Labor & Delivery: Lapse In Fetal Monitoring.

The patient was admitted for delivery of her third child. There were reportedly no special risk factors affecting this pregnancy.

A fetal heart monitor was attached in the labor and delivery unit. The fetal heart rate tracings were normal at the start.

The labor and delivery nurse assigned to the patient left the patient alone in her room at 3:30 p.m.

At 4:00 p.m. when the patient's nurse returned to the room she immediately recognized a slow fetal heart rate and called for an emergency cesarean.

The infant was delivered nine minutes later with poor Apgars and had to be taken to neonatal intensive care.

Now the child has serious developmental issues related to hypoxic brain injury at birth. An arbitrator awarded a cash payment of $3,594,656 for the child in addition to the defendant health maintenance organization's agreement to provide lifetime care which has a present estimated value of more than $26,000,000.

There was a remote fetal monitor at the nurses station, but apparently no one was present at the nurses station between 3:30 and 4:00 p.m. to keep an eye on the monitor. The fetus's distress was not noted and acted upon until the nurse actually returned to the patient's room.

"Subsequent Remedial Measures"

The legal rules of evidence for civil cases expressly state that "subsequent remedial measures" are not to be taken as evidence of negligence.

Safety improvements after the fact do not necessarily prove negligence. The legal system does not want to penalize defendants in civil lawsuits who learn from their mistakes.

Nevertheless, it reportedly came out during the case that the hospital system changed its policies as a result of this incident and now requires the continuous presence of trained personnel at remote monitoring stations. **"S.A." v. Kaiser Foundation Hospitals, 2009 WL 692095 (Med. Mal. Arbitration, California, March 5, 2009).**

EMTALA: Nurses Did Not Violate The Law.

The US Emergency Medical Treatment and Active Labor Act (EMTALA) makes it unlawful for a hospital which has an emergency department to refuse to give an appropriate medical screening examination and necessary stabilizing treatment to any individual who comes to the emergency department seeking emergency care.

A motorcycle accident victim was brought to a hospital's E.R. with degloving injuries to a lower extremity. The hospital did not have a plastic surgeon on call and the only one who could be reached had had his hospital privileges revoked.

A family member of the victim, who was a nursing supervisor at another hospital, called a third hospital's E.R. The E.R. nurse on duty there called a plastic surgeon with privileges there, but he refused to treat the patient because the patient was already being treated.

Nurse Refused to Promise Admission
No EMTALA Violation

The E.R. nurse, after calling her unit director at home, refused to promise to admit the patient, having no authority to override a staff physician's decision.

The E.R. nurse reportedly did tell the family member that the patient would be handled the same as any other emergency case if she were brought to the hospital.

The Court of Appeals of Arkansas ruled that the hospital where the staff physician and E.R. nurses would not promise to admit the patient did not violate the US EMTALA.

No Specialized Capabilities

The court noted in passing that a hospital with specialized medical capability pertinent to the particular patient's needs, e.g. a burn unit, shock unit or neonatal intensive care unit, does have an obligation under the EMTALA to accept and admit a patient transfer from the E.R. at a hospital that lacks such specialized capability, but that was not the situation here. **Thompson v. Sparks Regional Medical Center, __ S.W. 3d __, 2009 WL 700644 (Ark. App., March 18, 2009)**

Pathology: Nurse Faulted, Did Not Send Specimen To The Lab.

The patient went to her family physician's office to have a mole removed from her foot after the mole, several years old, began to grow and itch and turned red.

The physician told the patient he did not think the mole was cancerous, but he was going to send it to the pathology lab anyway. Then the physician handed off the specimen to the office nurse.

The nurse apparently never prepared or sent the specimen to the lab.

The patient went to a different doctor to have her stitches removed. Then she transferred her primary care to still another medical group.

The lesion recurred. It was diagnosed as malignant melanoma and surgically removed a second time.

The first office nurse's error was discovered afterward when the medical charts from the different physicians' offices were sorted out.

The jury in the Circuit Court, Delaware County, Indiana awarded a verdict of $3,250,000.

Reportedly the patient recovered uneventfully from the surgery to excise the melanoma and has no residual disability. The jury believed, however, that she is at increased risk for recurrence of cancer.

The nurse was faulted by the expert witnesses at trial, first and foremost, for not sending the specimen to the lab.

The family practice physician, the experts said, erred by not having the patient come in to his office as routine practice to review the pathology results and make any necessary recommendations. Or the physician or nurse should at least have logged the file for follow-up review. In this case that would have prompted them that the pathology specimen was not sent in, the experts said. **Mieth v. Yorktown Health & Diagnostic, 2008 WL 5666509 (Cir. Ct. Delaware Co., Indiana, June 25, 2008).**