



**LEGALLY SPEAKING**  
Risk management in obstetrics and gynecology

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## CASE STUDY: BRAIN INJURY AT BIRTH

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### THE FACTS:

A 24-year-old woman was admitted to the hospital on December 8th as a private patient of the defendant obstetrician for a repeat cesarean delivery. Her estimated date of confinement was December 15th and she had been seen by the attending for a total of 10 routine prenatal visits. Eighteen months earlier, she had a C/S at the same hospital.

Preoperatively, the patient was placed on an external monitor and the fetal heart rate was noted to be 148 to 150 bpm, regular, and with good variability. According to the labor and delivery report, there were no difficulties noted through and including the time of delivery, aside from a nuchal cord. The Apgar scores were recorded as 1, 6, and either 8 or 9 at 1, 5, and 10 minutes, respectively. The 1-minute score was attributed to a heart rate below 100 bpm (1 point) and no points for respiratory effort, tone, reflex, or color. The 5-minute score of 6 was attributed to the infant receiving 2 points for heart rate over 100, a slow and irregular respiratory effort, some flexion of extremities, a weak cry, and a pink body and blue extremities. The labor and delivery report lists the Apgar score as 8 at 10 minutes, but the anesthesiologist's report notes "cord around neck" and the obstetrician's operative report lists the 10-minute Apgar as 9.

Significantly, the obstetrician dictated two different operative reports. The first, dictated 2 months after the delivery, indicates that at delivery the cord was clamped and cut and the baby was handed over to the pediatrician for further care; on the table, the infant cried immediately after suctioning. The second operative report, with no dictation date but a transcription date 3 months after delivery, indicated that "the infant's body was delivered, and the baby was crying on the table. The infant was handed over to the pediatricians with good color, good muscle tone, good reflexes. After giving the infant to the pediatrician, it did not cry, so Apgars of 1, 6, and 9 were given."

According to the pediatric resident's admitting notes, however, the infant did not cry at birth. There was a poor cry at 10 minutes. The resident was present for the delivery and there were no decelerations or any evidence of fetal distress, but there was a "2-3 minute delay" in the delivery of the baby after incision of the uterus. The baby was born limp with no cry, pale color, a heart rate below 100 bpm, and no activity. The baby was suctioned and bagged, and 10 to 15 mL of fluid was aspirated. At 5 minutes, the heart rate was above 100 bpm and the baby had a poor cry, with peripheral cyanosis. The baby was brought to the neonatal intensive care unit (NICU) for observation and the impression was appropriate for gestational age, term male baby with low Apgar scores at birth, rule out aspiration.

The pediatric resident's note on the day after delivery suggests the infant most likely aspirated amniotic fluid during a "difficult delivery of the head," and mild perinatal depression was potentially related to cord compression during delivery. Other than being jaundiced, however, no abnormalities were noted at the time of discharge.

Nine months after he was born, the infant was evaluated by the hospital's Director of Pediatrics, who found mental and motor retardation along with speech delay and microcephaly. The impression was hypoxic ischemic encephalopathy and delayed motor development.

At 10 <sup>1</sup>/<sub>2</sub> months of age, the infant was evaluated by a pediatric neurologist, whose impression was that the child was microcephalic, with global developmental delays at the 2- to 3-month-old level, and generalized hypotonicity and right-sided hemiparesis, most likely secondary to hypoxic ischemic encephalopathy. An MRI done at 10 months was consistent with cerebral hypoxia. The neurologist's etiological diagnosis was perinatal insult. In reviewing the placenta, a pathologist noted that the mature placenta with meconium pigment-carrying macrophages in the membranes was consistent with intrauterine fetal distress.

#### **THE ALLEGATIONS:**

Plaintiff alleged that the defendants failed to recognize fetal distress, and as a result, to effect earlier delivery via C/S. Furthermore, the plaintiff alleged that resuscitation of the infant was negligently performed by the pediatricians present at delivery. The plaintiff also alleged a failure to appreciate the significance of variable decelerations. As a result, it was alleged, the infant suffered brain damage; CP; global developmental delays including right hemiparesis, visual impairment, speech impairment, language delay; and emotional distress, as well as impairment of future enjoyment of life and earning capacity.

#### **DISCOVERY:**

The infant's mother testified that the delivering obstetrician told her that when the infant was born, the cord was "wrapped around his neck 3 times" and he had aspirated amniotic fluid. She asserted that her

son did not reach his developmental milestones and had a significant learning disability. She further testified that while he can walk, his balance is poor and he needs assistance with most activities of daily living.

The defendant obstetrician testified that there were multiple operative reports for the delivery in question because the first one, which he dictated immediately after the delivery, was never transcribed. Medical Records approached him with an incomplete chart and asked him to dictate a report, which became the first report in the chart, and was placed there without either his knowledge or his signature. Thus, he dictated the report a third time, and it unfortunately to some extent contradicted the one that had already been placed in the record.

The obstetrician testified that the Apgar score of 1 at 1 minute was not accurate, in that the infant cried at birth, meaning he was breathing and had muscle tone and a heartbeat. He testified that he independently recalled the child having good color and tone. That, of course, indirectly implied that "something" happened in the first minute of life to cause the pediatricians and the anesthesiologist to conclude the infant was in poor condition.

The defendant obstetrician, however, testified that he turned over to the pediatricians a "well baby" and that nothing out of the ordinary occurred in the delivery room to explain the child's subsequent difficulties. He confirmed that the child was born with a nuchal cord, but disputed that there was cord compression or asphyxia at the time of delivery. Furthermore, he testified that there were no signs of fetal distress during the prenatal period or at the time of delivery, and refuted plaintiff's suggestion that the placental pathology reflected possible meconium aspiration. The obstetrician also refuted the pediatric resident's suggestion that there was a 2- to 3-minute delay in delivery after the uterus was incised, and stated that the record confirms that 2 minutes elapsed from incision to extraction.

Experts in obstetrics and gynecology, pathology, and neonatology reviewed the care. The neonatologist felt that it was not unusual for the infant to have excessive fluid in the airway during the first minute of life after C/S, and that appropriate suction and resuscitation efforts were documented. There were no signs of asphyxia on transfer to the NICU, and although no cord blood gases were done, the infant's blood pressure was normal, as was chest x-ray and the lab work that was undertaken. The infant was not floppy or hypertonic, and the neonatologist said she believed that the infant's microcephaly and poorly developed eyes (part of the iris was absent) were consistent with intrauterine disruption to development.

The pathologist felt that the number of syncytial knots present on the placental pathology slides reflected a lack of oxygen to the infant for an extended period before delivery. She felt this occurred when the short cord around the infant's neck was pulled tight as he moved within the uterus.

The obstetrical expert felt there was no reason to expedite the C/S because this was an elective C/S, the mother was not in labor at the time of delivery, and the FHR strips indicated good variability and no distress. He concurred with the pathologist that an intrauterine event likely preceded the delivery.

The attorneys for the patient waived deposition of the defendant pediatricians. This strategic maneuver prevented the defense from knowing whether the plaintiff intended to pursue obstetrical malpractice, pediatric malpractice, or both at trial. It also made it impossible for the pediatricians and the obstetrician to reconcile their disparate version of events through deposition testimony.

## **CONCLUSION:**

The case settled before trial for \$5 million, payable by the hospital on behalf of all of the physicians involved. This case was potentially medically defensible, and settled almost exclusively for medicolegal reasons. The venue was not "defense-friendly" and had been the site of prior excessive plaintiff verdicts. Counsel for the patient was a renowned malpractice attorney and skilled interrogator.

Plaintiff's experts were prepared to contradict the testimony of the defendant's experts on the timing of the infant's injury, thus rendering the case a credibility battle. However, the defense would have had to overcome poor charting, multiple operative reports by the obstetrician with differing synopses of the events that occurred after delivery, and the irreconcilable differences between the obstetricians and the pediatricians about the condition in which the infant was turned over to pediatric staff.

Therefore, the defendant decided that far too much grist for the mill existed in the hands of an experienced, effective interrogator to win the battle. The circumstances of the case—the significant, undisputed brain injury suffered by the infant, absence of an explanation from any of the defense experts about what caused the insult if it was not related to perinatal asphyxia, weaknesses in the records, and discrepancies between the defendants—were simply too formidable to overcome to obtain a successful verdict on behalf of the physicians and the hospital. Although it is unsettling, good medicine does not always make for a defensible case.

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