which twin's rate undetermined) to 90 to 100 bpm. The FHR tracings displayed poor variability at this point as well. At 3:00 PM, the chief resident had the patient transferred to a delivery room where a repeat U/S was performed that indicated twin "A" had an FHR in the 90s and twin "B" had an FHR of 140.

At 3:15 PM the resident entered a note indicating that both FHRs were now in the 130 to 150 range, but in light of bradycardic episodes and late decelerations as well as occasional contractions, the decision had been made to deliver. He noted that although there would be complications associated with prematurity, the fetal heart responses indicated uteroplacental insufficiency and the slow recovery could indicate poor fetal reserves. Due to the high risk of fetal demise and the unlikelihood that the infants would tolerate the labor process, cesarean delivery was recommended.

At 4:21 PM, twin "A" was delivered, weighing approximately 4 lb and at 4:23 PM, twin "B," weighing approximately 2 lb, 4 oz, was delivered. Both displayed metabolic acidosis at the time of birth according to the blood gas readings. Twin "A" required full resuscitation at delivery and survived for 18 days, although the records indicated the presence of significant porencephaly within the first 24 to 48 hours of life, so there was little hope for long-term survival. Significantly, the records reflect his brain and body were overcome with cytomegalovirus (CMV), a devastating viral infection.

Twin "B", the subject of the lawsuit, was delivered and noted to be pale, without respiratory effort. He was intubated and responded well to positive pressure ventilation with 100% oxygen. However, he was noted to be microcephalic with a head circumference of 28 cm. His Apgars were listed as 3, 5, and 7. He was taken to the NICU, where he remained for over 2 months. He was septic, suffered from respiratory distress syndrome, and had evidence of renal involvement, severe anemia, and progressive thrombocytopenia. Head U/S on the day of delivery was normal, but a week later revealed a grade IV intraventricular hemorrhage on the right side. By the time of discharge, he was active and alert, feeding well, and weighing close to 5 lb, with a head circumference of 34 cm. The infant was diagnosed with severe cerebral palsy and profound retardation.

ALLEGATIONS

Initially, the plaintiff's claims were inconsistent. She simultaneously alleged that the physicians at the hospital center failed to appropriately extend her pregnancy long enough to deliver healthy infants, while at the same time arguing that, on August 15, twin "B" should have been delivered an hour earlier to avoid a hypoxic ischemic event resulting in his profound deficiencies.

AT THE TIME OF TRIAL, the plaintiff had refined her allegation and claimed that the failure to deliver earlier was the culprit.

DISCOVERY

Our experts, a neonatologist and pediatric neurologist, insisted that the infant's physical deficiencies were the result of the aforementioned CMV rather than the result of the events that took place in the immediate hour or 2 prior to delivery.

OUR EXPERTS SUGGESTED that the underlying CMV infection was clearly confirmed by the autopsy report on twin "A" and that the disparity in birthweights between the two infants was a byproduct of "third space" fluid buildup or edema, and that twin "B" weighed as little as he did because he, too, was afflicted with CMV but reacted differently than twin "A."

While the plaintiff countered that no diagnosis of CMV had been made for twin B, our experts responded that this was more a result of the severity and the multiplicity of the difficulties encountered up through his time of discharge from the hospital, rather than a definitive ruling out of the infection. In fact, our pediatric neurologist added that microcephaly would not be caused by perinatal asphyxia/hypoxia but, rather, the infant's persistent microcephaly over time, in conjunction with a decrease in his physical abilities over time, supported the diagnosis of CMV infection rather than a lack of oxygenation in the hour or 2 prior to delivery.

Within the infant's NICU record was an unfortunate entry by two of the neonatologists, indicating that while twin "A's" difficulties were "prenatal," twin "B's" difficulties were "perinatal." The plaintiff attempted to use this to support their hypoxia argument; but the physicians testified that none of twin "B's" problems were a byproduct of perinatal hypoxia occurring in the immediate hour or 2 before birth, but that it was more likely that the infant's anemia and physical difficulties were a byproduct of the CMV infection.

The plaintiff's expert also intended to testify that the initial arterial blood pH of 6.92 supported the argument of a hypoxic event occurring prior to delivery. Our neonatology expert pointed out, however, that one would expect the infant to have metabolic acidosis secondary to the chronic and longstanding severe CMV infection and that his compromise was hidden due to the severe intrauterine anemia caused by the CMV. The CMV caused low hematocrit readings, which meant that there were enough red blood cells to carry oxygen into the blood, contributing to the acidosis. This expert opined that the CMV was an early onset infection that prevented the infants from producing red blood cells, and this would explain the acidosis.

RESOLUTION

The plaintiff's initial demand in the case was \$8 million (given the physical infirmities, life expectancy, and the need for long-term care, the "sustainable value" of the case was in the \$6 to \$7 million range).

GIVEN THE UNIFIED OPINIONS of the defendant physicians in the case, as well as the retained experts, we were able to take a defensive posture with plaintiff's counsel and to punch holes, as it were, in their theories before the judge was assigned to try the case. As such, within a month prior to trial, plaintiff's demand had dropped to \$3.75 million and again to \$2 million. Ultimately, given the exposure in the case and some of the difficulties to be faced by the hospital in defending the care—a nurse's note indicating it was the intention of the residents to perform a "stat c-section," hours before it was actually performed, and that the plaintiff's expert at least had a viable theory with regard to the acidosis to support his contention that a hypoxic event took place, the hospital decided to settle the matter.

Discontinuance was obtained as to the named physicians and the hospital settled the case shortly before trial for \$1 million.

ANALYSIS

At first glance, this looks like a case that would cause most physicians to throw up their arms in disbelief and ask "How could you settle this case?" Reality, however, requires a different perspective.

FIRST AND FOREMOST, we can't ignore the fact that a case involving a "brain-damaged baby" can be sustained for as much as \$6 or \$7 million as things currently stand. There was a fairly prolonged period of bradycardia and variable decelerations in the hour or 2 prior to delivery, which did not always return to baseline, nor was there good beat-to-beat variability thereafter. Infant "B" was acidotic at birth and despite the logic behind the argument that he, too, suffered from CMV, no definitive diagnosis of that infection had been made. The nurse's notes indicating that a "stat c-section" was always the plan, while refuted by the chief resident, would undoubtedly be highlighted before a jury.

The hospital appreciated the fact that the plaintiff's expert had enough evidence at his disposal to argue there was a departure from good practice in not performing the delivery earlier, and that the mismanagement on the date of delivery proximately caused the infant's severe injuries. That would have been enough to get the case to a jury where, literally, anything could have happened. Even though we were prepared to try the case to verdict, the hospital made a very difficult, reluctant, although reasoned, decision to settle the case at a "discount," rather than risk losing and having it be priced.

***ANDREW I. KAPLAN**, a graduate of the University of Michigan and Brooklyn Law School, is a partner at Aaronson, Rappaport, Feinstein & Deutsch, LLP, specializing in medical malpractice defense and health-care litigation. Mr. Kaplan is a regular contributor to this column.*