LEGAL ISSUES IN LABOR AND DELIVERY NURSING

For the Nursing Profession

Hello, my name is Ken Snyder. I am an attorney and a registered nurse. For more than twelve years I have been writing and publishing Legal Eagle Eye Newsletter for the Nursing Profession, in which I follow and highlight the latest legal developments affecting nursing practice.

In this program I will focus on the latest legal developments in labor and delivery nursing. The format for this program will be to discuss some important recent court decisions which show where the law is going and some decisions that re-affirm the traditional legal principles that still apply in this specific clinical area.

I want to repeat that this program focuses on labor and delivery nursing. There are lots of things that can go wrong in the labor and delivery unit. It is a very complicated area of clinical practice. I do not claim to be a qualified nursing expert in this area.

Medical ob/gyn practice and hospital labor and delivery units are big sources of opportunity for plaintiffs' trial lawyers looking for lucrative damages cases. I am not focusing on the whole field of labor and delivery, just on legal issues directly applicable to nurses, issues that have come up in the US state and Federal court decisions over the past few years.

The most typical scenario that comes up in court time and again in labor and delivery cases involving nursing negligence is when the nurses monitoring the progress of the mother's labor fail to notify the physician of monitor tracings that indicate the fetus is in distress.

A good place to dive right into this topic would be to look at a recent case that is very, very typical of the court cases which fault labor and delivery nurses for negligent errors and omissions. The case is Garhart versus Columbia/Healthtone 95 P.3d 571 Supreme Court of Colorado June 2004.

The nurse phoned the ob/gyn physician at 11:15 pm. She happened to be very close by in the hospital's physician's lounge. The nurse told her there were (quote) "mild to moderate variable decelerations."

Six minutes later there was a further sharp decline in the fetus's condition, according to the court, based on the decelerations appearing on the monitor. The nurses repositioned the mother and gave her oxygen but did not phone the physician again for more than an hour.

One and one half hours after the first call to the physician's lounge the nurses did call the physician.

She came in and immediately attempted a very difficult expedited vaginal delivery which severely injured the mother and did not promptly relieve the fetus's distress.

The court believed the nurses should have promptly reported the decelerations seen six minutes after the first call, which were probably evidence of fetal acidosis mandating a prompt cesarean section. They should have insisted the physician come

to the delivery room to look at the monitor strips for herself.

The physician testified she would have promptly ordered an emergency cesarean at the six minute interval after the first call if the nurses had informed her of the true seriousness of the situation.

The verdict against the hospital was more than $12,000,000. The big issue in the case was **not** whether the nurses were negligent. The big issue was Colorado's new statutory cap on medical malpractice damages. Many other states have enacted legislation to try to stop the runaway damages awards civil juries are giving in these cases, but that varies from state to state and is more of a concern for the lawyers after the fact than for the nurses before the fact.

The exact opposite scenario from the Garhart case came out in the case Dumas versus West Jefferson Medical Center 722 So 2d 1210 from the Louisiana Court of Appeals in December 1998.

The mother came to the hospital in labor. She was admitted to the labor and delivery unit and an obstetrical nurse was assigned. Four hours later, at 3:48 a.m., the baby was delivered by cesarean. The baby had brain damage and died seven weeks later. The parents sued the hospital, the physician and the obstetrical nurse. The physician's insurance company settled. Then the court ruled the nurse was not negligent, and dismissed the lawsuit against her and the hospital.

The parents' lawsuit alleged the nurse was negligent for not calling the physician after a late deceleration was seen on the fetal monitor at 3:03 a.m. If he were called, the suit alleged, the cesarean might have been done sooner, and the baby might have been born healthy.

However, the court looked at the whole record. The court ruled on the basis of the whole record that there was no nursing negligence.

The obstetrical nurse phoned the obstetrician at 12:10 a.m., 2:45 a.m. and 3:00 a.m., shortly after each late deceleration the nurse saw.

When the obstetrician had phoned the nurse at 1:25 a.m., she reported the sporadic decelerations that had been happening. The nurse also reported that the fetal heart rate had returned to baseline when she repositioned the mother on her side.

At 2:45 a.m. the nurse, according to the court, again repositioned the mother on her side and administered oxygen. Although the fetal heart rate returned to baseline there were indications of fetal distress on the monitor tracing. At this point the physician headed to the hospital, and the cesarean was called at this time.

As of 2:45 a.m. the obstetrician was en route to the hospital. The nurse apparently spoke with the obstetrician on his car phone at 3:00 a.m. By then the obstetrical nurse had seen to it that the cesarean team was being called in, that is, a surgical assistant, nurse anesthetist, anesthesiologist and pediatrician were being assembled. She had also notified the emergency room doctor and the house nursing supervisor. The patient had been prepped and taken to the operating room and the surgical instruments were all there, according to the court record.

Nurse competency is a very basic issue in this area. I can recall covering a case in

my newsletter some years ago for which I have not been able to locate the exact chapter and verse citation – I believe it was also from Louisiana - that said that to work in labor and delivery the minimum level of competency for nurses is to understand the fundamental physiology behind early as opposed to late decelerations in the fetal heart rate occurring after the mother's uterine contractions.

Early decelerations are a normal finding. Early decelerations are caused by the downward pressure on the fetus's head pressing against the pelvic floor during a uterine contraction, which stimulates parasympathetic nerve action from the Tenth cranial nerve to the fetus's heart, slowing the heart. Late decelerations are abnormal and ominous. Late decelerations take longer to appear than early decelerations because late decelerations of the fetal heart rate are caused by sensors in the brain detecting blood acidosis. The acidosis comes from compromised umbilical artery blood flow due to the umbilical cord being twisted, tied, caught under the fetus's head, etc.

Acidosis is accompanied by compromised oxygen availability to the fetus. Compromised oxygen availability can cause severe, disabling, life-long brain damage to the newborn.

The multimillion dollar verdicts in these cases are arrived at as compensation to provide a lifetime of very expensive special care to a profoundly disabled individual injured by brain hypoxia or anoxia at or shortly before birth. The money generally does not go into a lump sum for the parents like some big-ticket lottery jackpot, but goes into a court-administered trust fund for the child's benefit. The astronomical dollar figures are not unreasonable in light of what they are meant to pay for.

Now that our anatomy and physiology review is completed, I will say that the common scenario in deceleration monitoring cases involving nurses is that the nurses see the late decelerations, know they are seeing late decelerations, know it is a problem and do not call in the physician anyway. This keeps happening time and again.

In my personal opinion the leading case in this area is from the California Court of Appeal, Nicholas versus Good Samaritan Hospital, October 2004. I will caution any lawyers in the audience that this is an unpublished opinion and technically cannot be cited as a court precedent. Nevertheless I do think this case is leading the way.

The California court agreed with the patients' nursing expert witness that it is a nursing responsibility to classify a labor and delivery patient as high-risk when the nurses first observe abnormal decelerations in the fetal heart tracings.

At that point it becomes a nursing responsibility to ascertain that nursing staff are present with the mother who are fully competent to monitor and assist with a high-risk delivery.

It is also a nursing responsibility when a labor and delivery patient is first classified by the nurses as high-risk to ascertain who is the attending physician, where exactly the physician is presently located and exactly how the physician can be contacted.

More vitally, when a patient has been classified by the nurses as high-risk, the nurses must ascertain who is the backup obstetrician and must plan how to call in the backup immediately if necessary.

In this case the primary ob/gyn was in surgery with another patient during a critical time frame, making him completely unavailable to the nurses' high-risk patient. In

this area of clinical practice time is recorded very precisely by human actors and electronic devices are also marking the times that things happen. It is fairly easy for the lawyers to sort out afterward who was or was not doing what and when while exactly what was happening according to the electronic physiologic monitors.

The nurses had the mother push twice, seven hours after ominous decelerations were first seen, without a physician present. These pushes each produced two more periods of extended fetal heart rate deceleration which should have been seen as signs that an emergency cesarean was indicated.

The nurses also failed to ascertain that the mother was fully dilated before having her push, an error the Court thought was especially significant in conjunction with signs of ongoing fetal hypoxia. After the mother had pushed and the fetal heart rate had slowed unacceptably, the nurses neglected to stop the pitocin, a critical error in the opinion of the patients' nursing and medical experts.

In any negligence lawsuit, more than one party can be at fault and ruled liable to pay damages.

It is no defense for nurses to argue that one or more physicians were also negligent. Nurses have legal responsibilities independent of what the doctors are doing or are not doing for their patients.

On a practical level the patients' lawyers want to maximize their chances of obtaining a large recovery by suing each of the doctors as well as the hospital. The physician or physicians may or may not be hospital employees but the nurses usually are hospital employees.

It is not uncommon in these cases for the doctors to be faulted on the medical issues along with the nurses being faulted on nursing issues. It is almost never a case of one but not the other being at fault, but in a few moments I will discuss such a case.

Nurses have the responsibility to chart very carefully and precisely during the course of labor and the delivery. I will go into charting in labor and delivery in more detail later in the program. I bring up the charting issue at this point only to caution nurses against any sort of charting that attempts to point the finger of blame at someone else.

It may turn out to be a case where the doctor or doctors are at fault and the nurses are not, but the lawyers and the expert witnesses and the judge and the jury need to sort that out. You as a nurse are only asking for big trouble if you try to editorialize about another professional's fault in your charting. You may be quite surprised at the spin a clever lawyer will be able to put on what you have written.

This is true in labor and delivery and in every other area of nursing clinical practice, and I have another videotape on the subject of nursing documentation.

I had to look back a ways to find a case where the court ruled the physician was at fault and the nurses were not. The case is Nguyen versus Tama 688 A 2d 1103 February 1997 Superior Court of New Jersey Appellate Division. It involved the nurses' assessment and clinical judgment in the treatment of the expectant mother rather than the fetus or baby.

The hospital had its own pre-printed form checklist developed by the department of obstetric medicine, which gave the telltale signs of severe preeclampsia as blood

pressure greater than 160/110 or proteinuria greater than plus two after twenty-six weeks gestation.

A mother came to the hospital in advanced labor. The labor and delivery nurse first had the patient weighed, for comparison with her last pre-natal-visit weight. Then she noted a blood pressure of 170/120. The nurse turned the patient on her left side, and got a blood pressure of 186/118.

The nurse noted the patient's reflexes were plus two and that she had large amounts of edema in both legs. The resident physician on duty himself made note of massive pitting lower extremity edema on both sides with abnormal deep tendon reflexes.

When the patient's obstetrician arrived, the nurse reported her findings. The nurse expressly asked the physician if he wanted to check the mother's urine for protein and suggested he order magnesium sulfate to try to reduce the mother's blood pressure.

The court made note that the physician refused to do either of these things. The baby was delivered a short time later. Four hours after delivery, another nurse found the patient with her right arm dangling uncontrollably off the bed. She had had a hypertension-related cerebrovascular accident which seriously and permanently affected the entire right side of her body.

The labor and delivery nurse and the resident physician were dismissed from the case. The obstetrician alone faced a $1,4 million verdict.

According to the court, the labor and delivery nurse's assessment was right on the mark. Preeclampsia is a fairly common and dangerous condition in late pregnancy, characterized by elevated blood pressure, excessive weight gain and fluid accumulation in the lower extremities and proteinuria. This patient had gained a lot of weight after her last pre-natal office visit. The court said this should have worried the obstetrician, but beyond weighing the patient on admission to the hospital, the court did not say a labor and delivery nurse must fully review the prenatal office notes.

A good example of the importance of charting comes from O'Donnell versus Holy Family Hospital 682 NE 2d 386, a June 1997 case from the Appellate Court of Illinois.

The lesson from this case is that detailed charting of events as they transpire is absolutely essential to defend a lawsuit in court several years or more later.

Labor and delivery nurses noted the specific time the monitoring strips began to show a problem and that a physician came and looked at the strips within six minutes of being summoned.

The nurses noted the exact time the cesarean was called, when the anesthesiologist and neonatologist each was phoned and where each was, when the mother went to surgery, when she was prepped, when anesthesia started and the exact time the incision was made. It all was within the accepted thirty-minute medical standard.

A nurse noted carefully the appearance of the newborn, that he was not breathing and that a thick bloody mucus was extracted from the mouth and nose.

The court concluded the fetus was essentially born dead, with its airways so hopelessly obstructed *in utero* that it could not be brought to life, despite the physicians' best efforts. This was a tragedy, the court said, but there were no grounds for a

negligence lawsuit.

Again I want to stress how inappropriate it is to chart anything which expressly criticizes or finds fault with another healthcare professional. One more reason, aside from what I have already said and the obvious ethical and political considerations, is that nurses have the duty to act as advocates for their patients.

Nurses have a legal responsibility to advocate for their patients. That is, when a nurse believes a physician is ignoring the correct treatment measures or is pursuing inappropriate measures, the nurse must take action. There is a real Catch 22 for a nurse who charts that someone else is dropping the ball if the nurse himself or herself does nothing to correct the situation.

Nurses are required to access the nursing chain of command, as the courts phrase it.

A staff nurse must go to the charge nurse. The charge nurse, if there is reason, must go to the unit manager, house nursing supervisor or director of nursing.

Depending on the level of time urgency, the highest-level nursing officer available must approach the physician, if it appears necessary, then go over the physician's head within the medical chain of command until a suitable resolution is achieved.

The courts are imposing liability on nurses for failing to advocate in this manner for their patients. The courts also expect healthcare institutions to have policies so that any nurse at any level in the hierarchy has his or her duties and authority clearly spelled out as far as patient advocacy is concerned

Back to nurse competency. A January 2001 case involved an inadequately trained nurse. When the baby's shoulder got hung up, the ob/gyn told the nurse to apply supra-pubic pressure. The nurse froze, not knowing what to do. Precious time was wasted getting someone else into the room who knew what to do.

The doctor then had to rush the delivery along and the baby was left with a brachial plexus injury. The jury ruled the doctor and the hospital each were 50% at fault. The case was Ponce versus Ashford Presbyterian Community Hospital 238 Federal Third 20 (US First Circuit Court of Appeals January 2001).

The Nicholas case from California did make the point about nurse competency in assisting the mother with her own pushing, which can be exactly the wrong thing to do at the wrong time during a problem labor.

The case Long versus Missouri Delta Medical Center 33 SW 3d 629 from the Missouri Court of Appeals in November 2000 said that when fetal distress is evident from the fetal heart monitoring strip the nurse should stop the pitocin, caution the mother not to push, start O_2 – assuming there is a standing order, and turn the mother on her side pending an immediate call to the physician.

The big issue in the Long case was that the nurse apparently did not understand the importance to the possibly acidotic and hypoxic fetus of the high-flow O_2 going to the mother through the mask such that the nurse did not bother to deal with the O_2 mask that would not stay in place.

That is about all the time left for this short program. I hope I have been able to hit the most important issues, like I said at the beginning, that are coming up in court cases involving labor and delivery nursing. Thank your for your time and attention.