LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession
August 2015 Volume 23 Number 8

Labor & Delivery: Jury Finds That Nurse, Midwife Met The Legal Standard Of Care.

A nurse and a midwife took charge of the mother's labor while all of the hospital's ob/gyn resident physicians were away at a conference.

Pitocin was started at 4:00 a.m. but by 7:00 a.m. little progress was seen.

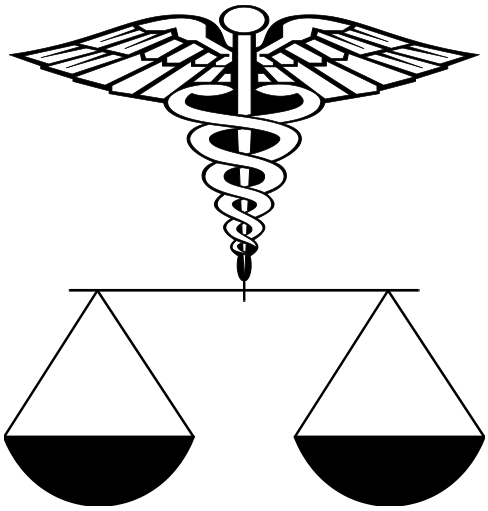
At 8:40 a.m. the nurse turned off the Pitocin because she was concerned the contractions were too close.

Following the hospital's nursing protocol, she waited twenty minutes and resumed the Pitocin at a lower rate.

When the fetal heart rate decelerated during an episode of vomiting, the nurse stopped the Pitocin altogether. O_2 was started and the mother was turned on her side.

Another deceleration soon followed. The midwife placed a fetal scalp monitor. After yet another deceleration, this time lasting two minutes, the midwife tore off the monitor strip and walked down the hall to speak with an obstetrician in his office who specialized in high-risk deliveries, while the nurse drew blood for the lab.

The obstetrician opted to wait. The mother was only fourteen and her 8 to 9 cm dilation seemed to show good progress toward a vaginal delivery, but when decelerations continued the nurse and the midwife prepped the patient for a cesarean. The baby was delivered with hypoxic brain injuries.



The midwife tore off the monitor strip and took it to the obstetrician's office down the hall from the delivery unit.

Handwritten notations on the strip indicated when O_2 was given, the mother repositioned and a vaginal exam done that showed 8 to 9 cm dilation.

There was no negligence in the nurse's or the midwife's management of the labor.

COURT OF APPEALS OF WISCONSIN
July 21, 2015

The Court of Appeals of Wisconsin upheld the jury's verdict of no negligence by the nurse, the midwife or the obstetrician.

Another midwife testified as a defense expert witness that the nurse and the midwife carefully watched and competently read the monitor strips, managed the Pitocin, gave O_2, repositioned the mother and timely and accurately reported to the obstetrician.

The obstetrician testified as an expert witness for the hospital that the labor was Category II, requiring continuous surveillance but not necessarily indicative of fetal distress.

The patient's expert testified the fetal decelerations showed a "non-reassuring" pattern. The Court ruled the obstetrician was nevertheless not required to testify in terms of reassuring and non-reassuring fetal heart-rate patterns, that terminology being obsolete since a new classification system was adopted by obstetric specialists in 2009.

The Court also accepted a pathologist's expert testimony for the hospital. Microscopic examination of the placenta revealed abnormalities which compromised the fetus but produced no outward signs the mother's caregivers could have seen. **L.D. v. Patients Fund, 2015 WL 4429090 (Wisc. App., July 21, 2015).**

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