
Legally Speaking: Why was this cesarean delivery delayed?

By *Andrew I. Kaplan, Esq.*
Feb 1, 2008

THE FACTS:

The patient, a 27-year-old G5, P1, was admitted to the defendant hospital center at approximately 3:15 PM on September 27. Her prior pregnancy had ended 18 months earlier with a cesarean delivery (CD) via transverse uterine incision for nonreassuring fetal heart rate tracings.

IN THE CURRENT PREGNANCY she had been followed by the chief resident in obstetrics, who had been involved in the prior CD. Although her prenatal course had been uneventful, the patient was admitted for induction because of oligohydramnios, which had been confirmed during an ultrasound evaluation that morning. A prenatal progress note by the chief resident on June 7 specifically documented that the patient wanted a trial of labor after prior CD. The note also documented the fact that the risks of such a trial of labor, including the risk of uterine rupture, had been discussed with the patient.

On admission, gestational age was assessed to be 41 weeks and 4 days, considered term, as opposed to post-date (i.e., 42 weeks). The intern reported the results of the biophysical profile as 6/10, with points taken off for the decreased fluid levels and a nonreactive nonstress test. The intern's vaginal examination revealed a long, closed, posterior cervix, while a Leopold maneuver yielded an estimated fetal weight of 3,875 g, as compared to the September 23 estimated fetal weight by ultrasound of 4,100 g. The intern made reference to a fetal tracing with positive accelerations and one variable deceleration with "good return." With the senior resident, she formulated a plan of induction that would be discussed with the attending. At 4:15 PM, the attending authored a lengthy note, which stated "counsels the patient against a trial of labor" based on four documented factors: macrosomia; prior cesarean section performed less than 18 months earlier; cervix long, closed and posterior; and a biophysical profile indicating that a successful vaginal delivery was unlikely." The note also

documented a lengthy discussion on the risks of CD, but it is also noted that the patient was Turkish-speaking.

The chief resident involved in the previous CD (#1) was called by the intern and arrived at the hospital some time after 5:00 PM to evaluate the patient, although the resident was not part of the regular labor and delivery team that evening. At 5:45 PM, she documented that the patient was "well known to her and desired a trial of labor," and that the case would be discussed with the second obstetric attending who, along with a maternal-fetal medicine (MFM) specialist, would be assuming care at the shift change. The MFM specialist, however, authored no consult or progress note regarding an evaluation of the patient or discussions with the attending, or chief resident (#1). The chart, however, reflected that the patient consented to a trial of labor and was informed of the risk of uterine rupture.

The chief resident (#1) then left the hospital sometime after her note of 5:45 PM with instructions to the junior resident to call her when the patient was near delivery. The responsible on-call attending for the evening wrote no notes in the chart with the exception of a postdelivery note. Between 11:00 PM and 2:30 AM there is no documentation of the attending having seen the patient or been consulted by residents concerning the patient's care. The resident documented the evaluations at 9:15 PM, 10:30 PM and 12:30 AM as to the reassuring fetal heart rate tracings and describing the oxytocin augmentation, which never went above 8 mU.

At 12:30 AM on September 28, the junior resident's vaginal examination revealed a cervix 7 cm dilated with oxytocin running at 8 mU. The plan was to anticipate normal spontaneous vaginal delivery and to call the chief resident, which was done. Painful contractions despite analgesia were also documented. The chief resident arrived in the hospital at approximately 1:00 AM, evaluated the patient, and continued the oxytocin at 8 mU. Contractions were adequate and FHR tracings were reassuring. At 1:20 AM, chief resident #2 documented the fact that the patient had mild variable decelerations and a prolonged bradycardia episode to the level of 100s for approximately 9 minutes. The latter responded to positional changes, hydration, and oxygenation, and the FHR returned to baseline. A favorable scalp stimulation sign was elicited, the patient was fully dilated, and the oxytocin was stopped. Neither the attending nor chief resident #1 was told about the prolonged bradycardia.

At 1:25 AM, chief resident #1 assumed management. Between 1:25 AM and 2:20 AM, the tracings showed variable decelerations with spontaneous recovery and positive scalp stimulation test. The pattern of contraction was adequate, there were no signs of uterine dehiscence, and the fetal station was assessed as 1+ during that time frame. At about 2:20 AM, the potential for a repeat CD was discussed, with the reasons cited including variable decelerations and slow progress of labor and lack of fetal descent. A nursing note showed that oxytocin was restarted at 4 mU by chief resident #1 at 2:20 AM and was "off at 2:30 AM." The tracings reflected a variable deceleration before the oxytocin was restarted.

After 2:30 AM, the variable decelerations became persistent and at that time the attending was contacted so that a CD could be performed. At approximately 2:39 AM loss of fetal station consistent with a ruptured uterus was appreciated when the chief resident attempted to reinsert an internal scalp electrode that had become dislodged, and the nurse's note indicated that the patient was in the OR at 2:41 AM. Delivery occurred at 2:48 AM and the placenta delivered 1 minute later. During the operation, it was noted that the fetus was expelled from the uterus into the peritoneal cavity and the placenta was detached from the uterus as well. The APGARs were 1/1/3 and the infant was intubated.

In the NICU the initial blood gases were pH 6.88, PO₂ of 66 mm Hg, PCO₂ of 52 mm Hg, and HCO₃ of 11.7 and the infant found to be hypotonic and developed seizure disorder shortly after birth. The infant remained in the NICU until December 1 with a clinical course consistent with hypoxic ischemic encephalopathy with seizure disorder; the baby required a feeding tube, and still needed it throughout the next 3 years. Physical examination revealed an infant with "profound mental retardation and spastic quadriparetic cerebral palsy." The child was dependent for all activities of daily living and was immobile with fisted hands and brisk reflexes. He had no verbal ability but at best responded to his parent's voices. According to our own examining physician, the infant had a significantly shortened life span.

ALLEGATIONS:

The plaintiff alleged a failure to timely perform CD and otherwise allow a trial of labor while ignoring the plaintiff's past obstetric history, failing to perform a CD for nonreassuring FHR tracings and arrest of labor, improperly restarting oxytocin in the presence of nonreassuring FHR tracings, failing to appreciate the risk of uterine rupture, and thereafter a failure to timely evaluate and diagnose uterine rupture, and failing to consult with the attending obstetrician regarding the change of labor status and the earlier need for CD.

As a result, the plaintiff asserted that the uterine rupture occurred and resulted in hypoxic ischemic encephalopathy and profound developmental delays.

DISCOVERY:

The patient testified at her deposition that she and the chief resident did discuss the manner of delivery toward the end of her prenatal care but she downplayed the bond between herself and the physician and denied preferring a trial of labor.

Chief resident #1 testified that she advised the patient of these risks throughout the prenatal course and always gave the patient the option of selecting CD. Chief resident #1 further testified that she had a discussion with the first obstetric attending concerning the situation (the attending who wrote the 5:45 PM note counseling against the trial of labor) but the attending testified that she had no recall of the conversation. That initial attending testified, however, that she would invariably discuss the matter with the other attending prior to "signing-off" and that the matter of a trial of labor versus a CD would have been discussed. The consensus was that a trial of labor was not contraindicated and the attending involved in the delivery provided excellent testimony that she was aware of all of the relevant information concerning that decision. In fact, the first attending who wrote the note counseling against the trial of labor testified that the only true contraindication would have been the presence of a previous classical incision, which was not the case in this situation. The other factors listed in her note were not related to an increased risk of uterine rupture but rather decreased chances of a successful vaginal delivery.

The maternal-fetal specialist acknowledged consulting with the chief resident regarding a trial of labor but believed that consult took place in the hallway and had no recall of discussing the case with the attending ultimately involved in the delivery.

As to the variable deceleration documented prior to restarting oxytocin, chief resident #1 testified that by the time she restarted the drug, the deceleration had recovered and she discontinued the oxytocin

within less than a minute after it had been restarted. The nurse testified that the oxytocin was off by 2:30 AM, not precisely at that time. Chief resident # 2 testified that the attending was called at 2:30 AM because of the persistent variable decelerations. Chief resident # 2 testified that the uterine rupture occurred moments before she attempted to reinsert the internal scalp electrode and although she was certain that the infant was extracted in under 5 minutes from the time of rupture (which she confirmed would be standard) we were only able to compress the time period through testimony and the records to between 2:40 AM and 2:48 AM.

The first MFM expert was willing to testify for the defense but conceded vulnerabilities. He believed that as of 2:22 AM and thereafter the tracings revealed variable decelerations without appreciable improvement and could defend the discussion of CD at that time. He believed the steps taken from 2:30 AM until delivery were appropriate and did not feel there was a dogmatic "less than 5 minutes" standard in extracting a fetus once lost to fetal station and probable uterine rupture were appreciated but that the physician must move "as quickly as possible." This expert could not defend the recommencement of the oxytocin at 4 mU at approximately 2:22 AM but concurred that if it was running at 4 mU for only a few seconds it would have no effect. A strict reading of the hospital records suggested the oxytocin was running for 8 minutes, however, which he could not defend. He was also somewhat noncommittal as to whether the contraction pattern from 1:25 AM up to the loss of fetal station at approximately 2:40 AM was suggestive of scar dehiscence or rupture.

A second review by an independent expert was more critical in that the second expert cited a "low threshold for strip abnormality" in VBAC patients. He felt that variable decelerations were the hallmark of uterine rupture and that at 1:10 AM the mother needed to be brought to a room where she could deliver abdominally within minutes as there was evidence of fetal bradycardia with an incomplete return to baseline. The attending physician should have been alerted at that time that an emergent rupture required immediate CD and that at 2:20 AM there was an "awful deceleration" that was unquestionably an evolving rupture. He cannot comprehend why the oxytocin was turned back on at that time.

OUTCOME:

The patient's economist submitted a report claiming anywhere between \$4,000,000 to \$10,000,000 in lost earnings for 27 years and future medical expenses in the amount of \$8,000,000 with projected expenses over 30 years.

Even applying a more conservative loss of earnings and conservative growth rates, the sustainable exposure in the case was in the \$10,000,000 range. The plaintiff's official demand was \$12,000,000 firm until just before trial. The case settled for \$6,000,000.

ANALYSIS:

While our experts could defend the care before 1:10 AM and perhaps even up to 2:20 AM, the primary concern was that they couldn't effectively defend the decision-making thereafter and that would call into question all of the defendants' other decisions and explanations.

While documentation of the initial attending physician counseling against the trial of labor and a subsequent decision to attempt a trial of labor in this patient was somewhat inconsistent, we felt that the expert testimony and the reasonable explanations of the physicians involved in the patient's care

could effectively support the decision to attempt this labor trial. The variable decelerations from 1:10 AM to 2:20 AM, the fact that positive scalp stimulation was documented, that oxytocin was never given in excess of 8 mU, and that the period of prolonged bradycardia responded to treatment would have been reassuring. We had two primary concerns, however: We didn't have a reasonable explanation for why the oxytocin was recommenced after the 2:20 AM variable deceleration. And we were unable to prove that the drug was given "on and off" within seconds, as opposed to administered over the course of 8 minutes. Both problems may have called all of the other explanations into question. Loss of credibility on one significant issue can often cause a jury to not believe everything else you're asking them to accept, reasonable or not.

Given the concern that the patient was incongruously given oxytocin at 2:20 AM, in the face of a deep deceleration, when she likely should have been taken to the operating room for a STAT CD, we believed that a jury would feel the contraction pattern as early as 1:10 AM should have received more attention from the senior attending, as opposed to just residents, and that that failure resulted in a cascade of events that prevented the team from recognizing an emerging or existing uterine rupture and significant injury to the child. As a result, we decided to settle the case rather than go to trial.

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.