
Legally Speaking: A botched case of postpartum pulmonary hypertension.

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Any break in the chain of communication between physician and patient or between resident and attending can delay a crucial diagnosis.

THE FACTS

The patient, a then 33-year-old G4, P2, presented to the co-defendant obstetricians in August 2001, seeking treatment from physicians "expert in high-risk pregnancy." The patient had two episodes of fetal demise in 1999 and 2000, as well as a heart murmur due to congenital heart disease (CHD), requiring prophylactic antibiotics. As a result of the patient's CHD, she was considered high risk and in fact said she was afraid of dying after her delivery, as her own mother had, as a result of her underlying cardiac condition.

OTHER THAN SOME spotting during the first and second trimesters, the patient's pregnancy was uneventful until premature rupture of membranes, on February 27, led her to present to the co-defendant Hospital Center (she had an EDC of April 21). However, the hospital records show that the patient was taking insulin for gestational diabetes, and had taken the "wrong" insulin the morning before her presentation. Her records also indicate that she had a long history of depression, exacerbated by fetal demise in consecutive years.

On presentation on February 27, the woman complained of uterine contractions and spontaneous rupture of membranes. The co-defendant attending obstetrician admitted her to labor and delivery, where tocolysis was administered in an attempt to delay labor. Despite this, the following afternoon, the patient delivered the infant on her own while she was on the toilet in the bathroom of her hospital room. The infant remained admitted for approximately 1 month thereafter because of its prematurity, but has done well.

The patient, however, was discharged on March 2 despite complaints that she was feeling "dizzy and nauseous." When she arrived home, her husband called the co-defendant attending physician

complaining that his wife looked "bloated and fat and could not walk because her feet were too swollen," and was told that this was a normal postpartum appearance.

On March 5, 3 days postpartum, the patient spoke to the co-defendant obstetrician and said that she was not feeling well. She went to his office with her husband for an evaluation, at which time a blood test revealed anemia. Although the obstetrician measured the patient's blood pressure and listened to her heart via a stethoscope, no EKG was performed despite her congenital cardiac condition. She was instructed to go home and rest, but while entering her apartment complex she collapsed to the ground. As a result, she was rushed by ambulance to the emergency department (ED) of the defendant hospital center.

In the ED, the patient complained of two syncopal episodes, facial bloating, headache, nausea, vomiting, and not feeling "right" since her delivery on February 28. The physician assistant performed a physical examination that was unremarkable, and the third-year obstetrics resident documented MP and depression. Dr. A, the ob attending, ordered a full workup, including assessment for pulmonary embolism, anemia, and preeclampsia, which included arterial blood gases, chest x-ray, bilateral venous Dopplers, and a lung perfusion/ventilation quantitative scan. The ABG results were pH=7.49, PCO₂=27, PO₂=78, HCO₃=20, with an oxygen saturation of 97%.

Unfortunately, there was a shift change soon after admission and attending Dr. B was misinformed by the third-year resident as to the ABG results. The resident advised the new attending ob that the PO₂ was 97 (the actual value of the oxygen saturation), instead of 78. As a result, and as a result of the patient advising that she was extremely agitated, "having a nervous breakdown," and wanted to see a psychiatrist, the attending Dr. B cancelled the workup based on the ABGs, and instead ordered a psych consult and administered paroxetine. The patient was discharged home with a diagnosis of anxiety, on the same antidepressant, with a discharge order instructing her to follow-up with her primary-care physician the following day.

The following evening, the patient's husband noticed that while she was sleeping, his wife uncharacteristically gagged and snored. She complained of feeling bloated and weak, and on March 8, collapsed on the way to her synagogue. She was transported to the co-defendant local hospital, where it was noted that her lips were blue and she was having difficulty breathing. On admission she complained of chest pain and shortness of breath, and a full workup, including EKG, was ordered. The EKG revealed a normal sinus rhythm and a right ventricular conduction defect, and this time, it was observed that her PO₂ was 71.9.

The attending pulmonologist ordered bilateral compression venous ultrasounds, which were negative for deep vein thrombosis, and a spiral chest CT scan with contrast, which was negative for pulmonary embolism. A cardiologist consult was performed, which ruled out acute or chronic pulmonary embolism, and it was recommended that the patient remain on anticoagulation therapy and gentle diuresis. An ob/gyn consult was obtained to rule out amniotic fluid embolism as the cause of the patient's pulmonary hypertension.

Due to the unknown etiology of her pulmonary hypertension, a decision was made to transfer the patient from the local hospital to a larger teaching facility for more intense medical management. Despite this, she died the following day, March 11.

ALLEGATIONS

The plaintiff alleged that the co-defendant primary ob/gyns were negligent in failing to be attuned to subtle changes in the woman's mental status during her last trimester, as they were a precursor to her pulmonary hypertension.

HE FURTHER ALLEGED that the patient should not have been discharged from the hospital after delivery, feeling "dizzy and nauseous," before the performance of an EKG, electrolytes, or efforts to rule out pulmonary embolus, which might have led to the diagnosis of pulmonary hypertension. Further, when the patient's husband called days later, he alleged that the co-defendant physician should have brought the woman back into the office for evaluation. They further asserted that the defendant hospital to which the patient was transported via ambulance on March 5 was negligent in canceling the full workup to rule out pulmonary embolism, given the patient's recent history and given the erroneous report of the patient's PO2 to the attending.

Finally, the plaintiff asserted that the local hospital was negligent in not transferring the patient to the larger teaching facility 24 to 36 hours earlier. The plaintiff asserted that had any of these physicians acted in accord with good and accepted practice, an earlier diagnosis of pulmonary hypertension would have been made, treatment would have begun, transplant could have been performed, and the patient's death could have been avoided.

DISCOVERY

Discovery revealed that at the time of her demise, the woman had two daughters, aged 3 and 7, and was not working. Her husband testified that although his wife experienced bouts of dizziness and syncopal episodes throughout the pregnancy, the co-defendant obstetrician never suggested that her cardiac condition put her at increased risk. He claimed that at the defendant hospital where she was taken on March 5, he was told by the physicians that his wife was suffering from severe postpartum depression, and would be discharged.

AT THEIR DEPOSITIONS, the co-defendant primary obstetricians each suggested the other was managing this patient's prenatal care. The first suggested that he wouldn't manage high-risk patients while the other suggested this patient was not high risk.

Ob attending B at the hospital during the March 5 admission conceded that she was advised of an erroneous PO2 value by the resident, and as a result thereof, cancelled the pulmonary workup orders. She also discharged the woman via telephone order without actually examining her at the time of discharge.

Attending A at the same facility insisted he was "off duty" as of 6:00 PM on March 5, and had no role or awareness of the decision to discontinue the workup he had ordered. The third-year resident confirmed at her deposition that she misinterpreted the PO2 and reported the ABG results to attending B as "normal." This physician had never treated a patient for a suspected pulmonary embolism and had never diagnosed pulmonary hypertension in a patient.

From an expert perspective, we first had a cardiologist review the case who felt that at the time of her presentation to the hospital emergency room on March 5, the patient likely had advanced pulmonary hypertension, which had been masked to some extent by her history of anxiety and her acclimation to

these symptoms during the pregnancy. He felt she should not have been discharged from the ED on March 8 without any significant treatment, but opined that it may not have made a difference since she was diagnosed with pulmonary hypertension at the local hospital 3 days later.

Two obstetricians reviewed the case. The first felt that the initial hospital, where the patient delivered, and her primary obstetricians were vulnerable, for failing to order an EKG or electrolytes following her complaints of dizziness and nausea, given her medical history. She was highly critical of the failure to perform a full workup after the miscommunication regarding the patient's PO2 at the defendant hospital center on March 5. She felt the obstetricians should have suspected hypoxia.

The second obstetrician opined that both the primary obstetricians and the physicians at the hospital center on March 5 "dropped the ball" in failing to perform a full cardiac workup or to suspect that the patient's inability to walk as a result of swelling and weakness was a symptom of primary pulmonary hypertension. But, in his opinion, it may have been too late to save the patient, as the only possible treatment would have been a heart and lung transplant, for which the patient might not have been a candidate if she was in end-stage disease.

To that end, we had a pulmonologist review the case who felt that the patient's recent history of syncopal episodes was an indication that the patient was in fact in end-stage primary pulmonary hypertension. He did not believe transplants could have or would have been performed in a timely fashion to save the patient's life, but suggested we retain a transplant expert to comment on those issues.

The transplant expert disagreed entirely with the pulmonary expert. He felt that the patient's pulmonary hypertension was an acute process and could have been remedied in a timely fashion. He felt there was no evidence that the woman had compensated for chronic pulmonary hypertension, further suggesting this was an acute process brought on by pregnancy and delivery. Ironically, this expert suggested that more should have been done at the larger teaching facility where the patient expired (which was never sued). In fact, the patient was administered dobutamine at that facility, which reduced the pulmonary pressures, but at the same time, the drug placed significant strain on her heart, causing the right ventricle to lose strength and rendering it unable to produce high pulmonary pressure. He felt that dobutamine hastened the right ventricular failure and ultimately killed the patient.

RESOLUTION

Given the rather universal criticism of the various specialists and the contradictory testimony interposed amongst some of the defendants, a decision was made to settle this case rather than try it before a jury of six. Given that the woman left behind two infant daughters, a settlement demand of several million dollars was interposed by the patient's attorneys (in the State of New York, loss of parental guidance can fall anywhere between \$1 and \$1.5 million per child).

EFFORTS WERE MADE to use the transplant expert's opinions during settlement negotiations to the extent that the patient's attorneys had never named nor sued the hospital where the patient expired, despite the fact that they may very well have ultimately been "responsible" for her death. Ultimately, the hospital to which the patient had been admitted on March 5 paid \$1 million in settlement and the primary attending ob/gyn who managed the patient's pregnancy contributed another \$250,000 to resolve the case.

ANALYSIS

Other than the obvious error of a resident misreporting blood gases to an attending, this is a case that largely was a result of a patient's symptoms or the cause of those symptoms slipping through the cracks.

FIRST AND FOREMOST, a lesson to be learned from what occurred at the hospital center: The physician assistant reported the blood gases to the third-year resident, who then reported to the attending that they were "normal." While, granted, in a teaching facility, attendings have to rely on residents, interns, and physician assistants, an argument can certainly be made that the physician assistant should have reported those values directly to the attending, who had just started her shift, and was seeing the patient for the first time, or that there should be a system of checks and balances whereby the attending would be responsible for "eyeballing" the values prior to discontinuing medical workup for a rather significant condition. In addition, this patient's history of depression and anxiety, when superimposed upon the customary emotional and physical changes that occur during pregnancy, to some extent lulled her primary physicians into a false sense of security.

While her congenital cardiac condition ultimately might not have played any role in the onset of primary pulmonary hypertension and her demise, a logical argument could be made that the patient's medical history should have at least led the primary obstetricians to place greater weight on her postpartum complaints of weakness, bloating, swelling, and syncope. Whether or not earlier workup or diagnosis would have obviated the need for transplant or the patient's ultimate demise will never be known, but arguing in front of a jury that none of these missteps caused or contributed to her death was something the hospital and the attending were not willing to risk.

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