
CASE STUDY: THE BRAIN-DAMAGED BABY

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Oct 1, 2002

THE FACTS:

The then 36-year-old plaintiff presented to a hospital for delivery in December, 1991. Her obstetrical history included two full-term vaginal deliveries (7 ¹/₂ and 8 lb) and two spontaneous abortions. Her last delivery was 14 years prior.

On admission at approximately **6:15 pm** by Dr. R (house physician), the woman was 2-cm dilated with 70% effacement and was placed on an external monitor. At **8:45 pm**, she was administered 50 mg of meperidine and 50 mg of hydroxyzine; shortly thereafter, poor beat-to-beat variability was observed on the external monitor. The results of a scalp pH performed at **10:38 pm** were "7.33." At **11:45 pm**, Dr. C (chief resident) noted the patient was dilated to 6 to 7 cm with poor beat-to-beat variability and occasional variable decelerations. The matter was discussed with co-defendant attending, Dr. I, and oxytocin augmentation was commenced at approximately **12:00 am**.

By **1:10 am**, the patient was fully dilated, and at **4:05 am**, the patient was brought into the operating room for a cesarean section for failure to progress and maternal exhaustion. The infant was delivered from the OP position with Apgars of 8 and 8, and weighed approximately 6 lb, 10 oz. While in the nursery, she had coarse tremors of all extremities and left-handed weakness. The infant continued to suffer from a progressive seizure disorder after discharge and expired in **November of 1998**. The cause of death was believed to be an acquired infection related to her underlying neurodegenerative condition.

THE ALLEGATIONS:

The plaintiffs alleged negligence in failing to designate the patient as "high risk" based upon her advanced age and obstetrical history; in failing to timely perform C/S; and in failing to appreciate and respond to evidence of cephalopelvic disproportion. It was asserted that as a result of the negligence of the defendants, the infant plaintiff suffered from traumatic labor, which resulted in hypoxia and significant brain injury in utero.

DISCOVERY/DEPOSITIONS:

The focus during this stage of litigation was to establish discrepancies between the plaintiff's recollections and documentation in the chart, minimize damages (if possible), and coordinate a unified defense.

At her deposition, the plaintiff testified that after pushing for a "long time" she asked the attending about a C/S but was told that no operating rooms would be available before **4:00 am**. The operating room logs, however, revealed that the last C/S performed before the plaintiff's was completed at **9:51 pm**. The logs also established that the co-defendant attending performed vaginal deliveries at **9:30 pm** and at **12:35 am**.

The attending was initially reluctant to admit that he was present and had been contacted by the chief resident several hours *before* delivery. Ultimately, he confirmed that he was contacted about administration of oxytocin, and that based upon the fetal monitoring strips, there was no indication to perform a C/S any sooner than **4:00 am**.

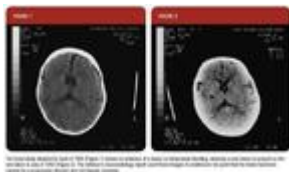
THE TRIAL:

At the time of trial, the plaintiffs called experts in obstetrics and gynecology, pediatric neurology, and neuroradiology in support of their theory that hypoxia secondary to head compression occurred during the prolonged second stage of labor, resulting in irreversible brain damage. The defense countered with experts in the same fields, who argued that the mother had a tested pelvis; there was no evidence of fetal distress based upon the strips or the Apgars; that the decrease in variability was directly related to the meperidene; and that the infant's neurological dysfunction was the result of a progressive neurodegenerative condition as opposed to birth hypoxia.

The plaintiff's pediatric neurologist testified that significant head compression prior to delivery caused ischemia and timed the insult to 1 hour prior to delivery. The plaintiff's expert in ob/gyn testified that there was a 1-hour delay in the performance of the C/S, but that the child *did not* suffer hypoxia from head

compression by virtue of the fetal monitoring strips. Plaintiff's neuroradiology expert testified that the progression of the infant's brain lesions as shown on the head studies was consistent with a hypoxic ischemic event at birth.

The defense neuroradiologist used enlargements of the head studies to show the progression of the infant's lesions and to demonstrate that the lesions did not exist before she reached age 5 months (Figures 1 and 2). The infant's treating pediatric neurologist testified that in the 5 years prior to her death, the infant was being treated for a progressive neurodegenerative condition that was not related to a birth injury.



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A preliminary factual question was posed to the jury: Did the infant suffer from a progressive neurodegenerative condition or birth hypoxia? Because the panel's answer was a progressive neurodegenerative condition, they never got to the departure questions and rendered a verdict in favor of the defendants.

ANALYSIS:

This is an example of defending a case of significant exposure largely through the efforts of the defendants and treating physicians. The hospital residents' well-documented chart enabled counsel to set forth a consistent and reasonable defense. In addition, the physicians were willing to testify in a unified fashion despite their instincts for self-preservation, which allowed their attorneys to coordinate their defenses at trial and to avoid confusing the issues and inflating the value of the case by finger-pointing. The medically consistent testimony of the defense witnesses contradicted the inconsistent testimony of plaintiff's pediatric neurologist and ob/gyn.

This case was tried by Carol Russell, a Partner in the New York firm of Aaronson, Rappaport, Feinstein & Deutsch, LLP. Ms. Russell is a 1988 law school graduate who has specialized in medical malpractice defense since entering private practice. Ms. Russell gained experience as a registered nurse specializing in emergency medicine, surgical intensive care, and open-heart-surgery and heart transplant units.

Andrew Kaplan is a Senior Associate Attorney with Aaronson, Rappaport, Feinstein & Deutsch, LLP. Mr. Kaplan is a 1993 law school graduate and has specialized in medical malpractice defense/health-care litigation since entering private practice.