
CASE STUDY: DEFICIENT PRENATAL ASSESSMENT

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THE FACTS:

On July 18, the 23-year-old patient presented at 23 weeks' gestation to the defendant hospital's labor and delivery floor complaining of headache, dizziness, lightheadedness, and "occasional contractions when in the bathroom." This was her first pregnancy and she had a last menstrual period of 2/7, an estimated date of conception of 11/16, and no identified risk factors. Her previous two prenatal care visits were uneventful.

The woman was evaluated by a second-year resident, but no physical or pelvic examination was documented. The chart noted good beat-to-beat variability in the fetal heart rate, but the actual monitor strips were never located. The assessment was an intrauterine pregnancy at 23 weeks, with vomiting secondary to gastroenteritis. There was no evidence of any attempt to hydrate the patient, and although reference was made to normal lab values, the chart did not contain any lab results from that date. The patient was discharged.

At 6:15 AM on July 26, the patient was readmitted and an admission note written by another second-year resident and co-signed by the Chief Resident documented complaints of lower abdominal pain and fluid leakage for 2 days prior to admission. Fetal movement was adequate, there was no vaginal bleeding, and the note also made reference to a normal sonogram obtained on July 21.

A sterile speculum exam (vaginal exam was "deferred") indicated that the woman's membranes were ruptured, her cervix was thought to be 1- to 2-cm dilated, she was contracting, and the amniotic fluid index was 17. Thus, the patient was 23 weeks and 5 days pregnant, with spontaneous rupture of

membranes for 2 days. The plan was to admit her to Labor and Delivery, provide prophylactic antibiotics, and administer dexamethasone, but not magnesium sulfate for tocolysis. There was also a notation that pediatrics was informed and would consult regarding the patient.

A note made at noon described the woman's cervix to be 3- to 4-cm dilated and 100% effaced, with an impression of progressing labor. Although the FHR strips could not be located, the labor flow sheet reflected the FHR in the 140s or 150s and good beat-to-beat variability with no late decelerations, documented every 15 minutes from noon through delivery at 5:37 PM. Sometime after 3:15 pm, the Chief Resident wrote a note concerning her examination, which described cervical dilation of 6 cm, and noted that the patient was in active labor but "will not artificially rupture membranes now as may risk cord prolapse."

At 5:37 PM a 1-lb, 5-oz infant was delivered by the Chief Resident with the attending present, with Apgars of 2 and 6. The delivery note at 6 PM states that the infant was suctioned and evaluated by Pediatrics; the neonatal intensive care unit attending notes that the infant was intubated in the delivery room and brought to the NICU. Placental pathology revealed "acute chorioamnionitis." Venous cord blood revealed a pH of 7.4, but the arterial blood "leaked from the syringe" and couldn't be tested. Likewise, cultures for group B streptococcus and chlamydia were either never done or not reported.

The infant remained in the NICU until November 2, where he was diagnosed with staphylococcus aureus sepsis and developed osteomyelitis and shortening of the right leg. He was also diagnosed with retinopathy of prematurity, and despite multiple attempts at cryotherapy, was discharged with complete retinal detachment and total blindness.

THE ALLEGATIONS:

The plaintiffs alleged that as early as July 18 and on July 26, the patient should have been on bed rest and/or tocolysis to arrest early labor and prevent premature delivery. They further alleged that the defendants were negligent in examining the patient on July 18 and in failing to hydrate the patient to "prevent premature labor." During the neonatal period, they claimed, the infant was inadequately oxygenated, cryotherapy was either untimely or inappropriately performed, and there was a failure to timely respond to and treat infection in his right leg and knee, resulting in leg shortening.

The plaintiffs claimed that the infant suffered from total blindness, leg shortening, and brain damage, even though the records did not support the latter injury.

DISCOVERY:

According to the infant's mother, she not only presented to the hospital center on July 18th but returned 3 to 4 days later, at which time she was seen on the L&D floor for diarrhea, dizziness, tiredness, and

leaking of clear fluid. She claimed that only a urinalysis was performed, not an internal examination, and that she was told that "everything was normal" and discharged. No evidence of such a visit existed in the hospital record. The mother also testified that she was unaware of the diagnosis of retinal detachment at the time the infant was discharged from the hospital's NICU, and asserted that aside from the shortened leg and blindness, he suffered from behavioral difficulties at school.

The plaintiff's husband testified that, to his recollection, his wife made only one predelivery visit to the hospital center, on the day before delivery. At that time, he claimed, the patient was discharged without examination, despite her physical complaints. The infant's father further gave emotional testimony about a family vacation to Disney World, during which their older, sighted son rejoiced at meeting the "Disney characters," while the infant plaintiff became frustrated and inconsolable at his inability to share his brother's vision. While the infant's father confessed that neither an educator nor a physician had labeled their son as brain damaged or neurologically impaired, a teacher from the infant's school indicated that he was "learning disabled."

During the course of discovery, the plaintiffs did not pursue deposition of the obstetrical resident who evaluated the patient on July 18th, deciding not to allow the hospital staff to attempt to "explain away" the care or lack thereof rendered on that date. The delivering obstetrician—the Chief Resident—testified that while the patient had complained of leaking for 2 days at the time of admission, her membranes had not ruptured at the level of the cervical os. This was confirmed by the amniotic fluid index of 17 and the absence of evidence of infection. Labor would not have been delayed by tocolysis, however, as the mother had a consistent contraction pattern and was leaking fluid for 2 days, increasing the risk of an environment hostile to the fetus. In fact, the placental pathology revealed acute chorioamnionitis, which further supported the decision to deliver the infant.

The admitting neonatological attending testified that the infant had metabolic acidosis that was not the result of a hypoxic birth injury or respiratory distress syndrome, but consistent with prematurity. In fact, the infant had "mature lungs" for his size and gestational age, since he required minimal oxygenation during the first week of life before being weaned to room air.

Our obstetrical expert could not defend the omissions by hospital staff when the patient presented on July 18. The absence of a pelvic examination to determine whether the cervix was long and closed, rather than dilated or ripening, deprived the defense of making a medically sound argument that tocolysis and bed rest were unwarranted as ways to prevent premature delivery. Furthermore, dehydration is a known risk factor for premature delivery, and despite the patient's complaints of gastrointestinal distress, dizziness, lightheadness, and diarrhea, she was not hydrated on that July 18th presentation.

RESOLUTION:

The case was settled for \$3.5 million before trial. Although many—if not all—of the infant's difficulties could be attributed to his prematurity, the hospital had no documentation that would have enabled it to defend the premature delivery as a necessary and unavoidable event. The failure to adequately assess the mother by pelvic examination or take the appropriate steps to prevent the potential for premature delivery in the face of significant warning signs 1 week before delivery ultimately would have made the hospital responsible for the consequences of the premature delivery. These omissions, in conjunction with issues surrounding the cryotherapy for the infant's retinopathy of prematurity and the septic right knee, which are not the subject of this article, were the significant factors in leading the hospital to settle this case in the face of its significant emotional portents.

ANALYSIS:

From the hospital's perspective, this was a particularly difficult case to settle, as reasonable explanations for the retinopathy of prematurity and the septic arthritis were investigated and available, as was the lack of evidence of hypoxia either post-or perinatally. Prematurity was the obvious explanation for all the infant's problems, thus, a failure to predict or prevent premature delivery became the focal allegation. Unfortunately for the hospital, the staff's lack of awareness of the potential for early delivery—which was clear from the prenatal assessment that was devoid of conscious thought—gave the patient the opening to argue that the unfortunate events might have been preventable, had the doctors not dropped the ball.

Often, we are put in the position of all but conceding departures from acceptable care but arguing that those departures were not the "proximate cause" of the patient's injuries. This requires a more sophisticated medical defense. In this case, there was no way around the simple fact that, accepting plaintiff's theories, the initial omissions led directly to the instrument of injury. Here it was wiser to settle than to let a jury sympathetic to the infant's disabilities price the award by weighing what the deficiencies in charting and care were worth.

From the Editor in Chief

This case provides yet another example of the arbitrary and capricious nature of the current tort system. Prematurity cannot be prevented, and certainly not by hydration. Antibiotic therapy and corticosteroids without tocolysis represent a completely rational approach to care in this setting. Finally, the decision to deliver was completely justified by the subsequent findings of neonatal sepsis and placental chorioamnionitis. Indeed, if the physicians had attempted to delay delivery in this setting, I posit that the plaintiff's attorneys would have reversed their allegations and claimed that the patient was not delivered early enough. The truth is that intact survival following advanced premature delivery at 23 to 24 weeks is relatively uncommon and such verdicts are unjust, unfair, and unworthy of the judicial system so skillfully crafted by our founding fathers. —Charles J. Lockwood, MD