

Transfer: Nurse Did Not Report Ob/Gyn Patient Showing Signs Of Abruption.

A very complicated labor and delivery case from the US District Court for the Northern District of Iowa produced a jury verdict of \$1,710,000 for the parents of a stillborn child.

After she began having vaginal bleeding, abdominal pain and contractions at home the mother was taken to the emergency room at a rural community hospital.

The physician on duty got the ultrasound tech to perform an ultrasound, but had to send the images electronically to an on-call ob/gyn in Minnesota for interpretation. They decided it was best to have the mother transported to a hospital one-hundred miles away in Sioux Falls, SD which had far better obstetric capabilities.

A nurse from the rural community hospital was assigned to ride along with the mother.

During the trip the mother was reportedly having rapid contractions, profuse vaginal bleeding and severe abdominal pain while the fetal monitor in place was showing clear signs of fetal distress.

Nurse Failed to Report

While Patient Was In Transit

The nurse, however, made no effort to contact a physician at the first hospital or at the hospital where they were going to report that the fetus was in distress because signs were there that the placenta had abrupted and/or the uterus had ruptured.

Had the nurse reported what was going on, the experts told the jury in court, the ambulance could have been diverted to one of several community hospitals along the way where an emergency cesarean could have been done which, more likely than not, would have saved the baby.

There were also allegations that the physician at the first hospital did not follow the letter of the Emergency Medical Treatment and Active Labor Act (EMTALA) before sending the patient to another facility. **Heimlicher v. Steele**, __ F. Supp. 2d __, 2009 WL 1361164 (N.D., Iowa, May 14, 2009).