

# CAUSE NO. 95-02288-I

by Alan Smithee, Esq.

## SUMMARY OF THE FACTS

The plaintiffs had wanted a child for many years. Their first child was finally conceived in the fall of 1993 after treatment with Clomid. Prenatal course had been unremarkable. On March 6, 1994, she was 41 weeks and six days gestation, scheduled for induction of labor at 0700 hrs. the following day at 42 completed weeks gestation.

MARCH 6, 1994, 2200 hrs. The patient spontaneously ruptures her amniotic membranes. After contacting her obstetrician on call she presents to the hospital labor and delivery suite.

2345 hrs. "SROM @ 2200 6 MARCH 1994 with Mod. Meconium" is recorded by the Labor and Delivery (L&D) nurse. Her initial evaluation notes no abnormalities on Electronic Fetal Monitoring (EFM) with Fetal Heart Rate (FHR) "130s-140s, variability +, no accels or decels." The cervix is 70% effaced and 3 cm. dilated with the vertex at -2 to -3 station and meconium is noted to be absent. *SEE SUPPLEMENT PAGE 1: EFM TRACING PANELS 28792-28794 AND EXCERPTS FROM DEFENDANT DEPOSITIONS.*

### **DEFENDANT OBSTETRICIAN:**

Q. Okay, the term, "Intrauterine hypoxia" would be consistent with prebirth asphyxia as we are using it today, correct?

A. You will have to show me where that is in the report.

Q. Okay, page 4 under "Findings". Are we on the same document?

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## THE PRESIDENTIAL BOX

Dan Avery, President

Are operative vaginal delivery and pelvic surgery dying arts within our specialty? I suspect they are. I was once reprimanded as a junior resident on call at the county general for performing a successful midforceps delivery of an infant in acute intrauterine fetal distress. Your fourth-year resident had to be present for all midforceps deliveries, and mine had never done one. This was in the spring of her last year and since she was from a different training program which did not teach operative vaginal delivery, she wanted to do the delivery herself. Several months later another resident from her program incorrectly applied obstetrical forceps for the same indication, in the process avulsing the infant's globe from its orbit.

Just last week a new gynecology patient told me another horror story, this time about her own child being injured at birth by improper use of forceps. She is a juvenile-onset diabetic on insulin for many years. When inadvertently pregnant she registered at the local health department clinic, only to be transferred to the university complicated ob clinic 72 miles away. Travel was a problem and she missed appointments. Macrosomia was suspected and ultrasound examination at term revealed an estimated fetal weight of ten pounds.

Her perinatologist arranged admission to the labor and delivery suite for the following morning at 6:00 am, planning an elective Caesarean section. But as luck would have it she spontaneously ruptured her membranes that evening and presented to the labor and delivery suite. The junior resident on call, with the approval of his senior residents, decided upon a trial of labor with expected vaginal delivery.

The pelvis was borderline adequate but she labored through the night and was completely dilated by morning. She then pushed for six hours, only achieving +1 station. The junior resident decided to attempt a forceps delivery and delivered the head without difficulty, but then encountered a terrific shoulder dystocia which six other residents tried to resolve. The infant was ultimately liveborn but with a depressed skull fracture from the forceps, bilateral humeral fractures and Erb's palsies from the attempts at resolving the shoulder dystocia, and an avulsed umbilical cord requiring a four-unit transfusion immediately postdelivery. Not surprisingly the child is, and will remain so for the rest of its expected long life, seriously handicapped.

At the recent ACM in New Orleans I spoke with numerous fourth-year residents who described inadequate experience, expertise and confidence in both operative vaginal delivery and vaginal surgery. Each had performed ten or less vaginal hysterectomies and all were uncomfortable attempting more than the simplest procedures, even repairs of cystoceles, rectoceles or lateral vaginal wall defects. I suppose this resolves over time for some as they work in private practice with capable vaginal surgeons, learning and gaining valuable experience. But what about the rest?

Most of us haven't had the extensive experience in vaginal surgery that Colin Richardson of Atlanta has, for years the bread and butter of general gynecologists. Perhaps laparoscopic has replaced vaginal hysterectomy to some extent, but I doubt completely. Those of us trained prior to the mid 80s preceded advanced laparoscopic surgery, instead having to attend CME courses, find proctors, and satisfy our hospitals' credentials committees. Most but not all chose simple hysterectomies for our first few laparoscopic surgeries, knowing we could complete them vaginally if necessary. It's relatively simple with today's technology to partially dissect a fifteen-week-size fibroid uterus laparoscopically and remove it vaginally, but a twenty-week-size uterus

can be more easily and safely removed with a one hour abdominal hysterectomy than a five hour laparoscopy and/or vaginal hysterectomy.

The average resident in my training program did 100 vaginal hysterectomies during his third year and another 100 during his fourth, plus untold vaginal forceps and breech deliveries. But then I was taught by Dr. Thomas Boulware, who came to Birmingham in 1929 as the first board-certified obstetrician in Alabama and didn't retire from teaching until 48 years later. Although now apparently passé, training in operative vaginal delivery was a must in his program. No surprise since lack of expertise in the master obviously fosters the same in the apprentice. How can you teach others to be competent in operative vaginal delivery if you lack said competence?

Several years ago I remember reading a journal article about a survey of residency training programs which inquired into their commitment to teaching forceps deliveries. Obstetrical forceps were said to be excellent tools in experienced hands but instruments of destruction in others. I couldn't agree more, adding that the same is true of all our instruments and procedures. But here's the real question; "Is operative vaginal delivery a dying art?"

At last year's ACM in Las Vegas there was discussion of several future options for postgraduate training including continuing the current combined residency, adding a primary care residency, and splitting our residency into either obstetrics or gynecologic surgery as was the case 100 years ago. Some even espoused eliminating routine vaginal surgery from required residency training, instead recommending a fellowship for those who wished to master these skills.

Obviously resident experience in operative vaginal delivery and vaginal surgery is decreasing, I think in no small part due to the increasing demise of private and community-based hospital training programs. These were the source of most of the patients who had simple vaginal surgery for benign indications, an excellent teaching resource. I got operative vaginal deliveries and most of my benign vaginal surgery cases from such a hospital while the university hospital provided medical and surgical gynecologic oncology, reproductive endocrinology and surgery, and perinatology.

But I'm still worried. I'm worried that these are dying arts which will, too late, be sorely missed. I'm worried that great surgeons like Dan Thompson in Atlanta and James Breen in New Jersey will be eventually forgotten, and with them their techniques. Then again maybe I'm wrong. If you have thoughts or views along these lines, write us.

## THE WITNESS BOX

Doug Daniel, Editor

*“The fault, dear Brutus, is not in our stars, But in ourselves.”*

William Shakespeare  
Cassius to Brutus in Julius Caesar: Act I, Scene 2

First reported auscultation of the fetal heart, *“by applying the ear to the mothers belly”*, in 1818 by Geneva surgeon Francois Mayor (1779-1854).

*“Will it not be possible to judge the state of health or disease of the fetus from the variations that occur in the beat of the fetal heart?”*

Jacques Alexandre Lejumeau Kergaradec, MD (1787-1877)  
French physician and colleague of Laennec who first used his stethoscope to study fetal heart sounds, in Memoire sur l' auscultation, appliquee a l' etude de la grossesse, Paris, 1822.

*“The foetal pulsation is...about 130 to 140 in a minute; however, it is not necessarily observed to beat always at this rate...This variation may depend upon a variety of inherent vital causes in the foetus...An obvious explanation, however, is muscular action on the part of the foetus; and we shall very generally observe the pulsation of the foetal heart increased in frequency after such. The external cause, which we shall find most frequently to operate on the foetal circulation, is uterine action, particularly when long continued as in labour.”*

Evory Kennedy, MD (1806-1886)  
Irish obstetrician among the first to investigate the stethoscope for auscultation of the fetal heart, writing in Observations on Obstetric Auscultation, Dublin, 1843.

Since July is traditionally the dedicated issue of the Newsletter, we don't have an installment this month of Dan's series on impaired physicians, but it will return in October. The idea of this issue addressing Electronic Fetal Monitoring was to duplicate as closely as possible the old Clinical Pathologic Conferences (CPCs) I used to attend Wednesdays at noon in the Medical College of Georgia auditorium. A postmortem case would be presented, the clinical course summarized, and various consultants would discuss the possible diagnoses and treatments including the errors in management. There were always these really neat Kodachrome slides of the gross pathology and permanent histologic slides projected on a huge theater screen in the front. Add an element of suspense to the already existing drama and you've got first-class entertainment plus an exceptional educational experience.

Our case can be followed in real-time using the enclosed Supplement and covering the EFM tracings with the mask. You can look at the tracing, write your interpretation, lower the mask, read the nurse's and obstetrician's testimony regarding the strip, and lower the mask again to read the official peer-reviewed interpretation with the "ASFOG Seal of Approval". When you get to page 9 flip the whole thing over and continue on page 10. Hope you get as much out of reading it as I did producing it.

You already know most of the contributors since they're members of the Society, but a special thanks goes to Dick Paul for kindly giving of his time to review the strips and my readings of them plus writing an opinion.

Well, this year's ACM is history and so are the Society's New Orleans meetings. I have so-so news and bad news. The so-so news first: six members showed up for the presentations by Greg Avery and Bill Bradley; Joe Pastorek, Ray Cestero, Jon Hazen, Dan Laury, Blaine McCormick, Dan Avery and myself. Both were stellar performances. Greg's should be in the next issue (October 1998) as an article. The down side is we should have filled the room. Maybe next time. The bad news is we didn't get any signing promoting the Caduceus meeting for recovering physicians, ergo we once again gave a party and nobody came.

As for Philly next year, the chances of doing another Caduceus meeting are pretty good because it's both easy and cheap. If we can get the signing in the convention venue on Friday, Saturday and Sunday it could be a success. As for a meeting of the membership with an educational presentation, we'll see. If you're planning on being in Philly on Sunday evening of the ACM next year, call or write and we'll see what kind of interest there is.

Oh, by the way. Ob.Gyn.News was kind enough to ask me to write a guest editorial on sexual impropriety. It's on page 12 of the 1 JUNE 1998 issue. If you missed it and are interested, send me a SASE and you'll get a copy. They credited the Society and we should get some additional new members.

As usual we encourage submission of letters to the editor, articles and guest editorials for publication consideration. Letters and editorials are subject to editing only for space requirements with articles and editorials typewritten and double-spaced. Free reprints of individual past Newsletter articles are available to members at no cost upon submission of a SASE, back issues for \$10.00 each or \$20.00 per volume of four issues.

All opinions expressed in The Medicolegal OB/GYN Newsletter are strictly those of the bylined authors and do not necessarily represent policies, opinions or recommendations of the American Society of Forensic Obstetricians and Gynecologists, its members, Board of Directors, Editorial Board, etc.

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## THE BALLOT BOX

This just in! Ben Harer has again announced his candidacy for President Elect of ACOG, and needless to say he has the full and unequivocal support of the Newsletter and the Society. If you've never met Ben you've missed a rare treat. He is truly a renaissance man, with multiple scholarly interests both professional and personal that take him all over the world. Ben has served as Vice Chair and Chair of his Section, Vice Chair and Chair of his District, Chair of the Insurance Committee, VRQC Reviewer, member of the Committee on Health Care Economics, member of the Long-Range Planning Committee and, since 1991, College Secretary. He is still in our opinion the best qualified candidate to lead the College into the 21st century. I'm sure he will appreciate any encouragement or support you may provide.

## THE MAIL BOX

13 APRIL 1998

Dear Doug,

I would have appreciated the chance to respond to your concern about our new publication policy rather than have you express an opinion without background.

Let me explain that we are not discontinuing the Bulletins, Opinions, etc. However, in a survey about two years ago, the overwhelming response was to reduce the size of our mailings. We responded by investigating a number of avenues. One which many societies use is to publish documents in the official journal of the society. This gives wider distribution and allows referencing. Incidentally, criteria sets are not included. Unfortunately, in the first issue the wrong paper and a poor perforation was utilized. This will be changed. We have received numerous letters of thanks for the change along with the complaint. In addition, those Fellows who wish to continue to receive the separate mailing get them free, not at \$150 which is for non-members. Also, all documents are on our website and can be downloaded whenever needed. This was another suggestion from our Fellows.

In addition, it is hopefully our plan to send a compendium of all current documents to our Fellows at year end free of charge.

No one, especially in medicine, likes change, but sometimes we must change behavior. The Resource Center is not the place to complain. They receive over 80,000 phone calls a year and should not be hassled over an item in which they played no role. I accept full responsibility for the change. It was presented to the Executive Board and upon my recommendation, they agreed to a one year trial.

Finally, although dues are a critical part of the College budget, they only compose 17-19% of our revenue. Since dues have not increased in over four years, we are constantly seeking ways to reduce expenses and raise revenue. This change helped in a small way. We hope to continue to keep dues unchanged for another 2-3 years if possible.

In relation to primary care, let me again caution on what is reality and perception. The College has never advocated for general medical care, only for primary ambulatory care within the training of the physician. Why even this? Basically because, in 1993-94 when the decision was made, Congress and the Administration told us that the only way they would agree to women seeing their ob-gyn without a referral from a gatekeeper was to be designated primary care. We succeeded and our members in many areas have benefited tremendously. We have received piles of letters telling us how this saved their practice. In the interim, we have worked extensively on direct access, a preferable position. We are succeeding and hopefully will eventually have federal legislation. However, had we not acceded to primary care we would not have direct access. As a reply to the program directors, the residents who took the CREOG exam indicated that over 90% plan to practice primary care as part of their practice.

I hope these explanations help to explain ACOG's position.

Ralph W. Hale, MD, FACOG  
Executive Director

Dear Ralph,

Thanks for the letter. Hope I wasn't the only one who bitched about the change in document distribution. I see these as one of the College's most important programs not only for members' CME and risk management but also for maintaining the specialty's quality of care. Unfortunately the format in which the Green Journal presented them was essentially useless.

Doug

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1 MAY 1998

Dear Doug,

I recently read the April, 1998 edition of your newsletter, and am concerned about both the content and tone of some of the articles. In addition, in my view, some of the information and advice given could be confusing and in some instances, incorrect.

First, regarding the IDEX program, which you wrote about in "The Witness Box", there is some significant information which you seem to have disregarded. First of all, ACOG does not financially support IDEX or any other witness information service. We do subscribe to their services in order to provide access to IDEX information for our members. This is a significant benefit for ACOG Fellows. The amount of each Fellow's dues which goes to provide access to this service is less than one cent per year. This seems to me more than reasonable, though you may disagree. Secondly, since we are a professional organization of physicians, it should not be surprising that we provide services likely to be useful to the majority of them. All of our members have the potential to be defendants in lawsuits, and in fact, most have been. It is reasonable that they want to know the qualifications of those testifying against them and accusing them of malpractice.

Secondly, ACOG's changing the name of "Standards" to "Guidelines" has not changed the mission of these documents; that it is to provide an educational resource to members regarding appropriate practice. They were not originally, nor are they now developed to establish a standard of care or outline the only acceptable approach to a clinical situation. Unfortunately, there have been occasions when "expert" witnesses have misused those documents in order to attempt to establish in a court of law a standard of care which does not, in fact, exist. Disclaimers placed on ACOG documents attempt to make clear the fact that there are often many acceptable approaches to care, and that those outlined are not applicable to all patients or in all circumstances. It is stressed that approaches to patients should be modified based on individual needs and specific conditions encountered. It is unfortunate that some seem to desire hard and fast standards which should be enforced regardless of circumstances. This would usually not be in the best interests of quality medicine, though it clearly might assist those who wish to promote a specific side in a legal argument, independent of science or medicine.

Thank you for permitting me to comment.

Larry P. Griffin, MD, FACOG  
ACOG Director of Program Services

Dear Larry,

Thanks for the letter and you're welcome. Your comments and opinions are always appreciated, but on these two issues we'll just have to agree to disagree.

Doug

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21 MAY 1998

Dear Doug,

I was able to attend the Forensic Society's meeting in New Orleans for most of the two presentations. I had a plane to catch and was not able to stay around and informally discuss the Society and other related issues, as I had hoped.

I want to take this opportunity to suggest that the meeting was well presented. I thought both the attorneys who spoke did a grand job of presenting their information. I was disappointed that there was such a poor turn out. However, I think that is par for the course when you are struggling and starting out with a new Society.

I want to encourage the continuation of these meetings. If there is some way that I can facilitate or help encourage membership or attendance, please contact me. A meeting itinerary may stimulate some interest. It seems to me that a distribution of our newsletter to other members of ACOG who have similar interests might also be fruitful. I realize there is considerable expense in this endeavor. However, I think the projected goals of our society are worth this effort.

I also wish I had time to chat with you about future meetings and presentations; perhaps on the phone or at a subsequent writing.

Jon M. Hazen, MD, FACOG

Dear Jon,

Thanks for the letter. I too regretted not having an opportunity to visit after the meeting that Sunday nite. Thanks also for the kudos. It's unbelievably frustrating to expend the effort and money necessary to have a Society meeting when you're convinced nobody will come, and I was pleasantly surprised that even six of us showed up. Greg Avery's talk is to be the basis of an article in the October edition of the Newsletter so everyone can benefit from his remarks.

Whether or not we continue to attempt Society meetings at the ACMs is kind of a toss-up. Right now we're planning a similar meeting with speakers, possibly a mock trial, in Philadelphia next year but I just don't know. We'll see. There will be an attempt to obtain grant money from the same drug manufacturer who underwrote our meetings in Las Vegas last year but there's no guarantee they'll go for it.

As far as encouraging membership, I would beg you to copy and pass around the Newsletter to your colleagues and residents. If you need any information packets or membership applications, just call. And don't forget, we are always looking for articles for the Newsletter, so don't hesitate to take pen to paper and share your experiences or thoughts.

When the Society was first founded the Newsletter mailing list had twice as many names as dues-paying members and there was no discernible benefit by carrying these non-payers. Therefore, based on past experience, we probably won't expand the mailing list beyond dues-paying and honorary members. Having said that, there are about fifteen folks at the College and various periodicals who receive the Newsletter, but all have in the past and continue in some way to contribute to the Society's progress and growth.

Doug

## **THE BOOK BOX**

**Doug Daniel, Editor**

### **YOUR WORST NIGHTMARE**

Litigation Assistant: A Guide for the Defendant Physician  
Second Edition  
Unillustrated. 43 Pages. Washington:  
American College of Obstetricians and Gynecologists.  
Paper, \$8.00

You should have recently received a complimentary copy of this monograph if a member of the College. If not a member, I would strongly urge purchasing a copy. Either way you would be well advised to read it immediately if you haven't already. It's essentially an update of a 1986 publication of the same title. We must be doing something right here at the Newsletter because everything we've published about medical malpractice litigation and the legal system seems to be confirmed by the College. On the other hand, they may have taught us everything we know.

Although the more things change the more they stay the same, we all know there has been a sea change in the practice of our specialty since the 1980s with the advent of "mismanaged care", increasing employment of physicians by HMOs and other entities, the National Practitioner Data Bank, and innovations in the insurance industry such as risk retention groups and self-insured employers.

Larry Griffin's sure touch is obvious. He is after all Director of Program Services for the College, but he credits the other staff members of the Department of Professional Liability (Ken Heland, Susannah Jones, Linda Esser and Charlene Burger) for their important contributions. I would guess that Ken had a major role in the previous monograph and this revision since there's clearly an experienced attorney's hand at work here.

Covered topics include professional liability insurance, incident and claims management, the care and feeding of defense attorneys, settlement options, your Data Bank dossier, the discovery phase of litigation including depositions and other legal maneuvers, and the trial phase including advice on testifying effectively. Although oriented toward the physician defendant, all the information and advice is pertinent to the medical expert witness whether for plaintiff or defense. There's also a very useful glossary of those unfamiliar and confusing legal terms including a cross-reference section, plus the bibliography is excellent.

The final advice? Get it and read it, now. Don't wait until you receive that dreaded letter, certified mail with return receipt requested, from The Law Offices of Algonquin J. Calhoun, Esq., advising he's going to sue your pants off.

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## **THE LITTER BOX**

**Doug Daniel, Editor**

Two of our members recently locked horns in intellectual combat over medical expert witnesses. Jerrold Weinberg writes an opinion piece for each issue of OB.GYN.NEWS and Julius Piver took particular exception in the 1 APRIL 1998 issue to Jerrold's comments of 1 FEBRUARY 1998. So for your edification, entertainment and reading pleasure we proudly present "Dueling Experts - 1998". Hey, who said forensic obstetrics and gynecology had to be dull?

**YOU'LL SEE THEM IN COURT**

by Jerrold Weinberg

There has been an outbreak in our local area: plaintiff's expert pachydermatosis (PEP), a syndrome characterized by thick skin (the ability to withstand cold stares by one's colleagues), defensive behavior at conferences, and a vivid imagination.

Our three patients - let's call them Larry, Moe, and Curly - are unimaginative clinically. None of their CV's are extensive enough to fill a page, unless you include their financial holdings. But I have been privileged to see some of their depositions, which are creative enough to border on poetry.

Larry, Moe, and Curly seem to always know what a defendant physician - whether MD or DO, specialist or generalist - should have done but didn't, no matter whether the physician practices in a one-horse town or megalopolis.

They know how long it should have taken an obstetrician to get to the hospital from any direction, in any weather. They always state that if it isn't documented it wasn't done, but they also testify that even though it was described it couldn't have been done. Most obstetricians struggle to understand fetal distress, but they can diagnose it on virtually any fetal monitor strip.

The attorneys for whom Larry, Moe, and Curly work even take courses given by other lawyers on how to diagnose fetal distress.

You see, it is much easier to accuse a doctor of malpractice, especially with a sad victim in court, than to prove that the physician did nothing wrong.

Since a lawsuit is not a scientific meeting, concrete validation of facts is unnecessary. Footnotes or references are superfluous. It is simply one "expert" against another.

So how does a jury know whom to believe? Jurors interviewed after a verdict often state that the experts canceled each other out and the testimony of the plaintiff and the defendant physician was paramount. The worst sin for the doctor is arrogance.

Obviously, not all plaintiff's experts are stooges. There are incidents of medical malpractice that should be litigated and expert testimony is required. You begin to understand the system, however, when you see the same plaintiff's experts repeatedly testifying in cases of questionable merit.

Surprisingly, some of these experts are nationally prominent professors of obstetrics and gynecology who have testified in contradiction to their own publications. Do they perhaps think that none of their colleagues read their depositions?

If you want the biggest house in town and don't have much of a conscience, consider a career as a medical malpractice plaintiff's expert. You will need thick skin and considerable creativity.

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**THE RESPONSE**

by Julius Piver

I take issue with several statements in "You'll See Them in Court". My curriculum vitae fills two pages. My financial holdings fill one paragraph (Keogh and IRA). I have given depositions over the past 10-12 years for both plaintiffs and defendants.

Your description of plaintiff's expert pachydermatosis should be replaced by the return to the dictum of primum non nocere - first do no harm - which you may recall from medical school.

You gratuitously noted in the last part of your article that there are incidents of medical malpractice that require expert testimony. This phenomenon is of only recent vintage due to the conspiracy of silence that prevailed until the 1990s.

If physicians would document problems with full explanations (and in legible handwriting), many allegations of malpractice would never see the light of day. If doctors would not try to remove dermoid cysts through the laparoscope for 3 hours or do laparoscopically assisted vaginal hysterectomy over a 4-hour period, the incidence of femoral neuropathies would decrease and so would the lawsuits.

How about leaving an 18-inch laparotomy pad in the abdomen after a laparotomy despite a correct count? How do you justify the second surgery to remove it?

Patients who have been truly harmed deserve their day in court. On the other hand, physicians deserve protection from frivolous lawsuits and should not hesitate to vigorously defend themselves.

I live in a modest house and drive a 2-year-old Chrysler; my wife drives a 3-year-old Oldsmobile. I have a conscience. My work as a medical malpractice expert (for defendants as well as plaintiffs) is a sideline to my private practice of gynecology. I tell it like it is and leave the results to a jury of my peers or to the judge.

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**CAUSE NO. 95-02288-I, Continued from Page 1**

- A. I think so. Autopsy Report A94-13 at the top, page 4, "Findings". I'm looking. Oh, "Intrauterine and perinatal hypoxia." My understanding and my statement would be that there is no way for a pathologist to make a statement about intrauterine hypoxia...
- Q. What are the signs and symptoms of the fetus becoming compromised due to deprivation of oxygen during labor?
- A. The first sign that compromise may be occurring would be changes in the baseline fetal heart rate, or I should say changes in the periodicity of the fetal heart rate. A periodic change would be a deceleration. In an older terminology those included both early, variable, and late decelerations. Those terms have to do with when the onset of the heart rate deceleration occurs. If it occurs at any time with respect to uterine contractions, its called variable. If it occurs late,

that means that the descent of the fetal heart rate occurs after the peak of the contraction and does not return to baseline until sometime--usually ten to thirty seconds after the end of the contraction.

Now, in current parlance early decelerations have been discarded as a term. They were meant to be related to vagal stimulus of head compression of the baby descending. Now, most people would use only the term variable to describe head descent or cord compression--intermittent cord compression.

Late decels are divided into several different types of late decels. You can have a late decel that is what's called a reflex or a reflex vagal late deceleration. You can have a late deceleration that is a variable occurring late repetitively by our definition of late. You can have a hypoxic late, which I believe relates to what your term--what your question is, and you can have, furthermore, in addition to deceleration changes in both the baseline of the heart rate meaning tachycardia or bradycardia...

...every normal labor has compromise to the fetus, but not every normal labor has a fetus who cannot compensate for that compromise.

So, compromise to me from a hypoxic standpoint would be either repetitive severe, meaning more than 60 beats per minute--I mean a decrease of more than 60 beats per minute, variable decels, or repetitive late decelerations of any degree of severity.

The absence of variability implies decompensation of the fetus. So, when variability disappears, not only has the fetus been compromised, but it is now no longer adequately compensated...

I did not ignore the heart rate strip...

- Q. How would you expect to see the progression of the fetal monitor strip, assuming that there is a decrease in oxygenation to such an extent that the child ultimately died?
- A. I would expect the pattern of decelerations to change from a steep slope as typical of a variable deceleration. Even if the deceleration is occurring late, it is not a late pattern deceleration. An hypoxic pattern deceleration also includes a mirror image picture of any depth. But, if in fact, those decelerations were of significant depth and became significant in terms of depth, but continued to occur spontaneously, that is a more ominous sign. It indicates that the myocardium or heart muscle itself cannot generate a heart rate significantly. I'm going to add that BTBV, in my estimation, is rock solid evidence of adequate fetal compensation. That means that in a circumstance where there is intermittent hypoxia, whether it is with each contraction or contractions combined with cord compression because of lack of flow or because of uterine placental insufficiency in general--that is if BTBV is present, the fetus will be able to compensate through oxygen to the blood and to the myocardium and to the base of the brain and cerebrum and medulla. When variability is decreased it means the fetus is not able to tolerate intermittent hypoxia at a certain point...

The decels that document that the fetal heart rate would drop beginning at approximately the peak of the contraction, those could be considered as late decels or variable decels...I would definitely come to the room after a period of two hours no matter what, because two hours of pushing is worrisome if a patient is not delivered...I would be in the office and she

(nurse) should call me when delivery looked imminent...There had been variable decels and late decels, but otherwise I thought the fetus was compensated...I will stipulate that the vast majority of contractions were associated with some type of deceleration...There is information in the literature that would suggest that the absence of BTBV, when it has just become absent, gives you some time before actual neurologic damage occurs."

**MARCH 7, 1994, 0600 hrs.** Over the preceding six hours "occasional...variable" FHR decelerations "from 140s down to 110s...with contractions...up by end of contraction...variability +...negative @ present...no accels or decels", and meconium-stained amniotic fluid have been noted. At 0140 hrs. "70%/3 cm/-2 to -3...BOWI" was noted. At 0150 hrs. the patient was "given option to go home or stay with Seconal, pt. wants to stay and take sleep med" and subsequently she was administered 200 mg. of oral Seconal. *SEE SUPPLEMENT PAGE2: EFM TRACING PANELS 28806-28808 AND EXCERPTS FROM DEFENDANT DEPOSITIONS.*

**DEFENDANT OBSTETRICIAN:** This is a strip that is consistent with a healthy baby...not experiencing significant hypoxia...asphyxia. *SEE SUPPLEMENT EFM TRACINGS AND DEFENDANT DEPOSITIONS, PAGE 3, PANELS 28849-28853.*

At 0417 hrs. "80%/4 cm/-2 to -3" had been noted and at 0557 hrs. "FHTs decrease from 140s-100s after peak of contr, return to base after end of contr, O<sub>2</sub> @ 10 l/min, Dr. in room, pt on Rt side." The labor and delivery nurse became concerned and independently started an intravenous infusion with rapid administration of fluids. *SEE SUPPLEMENT EFM TRACINGS AND DEFENDANT DEPOSITIONS, PAGE 4, PANELS 28886-28890.*

**0630 hrs:** "FHTs 120s-130s, variability +...FHT decreased to 110 from 140s x 1 minute, unable to see if before, with, or after contr as toco not reading well...no AROM as pt. ruptured Sometime before." Fetal scalp electrode is applied shortly hereafter by the obstetrical resident present at the bedside. The cervix is noted to be completely effaced and 5 cm. dilated with the vertex at -2 station plus meconium-stained fluid. The patient's obstetrician is called. She reviews the EFM tracing and takes no additional action. *SEE SUPPLEMENT EFM TRACINGS AND DEFENDANT DEPOSITIONS, PAGE 5, PANELS 28893-28899.*

**0700 hrs:** "Fhts 120s-150s, variability +, fhts varying 110s-150s with increase after contr, 140s-150s between contr...no accels or decels noted...fhts varying with and after contr, 150s-160s between." Physicians on call and nurses change shifts. The oncoming nurse receives report from the previous night's nurse. The patient's primary obstetrician comes on call for his group and assesses his patient. The oncoming nurse continues the interventions begun at 0557 hrs. including positional change, noting O<sub>2</sub> flow rate as 10 l/m and I.V. fluids "wide open". *SEE SUPPLEMENT EFM TRACINGS AND DEFENDANT DEPOSITIONS, PAGE 6, PANELS 28605-28609.*

**0705 hrs:** "Fhts with + variability...no accels, baseline 140s, decels noted to 100-110 after peak of u/c, recovery 30-35 seconds after u/cs...fhts down to 90s after u/cs, O<sub>2</sub> restarted per face mask...decels noted after u/cs, variability 3-6 BPM, no accels @ this time, decels noted after u/cs from 130s to 90s, duration 10-40 seconds...Dr. called @ office informed of uc, fhts pattern, decels after u/cs remain, some V-shaped, variability minimal in between u/cs." The patient's obstetrician reviews the EFM tracing and orders discontinuation of the O<sub>2</sub> since he is not concerned about the FHR pattern or the meconium-stained amniotic fluid. He then leaves for his office to see a full day's schedule of appointments. *SEE SUPPLEMENT EFM TRACINGS AND DEFENDANT DEPOSITIONS, PAGE 7, PANELS 28611-28615 AND PAGE 8, PANELS 28616-28618.*

**0825 hrs:** The nurse restarts O<sub>2</sub> therapy after FHR deceleration to approximately 90 BPM following a uterine contraction. The cervix is noted to be 80-90% effaced and 5 cm. dilated with the vertex at -2 station. *SEE SUPPLEMENT EFM TRACINGS AND DEFENDANT DEPOSITIONS, PAGE 9, PANELS 28632-28633.*

**0835 hrs:** "Contractions q 2 1/2-3 1/2, fhts 150s with decels variable noted as stated previously." The obstetrician orders a Pitocin intravenous infusion be started at 5 mu/min to remain at 5 mu/min. *SEE SUPPLEMENT EFM TRACINGS AND DEFENDANT DEPOSITIONS, PAGE 10, PANEL 28634-28636.*

**0840 hrs:** "Dr. here, strip reviewed." The obstetrician continues the Pitocin infusion after reviewing the EFM tracing and

performing a cervical assessment recorded as 80% effaced and 4-5 cm. dilated with the vertex at -3 station. *SEE SUPPLEMENT EFM TRACINGS AND DEFENDANT DEPOSITIONS, PAGE 11, PANEL 28637-28638.*

**1015 hrs:** "Fhts down to 90s after u/cs...variability +, no accels, decels as stated above...decels to 90-110s, some decels V-shaped, occurring after u/cs...Dr. here...fhts 150s, + variability, + decels as stated above, no accels." The nurse informs the obstetrician of his patient's status and the unchanged EFM tracing. He comes to the bedside and performs a cervical assessment recorded as 90% effaced and 6-7 cm. dilated with the vertex at -2 station. He also discusses the clinical situation with the nurse and patient. *SEE SUPPLEMENT EFM TRACINGS AND DEFENDANT DEPOSITIONS, PAGE 12, PANELS 28642-28646.*

**DEFENDANT OBSTETRICIAN:** There was excellent BTBV throughout that time, eventually variable decels that occur late and even reflex late decelerations can lead to decompensation of the fetus, so that I was concerned, but not concerned enough to do a C-section...I wanted to know about any changes that would occur...I was concerned about further decompensation of the fetus...because I was not concerned at 0835, but I was concerned at 1015 and we specifically discussed it...I was reassured that there was variability present...if there were any further changes in her fetal heart rate tracing, I needed to know about it...Our discussion surrounded the fact that while I was aware that the patient was having repetitive decelerations that they were almost all exclusively of a variable type pattern despite the fact that they had occurred late...I did not feel that an operative delivery was indicated at this point. I wanted to make sure that she (nurse) understood that while she saw decelerations that occurred after the contraction, which by definition would make them late or variable, since the definition of variable is a decel occurring anywhere in relation to the uterine contraction--that I thought the majority of those were of a variable pattern despite the fact that they occurred late. Late only has to do with circulatory delay unless you have depressed myocardium...we reviewed the heart rate tracing in the room. I reassured the patient that while we were seeing heart rate decelerations, that did not mean that the fetus was decompensated or that it wasn't getting adequate oxygen to the base of the brain...because it was obvious (as) we were looking at them that she was still having the decelerations...but there was variability present, they were variable type and...I did not think we needed to intervene now.

I was standing physically in the patient's room at 1015, reviewed the tracing that was there, allowed labor to continue on the basis of present variability. *SEE SUPPLEMENT EFM TRACINGS AND DEFENDANT DEPOSITIONS, PAGE 13, PANELS 28662-28668.*

**1100 hrs:** "Fhts 140s with decels noted after u/c, variability decreased, no acc." The nurse notes decreased FHR variability with cervical assessment recorded as 80% effaced and 7-8 cm. dilated with the vertex at 0 station. *SEE SUPPLEMENT EFM TRACINGS AND DEFENDANT DEPOSITIONS, PAGE 14, PANELS 28679-28680.*

**DEFENDANT OBSTETRICIAN:** This pattern is certainly consistent with ongoing development of asphyxia.

**1140 hrs:** "Baseline 140s-150s, down to 120s after contr, BTBV absent." The nurse noted absent FHR variability. *SEE SUPPLEMENT EFM TRACINGS AND DEFENDANT DEPOSITIONS, PAGE 15, PANELS 28692-28696.*

**1305 hrs:** "Fhts 150s...variability absent, no accels, decels continue to 120s-130s after u/cs." The second stage of labor began at 1250 hrs. with the cervix completely effaced and completely dilated and the vertex at 0 station. The obstetrician discontinues the Pitocin infusion by phone order, comes to the bedside, evaluates only the current EFM tracing without reviewing the preceding strip, and returns to his office appointments. *SEE SUPPLEMENT EFM TRACINGS AND DEFENDANT DEPOSITIONS, PAGE 16, PANELS 28702-28707.*

**1419 hrs:** "Fhts 120s-140s with decels after u/cs, no accels...variability +, fhts 150s, down to 120s after u/cs...pt crowning, Dr. called for delivery." A well-developed, cyanotic, flaccid female infant without spontaneous respiratory effort and covered with thick meconium is delivered vaginally at 1419 hrs with the obstetrician in attendance. Following a 20 minute newborn resuscitation with no signs of life the NICU pediatrician pronounces the infant dead, recording the cause of death as "Meconium Aspiration Syndrome". *SEE SUPPLEMENT EFM TRACINGS AND DEFENDANT DEPOSITIONS, PAGE 17, PANELS 28721-28722 AND PAGE 18, PANELS 28732-28738.*

### **SUMMARY OF DISCOVERY**

Depositions of the corporate defendants, nurses and obstetricians were taken with the nurses describing an "atmosphere of concern" among labor and delivery staff during the labor in question. Many of them had been following the EFM tracing on the central monitor bank in the Nurses' Station. Several nurses, including the Obstetrical Unit Director and the Labor and Delivery Charge Nurse, had asked the patient's staff nurse if the obstetrician knew about the abnormalities. She of course replied he had personally evaluated both patient and tracing a number of times during the labor.

The Labor and Delivery Charge Nurse described a very brief but important conversation which had occurred with the obstetrician shortly after 1100 hrs. While preparing the nurses' lunch relief schedule she had asked the obstetrician if he would be performing a Caesarean section upon the patient in question. He replied "She's a seven," indicating to her that he did not anticipate an emergency Caesarean section. He then left the Labor and Delivery Suite for his office and returned only briefly at 1310 hrs. to reapply a faulty fetal scalp electrode, not returning until shortly prior to spontaneous vaginal delivery. The L&D nurse took no other action following this conversation despite her concern for the welfare of the fetus.

The defendant hospital's management and staff were of the opinion that continuous EFM during labor was extremely valuable in the successful diagnosis and management of intrauterine fetal distress, even to the point of conducting yearly courses for its labor and delivery nurses. As a result of this training the nurses proved knowledgeable and experienced in EFM interpretation. They explained under oath their concern for this fetus by intelligently and accurately discussing the EFM tracing panel-by-panel including maternal signs and symptoms plus responses to nursing interventions, suggesting they were more knowledgeable in EFM interpretation than the obstetrician.

Plaintiff's medical expert witness review of the tracing noted over 180 consecutive late decelerations of the FHR from 0700 hrs. on March 7, 1994, until the fetal scalp electrode was removed shortly prior to delivery. Beat-to-beat variability became and remained absent shortly after 1100 hrs. He testified that this was the worst case he had ever seen and that the tracing in question would not be tolerated in hospitals in third world countries such as New Guinea, Burundi, or Patagonia. He also testified that the child most certainly would have survived and done well had she been timely delivered by Caesarean section. The tragic result had unfortunately confirmed the nurses' fears.

### DISCUSSION

The essence of the cause of action against the physician was failure to perform a timely Caesarean section when available clinical information required immediate action. Inexplicably, he failed to act when any reasonable obstetrician would have immediately delivered the infant. Plaintiff's position focused upon his failures to:

- Properly address many maternal risk factors such as obesity (67 inches tall X 268 pounds), smoking, hypertension, 42 week gestation and possible meconium-stained amniotic fluid upon presentation in labor and delivery
- Properly address the presence of thick meconium in the amniotic fluid documented during placement of the IntraUterine Pressure Catheter (IUPC)
- Properly address nonreassuring EFM patterns
- Immediately deliver the infant.

Proper consideration of the foregoing factors should have resulted in immediate delivery via emergency Caesarean section. Any reasonable physician's concern for the infant should have grown with each contraction's late deceleration as did the nurses'. The Nurse's Notes documented beyond dispute that the physician defendant personally reviewed the EFM tracing at approximately 10:15 hrs. after the nonreassuring patterns had persisted for approximately three hours. In deposition the defendant testified that, based upon this review, he instructed the nurse to call him if there were any changes in the tracing. This instruction was not documented in the hospital record nor was it supported by the nurses' testimony. Plaintiff medical expert witness testified at deposition that, irrespective of the foregoing, the only appropriate action at 10:15 hrs. was delivery via emergency Caesarean section.

Hospitals are legally responsible for care delivered in their facilities to the extent that they have an employment or agency relationship with negligent actors. One issue is the extent to which the hospital exercises actual control over patient care. The more detailed the control, the more likely responsibility will attach. Degree of control is typically established in voluminous hospital policies and procedures and their violation may be used as evidence of negligence.

The policies and procedures applicable in this case included the chain-of-command to be used when a patient was threatened by injury or loss of life. It was undisputed that the nurses in this case were greatly concerned for fetal safety yet

did not utilize established defendant hospital policy and procedure. This was a key aspect of liability since the Labor and Delivery Charge Nurse knew for a fact following her 1100 hrs. conversation with the defendant obstetrician that no emergency Caesarean section was anticipated as described supra.

In most states the hospital is the nurse's employer. Hospital responsibility is established under Respondeat Superior when the employee/nurse fails to act in accordance with applicable standards of nursing care. Nurse conduct is accordingly scrutinized for evidence of negligence.

In the state where this action was filed a registered nurse is required by law to take the following actions plus others which are less applicable in this case:

- Perform nursing assessments regarding the health status of the patient
- Make nursing diagnoses which serve as the basis for the strategy of care
- Develop a plan of nursing care based on the assessment and nursing diagnoses
- Implement the nursing care
- Evaluate the patient's responses to the nursing interventions
- Institute appropriate interventions which might be required to stabilize a patient's condition and/or prevent complications
- Clarify any order or treatment regimen that the nurse has reason to believe is inaccurate, non-efficacious, or contraindicated by consulting with the appropriate licensed practitioner and notifying the ordering practitioner when the nurse makes a decision not to administer the medication or treatment
- Know the rationale for and the effects of medications and treatment and to correctly administer same
- Implement measures to promote a safe environment for the patient.

(Board of Professional Nurse Education, Licensure and Practice, paragraph 217.11)

The regulations stated require the nurse, by law, to:

- Know the rationale for all drugs and treatments administered to the patient
- Question every order received to determine if, in his/her professional nursing judgment, the order is inaccurate, non-efficacious, contraindicated, or places a patient in danger
- Recognize when circumstances exist that unreasonably place the patient at risk of harm and take timely and appropriate steps to alleviate such risk of harm.

In this case the contraindications to Pitocin infusion at the time it was ordered and administered, the contraindications to discontinuing O<sub>2</sub> therapy as described above, and the nurses' failure to utilize the chain-of-command when they knew subjectively that the fetus was in serious danger without intervention by the defendant obstetrician all are addressed by these rules. Most important was the

fact that the nurses had proven expertise in EFM interpretation as a result of extensive hospital-sponsored training.

In addition to hospital responsibility for the acts/omissions of negligent employees, hospital administrators may influence physician practice patterns by such means as efforts to lower Caesarean section rates. In deposition it was established that the defendant hospital held medical staff meetings in which each obstetrician's Caesarean section rate was scrutinized and that the defendant medical group was proud of its low rate. The defendant obstetrician had even touted his personal low Caesarean section rate according to the plaintiffs. It certainly appeared that his management of this labor may have been effected by a reluctance to perform Caesarean deliveries.

### CONCLUSION

In plaintiff's opinion the defendant hospital was in part responsible for the death of a child through the acts of its nurses/employees. Settlement was reached before discovery fully explored the hospital's role concerning possible pressure exerted upon its medical staff to discourage expensive procedures such as Caesarean sections. The allegations of nursing negligence centered around EFM strip interpretation and subsequent actions/inactions.

Continuous EFM is here to stay regardless of the long-standing debate regarding methods of intrauterine fetal assessment and their efficacy. The obstetrician with an EFM knowledge deficit practicing in today's hospital is a liability nightmare, not to mention the resulting costly and unnecessary loss of life or patient injury. A nursing staff more knowledgeable and accurate in EFM interpretation than the obstetrician will only highlight the problem.

Some lessons can be learned from this case. Responsible healthcare facilities must continue to educate their nurses in proper use and interpretation of EFM and assure, via the credentialing process, that their obstetricians as well have an adequate knowledge base. They must also take steps to allow and insure nurses utilize an established system of communication when there is a question of patient harm resulting from physician acts of omission or commission. And finally they must accept a larger responsibility for medical and nursing negligence in our modern healthcare system.

**REFERENCE:** Plaintiff's expert obstetrician: Leslie Iffy, MD, FACOG. For the Plaintiff: James E. Girards, Esq. For the Defendants: Barbara Pilo, Esq.; William Dixon Wiles, Esq. and Gerald W. Benson, Esq. Dallas County, Texas. The editor wishes to thank Richard H. Paul, MD, FACOG, for review of the fetal monitor tracings.

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The EFM tracing along with the clinical history of postdatism, meconium passage and nulligravidity should be considered in the clinical management of this patient's labor. The question must be raised as to when the decision for delivery, if necessary via Caesarean section, should have been made with delivery accomplished within thirty minutes. Decision between 0700 hrs. and 0800 hrs. is easily justified, and with the examination recorded at 0840 hrs. on panel 28637 (4 cm. dilation at -3 station) the standard of care would likely demand decision by that time.

Dick Paul

**Editor's Note:** Dr. Paul is Professor, Department of Obstetrics and Gynecology, University of Southern California School of Medicine and Director, Division of Maternal-Fetal Medicine. He has also written multiple textbooks and peer-reviewed articles on EFM interpretation and treatment, both alone and in conjunction with others including Edward H. G. Hon, MD. He and Roy H. Petrie, MD, co-authored Fetal Intensive Care published by Corometrics Medical Systems, Incorporated.

This case represents an unfortunate but preventable obstetric catastrophe which makes it imperative for all practicing obstetricians to take an active role in addressing the issues of provider incompetence and chain-of-command responsibility. It's very educational for all of us because it clearly illustrates what will eventually happen if an ominous EFM tracing is not recognized and appropriately treated. It gives us some idea of the quality of obstetrical care being delivered today and represents one extreme of the spectrum of care being rendered by our colleagues. It teaches volumes about the lack of effective Continuing Medical Education (CME). It demonstrates what happens when a nurse sees clinical complications worsening yet does nothing. It allows appreciation of what happens when we do not police our own specialty. The deposition excerpts plainly exhibit that the more we talk about something we know very little about, the more ludicrous we appear. This case vividly defines the most troubling aspects of medical malpractice. It's also why we are facing a medical malpractice crisis. When a practicing physician has no idea what is happening clinically, tragedies such as this happen.

I strongly agree with the presentation's discussion and conclusions. Total lack of understanding and improper interpretation of EFM tracings ultimately led to the intrapartum death of this infant. It is interesting though unfortunate that this case illustrates exactly what the early researchers of FHR physiology and patterns taught us fifteen to twenty years ago: untreated fetoplacental insufficiency gets worse during labor and finally results in loss of reactivity, loss of BTBV, a flat tracing, severe fetal acidosis, and eventually death.

The physician in this case unfortunately had absolutely no idea of what EFM is all about. I do believe I could give my wife a five minute explanation of the physiology of FHR decelerations, let her review this case, and she would finally understand why I have to pay \$80,000 to \$90,000 each year for medical malpractice insurance even though I have never been responsible for one dollar in settlement or judgment of a medical malpractice action. It even crossed my mind that my twelve-year-old daughter could probably understand it, so a jury should have no trouble at all.

How much help is your cardiologist if he can't recognize ST segment abnormalities on your EKG while evaluating your chest pain? Your orthopedist can't properly reduce and immobilize your broken femur if he can't recognize a fracture on x-ray. Are you anxious about your neurologist turning off your ventilator because he is unqualified to read an EEG? If so, why should someone attend a labor and deliver a baby if he has no idea how to go about interpreting EFM tracings? We're talking about no understanding of decelerations, BTBV, fetal physiology, acid-base balance, agonal FHR patterns, etc.

I do however completely agree with the manner in which the litigation complaint was managed. I would have recommended settlement of this case the day after delivery or sooner if possible. In fact I probably would have just signed a blank check made out to the parents and worried about how much it was going to cost when the check came back from the bank.

Most of the EFM strips presented show recurrent late deceleration of the FHR despite all the descriptive terminology used. This baby was in trouble early on. BTBV and reactivity were lost as the situation deteriorated, culminating in fetal death. It should be no surprise to anyone that this baby died.

Over the past twenty years I have been involved in two similar situations when the attending physician could not interpret clinical data and subsequently failed to deliver appropriate care. One of these was very similar to this case. For about 24 hours the patient's EFM strip recorded recurrent late decelerations. Multiple attempts were made to get the attending physician to come to labor and delivery to interpret the tracing.

He finally did, but misinterpreted the strip and allowed the labor to continue with delivery finally producing a severely compromised infant who expired several hours postdelivery. This motivated the hospital administration, department members, and labor and delivery nursing staff to correct the problem and establish a protocol addressing such events in the future. The physician was required to obtain additional CME specifically including EFM interpretation and management, and was accompanied to the course by the Chief of Obstetrics.

Our department met and devised a protocol to be followed if a situation arose in the future when a physician would possibly misinterpret clinical data and place his patient at risk. All physicians and nurses alike agreed with the plan. If a nurse encountered a serious problem which a physician apparently failed to appreciate or appropriately address, after sufficient attempts to contact and explain the problem to the physician she could then with her charge nurse contact the Chief or Assistant Chief of Obstetrics and seek his immediate intervention. Should the Chief or his assistant be unavailable the nurses could then contact any department member. If a nurse did not render appropriate care to a patient for whatever reason, after first addressing the issue with that nurse the physician could then contact the charge nurse or Director of Nursing.

This protocol has worked well so far. It unfortunately creates some occasional unhappiness, usually on the part of a physician when a nurse goes over his head. But we have had no more obstetric disasters and the staff as a whole has worked more closely together. I believe the entire department's medical and nursing staffs feel comfortable with the plan and recognize the improved care it has produced. The responsibility of the hospital and its nursing staff cannot be overlooked. There must be a mechanism for managing the clinical situation when the physician has no idea what is going on.

Dan Avery

## FOR THE PLAINTIFF

### WILLIAM D. DANIEL, MD, FACOG

*Dr. Daniel is a 1970 graduate of the Medical College of Georgia and completed his residency in obstetrics and gynecology at Naval Hospital Bethesda, Bethesda, Maryland, in 1974. He was certified by the American Board of Obstetrics and Gynecology in 1976 and elected a Fellow of the American College of Obstetricians and Gynecologists in 1977. He has practiced in various locations around the world and the United States including Buckhannon, West Virginia.*

It is my professional medical opinion that undiagnosed and untreated chronic fetoplacental insufficiency most likely directly caused this unnecessary and preventable intrapartum fetal death. Amniotomy and internal electronic fetal monitoring via fetal scalp electrode and intrauterine pressure catheter should have been accomplished upon admission. Assuming the absence of both progressive labor and persistent late decelerations of the fetal heart rate two hours later, Pitocin augmentation or induction of labor should have been begun. Infusion of Pitocin should have been immediately discontinued if persistent late decelerations appeared and not restarted until their resolution. A decision for emergency delivery should have been made immediately if persistent late decelerations appeared which could not be resolved within fifteen minutes without recurrence. While attempting to alleviate the persistent late decelerations, uncompromised fetal status without

acidosis should have been confirmed by fetal scalp blood sampling for pH or fetal scalp stimulation with documented associated acceleration of the fetal heart rate. Delivery should have been accomplished within 30 minutes of decision, by Caesarean section if necessary. Considering only the available electronic fetal monitoring tracings, decision for emergency delivery by Caesarean section should have been made by 0715 hrs. 7 MARCH 1994 and accomplished by 0745 hrs. 7 MARCH 1994.

One of my early mentors used to say you could line up ten physicians against the wall, ask them the same question and get ten different opinions. Many obstetricians will say the one above is unjustified and overly critical. But if you believe what Dick Paul says about EFM interpretation and management of fetal acidosis, it's the only acceptable therapeutic plan in this case.

First of all the patient is 42 completed weeks gestation and only an idiot would contend that this is not a high-risk patient. She should become a priority patient upon presentation to labor and delivery with even a suggestion of SROM or labor. Add the question of meconium-stained fluid and the risk only becomes greater.

There was probably some antepartum fetal testing via serial NSTs over the few weeks preceding delivery but we couldn't get copies. Judging by the gross incompetence of the defendant's EFM interpretation, it's certainly possible or even probable that one or more were nonreactive. If so, a properly interpreted biophysical profile and/or contraction stress test would more than likely have revealed an inability of the fetus to safely tolerate labor. The best solution in such circumstances would have been delivery by Caesarean section before the onset of labor. Oh by the way, if you contend that the defendant's discussion and interpretation of the EFM tracing was accurate, informed, cogent, reflective of the current acceptable standard of care or anything less than negligent, don't waste your time reading the rest of this.

There's no evidence that the state nursing licensing board even was aware of the incident or that the defendant's hospital privileges were ever in serious jeopardy. The state medical licensing board initiated an investigation and held an inquiry regarding the defendant's licensure status, possibly triggered by a report from the defendant hospital or the state peer review agency. The board decided to take no action. There's several possible reasons for their reluctance to adequately address the situation.

It's always possible, though I hope unlikely, that political influence was brought to bear. The board members may have become entangled in the question of who told what to whom and when. Their peer reviewer may have known no more about EFM interpretation than the defendant. Everybody may have thought the defendant was a very nice guy who tried really hard and didn't deserve what they felt was just a run of bad luck. I'm sure they would in all fairness feel the same way about the plaintiff parents. The defendant may have had a concurrent though unrecognized chemical and/or psychological impairment. The board may have had no concern for the safety and well-being of its state's citizens.

The last seems improbable when all state licensing boards give the appearance of being on impaired physicians, stereotypically drunks and druggies, like a chicken on a June bug. But that may be the problem. We are about 20 to 30 years late in addressing physician impairment due to ignorance as opposed to chemicals. Thirty years ago you never heard of physicians in rehabilitation except to dry out, and recovery was unknown unless self-motivated.

The bottom line is that a human life was lost unnecessarily. The case was settled prior to trial for \$550,000 plus expenses, and I'm told that's about average for the state where this occurred. By a legal loophole, there would have been the

possibility for a multimillion dollar recovery if the child had been unquestionably liveborn instead of stillborn, hinging on a nurse's recording a delivery Apgar of one. The worse tragedy is that nothing was done to insure this won't happen again. The most chilling aspect of the case is that it occurred in a residency training program.

At any rate, you don't turn in for a good night's sleep after tucking this patient into a labor bed with an external monitor for a teddy bear. And for God's sake will someone please tell me how you could even consider sending her home at 2:00 a.m., let alone administer 200 mg. of a long-acting barbiturate? I've always told anybody who would listen that a labor and delivery service should operate at a high level of efficiency 24 hours-a-day, 7 days-a-week and not just nine-to-five Monday through Friday excluding nights, weekends and holidays. If you can't provide the same minimally acceptable level of care around the clock, get out of the business. Just because it's the middle of the night or Christmas Eve is no excuse for less than the recognized minimum standard of care. Actually in this case it made no difference because the care got no better after the sun came up.

Just a brief aside here. The defendant probably had no idea of the implications of the EFM tracing, otherwise he would have appropriately performed the early Caesarean section. Nobody I know enjoys delivering a dead baby, especially one that could have been saved. Yet his absence from labor and delivery would have implied to the jury during trial that he was more concerned with generating cash flow in his office than rescuing sweet, lovable, defenseless little cherubs like their children and grandchildren from the jaws of death. Juries have no mercy or compassion for such an evil, heartless villain.

Ignoring the defendant's incompetence, the nursing staff didn't do much better. They at least knew the EFM tracing suggested compromise of the fetus even if they couldn't recognize a late deceleration. Their biggest failure was not utilizing the chain-of-command to notify another physician with supervisory status and the ability to intervene, i.e. the Chief of Obstetrics. This responsibility falls squarely upon the Obstetrical Unit Director, or her superior if notified of the situation.

One last piece of advice. Don't ever try to bullshit your way through a deposition.

**P.S.:** I'm sure if any of you have gotten this far, some or most are thinking the above opinions and comments are unjustified, hypercritical, unprofessional and obviously those of a trial lawyer's whore or a traitor to the honorable profession of medicine. Think what you will. But if you ever go to court as a medical malpractice defendant you will hear the same or worse about yourself. Forewarned is forearmed.

## FOR THE DEFENSE

### W. BENSON HARER, Jr., MD, FACOG

*Dr. Harer is a 1956 graduate of the University of Pennsylvania School of Medicine and completed his residency in obstetrics and gynecology at the Hospital of the University of Pennsylvania, Philadelphia, Pennsylvania, in 1960. He was certified by the American Board of Obstetrics and Gynecology in 1964 and elected a Fellow of the American College of Obstetricians and Gynecologists the same year. He practices in San Bernardino, California.*

Dr. Daniel gallops onto the scene like a vigilante with guns blazing, a classic plaintiff medical expert witness's posture but one that may especially aid the defense if the expert is from far away. Simply implying that the defendant physician is "evil" or uncaring may backfire, especially in a tightly knit community where a good reputation is enjoyed by the hospital and its physicians. This is even more the case if the defendant is personable and well-spoken. At times we all make mistakes, focus our minds in the wrong direction or hope for unlikely benefits.

I will assume the defendant obstetrician was not affected by substance abuse or other impairment because if he were there was a clear obligation for his fellow physicians, his hospital administration and the appropriate licensing authorities to intervene as soon as it was suspected. The defendant physician recognized his patient to be 42 weeks gestation and addressed this problem in an orderly fashion. The risk here is slowly progressive since the clock does not strike midnight with a good pregnancy suddenly turning into a bad one like Cinderella's carriage turning into a pumpkin.

Why did this patient spontaneously rupture her membranes with meconium-stained amniotic fluid? Dr. Daniel states that his scenario is the "most likely", but that means there are indeed other possibilities. Perhaps this patient's chorioamnionitis caused the rupture. The presence of meconium could indicate some adverse event damaged the baby, thereby causing a complication which existed prior to labor and led to grief regardless of the management of the labor. A maternal beta strep infection causing antepartum chorioamnionitis is one such scenario, and following the suggested Cesarean section could subject the obstetrician to criticism for exposing his patient to increased risk for minimal fetal benefit. It may well have been in the patient's best interest to postpone surgery until morning when there would be better O.R. and anesthesia staffing. These cases are reviewed at leisure but they occur in hospitals with finite staff and facilities which must respond to varying levels of demand.

Barbiturates have been used judiciously in obstetrics for over half a century. This patient was obviously in for a long haul and had had little sleep before presenting to the hospital. Her obstetrician compassionately helped her get some rest before the morning's challenge of spontaneous or induced labor.

Fetal scalp blood sampling is not what we hoped for twenty years ago, but instead is fraught with error and not even recognized as standard of care. The relationship of fetal acidosis to neurological damage is far from clear and studies

have shown poor correlation between the two, while ACOG's definition of fetal acidosis by umbilical artery pH has been steadily lowered to less than 7.00.

Dr. Daniel states this patient should have been assessed by one of several modalities including Contraction Stress Test (CST), but it is my opinion that nature's labor is its own best CST and therefore it was perfectly reasonable to simply observe the labor.

Look again at the EFM strip, remembering that medicine is still as much an art as it is a science. It's always easy to review a strip and pontificate when you know the outcome, but the challenge is to look at it prospectively. We all have seen nonreassuring patterns which converted to normal without intervention.

Physicians with busy practices must rely upon trained nurses and/or residents to follow their labor patients. Acceptable standards of care recognize the ability and expertise of the ordinarily trained average physician practicing in the trenches, not that of the remote medical expert. A physician is not expected to be in constant attendance of his patient.

Dr. Daniel also thought internal EFM should have been initiated immediately upon admission, although it was applied a few hours later at 0630 hrs. He does however agree that there was no significant abnormality in the external EFM strip prior to 0700 hrs., so it clearly didn't make any difference and he is hypercritical. Internal EFM is not without risk. Scalp electrodes and intrauterine pressure catheters carry a risk of infection which increases over time. Why subject her to this unnecessary risk if there are no labor contractions?

We see both late and variable decelerations of the FHR as the labor progressed, worrisome but not serious since there is recovery and good BTBV. Dr. Daniel says he would have decided for delivery via Caesarean section at 0715 hrs., but I suggest that decision is influenced by hindsight. The EFM strip is worrisome but not compelling as long as there is good recovery and BTBV, the situation for two hours after his recommended time of decision. By then the defendant was busy in his office and relying fully on the hospital's employees to monitor his patient.

The subsequent EFM strip is a real problem for the defense medical expert witness. The defendant was relying on the hospital's employees for its interpretation, and in fact these nurses knew the patient was in serious trouble. They should have stuck to their guns! The obstetrician didn't want to hear the bad news, but it was their obligation to deliver it and then demand his appropriate response. If he could not or would not respond, they were obligated to intervene in the patients' best interests.

Now the relationships between and responsibilities to the hospital and the physician become critical. Plaintiff attorneys love it when defendants blame each other because then it's only a matter of who pays and how much. Cooperation minimizes losses as well as preserving future working relations.

Stipulating that the EFM strip is bad by any standard after 0915 hrs., it's not what I would expect in persistent intrauterine hypoxia. Though of poor technical quality, the intermittent EFM recordings of the last few minutes have a baseline FHR in the 120-140 beats per minute range which then abruptly stops. In the few cases I have reviewed involving anoxic infant death there have always been long decelerations with little or no recovery followed by a slow and steady drift downward to zero. This case suggests a sudden arrest compatible with the above hypothesis that there may have been an underlying sepsis. Apparently no autopsy was done so we will never know the answer. It is possible that delivery by Caesarean

section before 0900 hrs. would not have made any difference since this baby was already septic and desperately ill.

In view of all the above I would have frankly suggested the defense settle, but sometimes a reasonable settlement cannot be reached. This is my vigorous counterattack to Doug's equally vigorous assault. He properly promotes rehabilitation of impaired physicians and I concur, joining him in extending the definition to information and attitude impairments. Hopefully both the hospital and obstetrician were prompted by this experience to reassess their practices, policies and procedures.