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Risk Management Review

Soft Skill Failures Lead to Suboptimal Outcome for Obstetric Patient and Subsequent Lawsuit for Healthcare Providers

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Introduction

As with many medical specialties, the practice of obstetrics involves physiological testing that produces quantifiable results that inform treatment decisions. However, soft skills — such as judgment, reasoning, and communication — also are involved, especially when the patient's condition is complicated. In this interesting case from the Northwest, the managing physician and the bedside nurse were not necessarily "on the same page," which may have contributed to the suboptimal outcome.

Facts

A 24-year-old pregnant woman was a patient at an obstetrical practice, but was co-managed by maternal-fetal medicine (MFM) specialists because of her gestational diabetes. On Day 1, the patient had a nonstress test, which was nonreactive. As a result, she was sent for a biophysical profile (BPP), which was normal at 8/8. The fetal weight was estimated at 6 lbs. and 1 oz.

At 9:45 p.m. on Day 3, the patient presented to a hospital with complaints of cramping, bleeding, and decreased fetal movement. Dr. B was the obstetrician on call, and she ordered monitoring, intravenous fluids, urinalysis, and oxygen. Nurse A provided care during the observation period.

At 10:30 p.m., Nurse A called Dr. B and advised her that the patient's electronic fetal heart rate (FHR) strip demonstrated minimal variability, with no accelerations, no decelerations, and no contractions. The patient had not felt any fetal movement since arrival, and Nurse A had not palpated any fetal movement. Dr. B

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indicated she was not concerned unless decelerations were present. She advised that the patient's primary obstetrician could evaluate the patient in the morning.

At 11:40 p.m., Dr. C (a MedPro-insured obstetrician) was on the unit delivering another patient. Nurse A advised Dr. C of the patient's condition and asked her to look at the FHR strips. Dr. C noted minimal variability and no decelerations. She was aware that the patient had not felt fetal movement. She determined the FHR strips were Category II, which required close surveillance. At this point, Dr. C assumed management of the patient.

At 12:02 a.m. on Day 4, Nurse A noted that the patient still denied fetal movement and documented "Dr. C aware." At 12:14 a.m., Nurse A updated the patient and her mother on a probable cesarean section (C-section) in the morning. Dr. C saw the patient at 1:20 a.m., and the patient continued to deny any fetal movement. Dr. C performed an ultrasound at 1:30 a.m.; she noted breathing movement, gross fetal movement, and fine motor movement, resulting in a BPP of at least 6/8.

Dr. C asserted that she then talked with the on-call MFM fellow and conveyed her plan to repeat the BPP early in the morning; however, if the FHR strips became Category III, she would deliver the baby. No documentation of this phone call between Dr. C and the MFM fellow exists, and it cannot be confirmed because Dr. C said she made the call from a central line at the hospital. (Further, an audio recording of a later conversation with the MFM fellow suggests the earlier call never took place.)

Dr. C left the hospital at 3:00 a.m. When she left, the patient had no meaningful contraction activity, and the FHR demonstrated minimal variability and no decelerations. At 4:07 a.m., some contraction activity was detected, but it was not a regular pattern. The variability remained minimal with some brief periods of moderate variability. There were no accelerations, but some decelerations were noted. Additionally, the tracing was poor on several occasions.

Nurse A documented that she spoke with Dr. C at 5:08 a.m. and reported two decelerations, one lasting 90 seconds and another lasting 120 seconds. Dr. C did not specifically recall this conversation, but she believed she may have remotely reviewed the FHR strips.

At 5:28 a.m., Nurse A paged Dr. C again. According to the record, Nurse A advised Dr. C that the fetal heart tones were audible in the 80s. Dr. C did not change the plan of care. Subsequent to this conversation, Dr. C again

spoke with the MFM fellow. Based on this conversation, Dr. C decided that she would deliver the baby around 8:30 a.m.

At 5:40 a.m., Dr. C advised Nurse A of her conversation with the MFM fellow. The nurse documented that Dr. C reported a conversation with the perinatologist, who recommended delivery that morning. According to the note, Dr. C told Nurse A “I would like to wait until 8:30 to do the C-section; if she keeps having decelerations, then call.”

According to Nurse A, she reiterated that the patient had experienced three decelerations in the last hour, and the most recent one was into the 80s. Nurse A testified at her deposition that she repeated the information just to make sure Dr. C was aware and did not have any concerns about fetal status at that time.

At 6:38 a.m., Dr. C was paged because of low-to-absent variability and a deceleration. According to the record, she was advised of “a long period of absent variability and a prolonged deceleration to 40.” Dr. C did not change the plan of care and told the nurse to call if this happened again.

At 6:53 a.m., Dr. C was paged again — this time by the charge nurse. Dr. C was again advised of low-to-absent variability with decelerations. A C-section was scheduled for 8:30 a.m., with the MFM fellow to assist. The pediatrician on call was paged to be present for the delivery. At 7:31 a.m., an ultrasound was completed, and the BPP result was 4/8.

The actual uterine incision was accomplished at 8:54 a.m. Dr. C recalls the baby was floppy on delivery; however, the Apgar scores were 8 and 8. The baby's glucose was critically low at 12 mg/dL; despite multiple D10 boluses, the hypoglycemia persisted. The cord arterial pH was 7.17 and the base excess was -9.4.

The baby was transferred to a tertiary children's medical center for treatment of hypoglycemia, respiratory distress, and prematurity. One geneticist raised the possibility of an inborn error of metabolism, while another discounted that possibility and concluded it was more likely that the infant experienced a significant episode of hypoxia/hypoperfusion. The child suffered major, permanent neurological impairment (including cerebral palsy), which will require lifetime 24/7 living assistance.

A medical malpractice lawsuit was filed against Dr. C and her practice, the MFM fellow and his practice, Nurse A, and the hospital. The case against Dr. C was resolved with a payment in the very high range and defense costs in the high range. Additional payments were made by

the other defendants; however, those amounts are not known.

Discussion

In medical malpractice parlance, this case is known as a high-volatility case. Such cases are situations in which a valid defense is available, and the case should be won. However, if the case is lost, the damages may be very high — possibly exceeding the limits of the provider's insurance coverage. It boils down to defend versus settle, and it is not an easy decision to make.

The first factor that made this case difficult to evaluate was the etiology of the child's severe impairments. The plaintiff contended that events occurring during the birth process (specifically, a delay in delivery) resulted in the injuries. Although this belief was a legitimate theory of legal causation, the defense experts opined that the more likely etiology was either an inborn error of metabolism (resulting in severe, chronic hypoglycemia in utero) or coagulopathy in utero, which was probably genetic in origin. If either was the case, the damage occurred before the birth events and was unpreventable. In a malpractice trial, a jury (whose members are likely untrained in medicine) would be asked to choose one of these theories of causation — a choice they often are poorly equipped to make.

The defense experts were generally supportive of Dr. C's care *if* an early conversation and agreement with the MFM fellow occurred. However, the MFM fellow contended the earlier call did not occur. Without any documentation of this call — and no way to verify its occurrence by phone records — there was a disputed question of fact and a conflict between the defendant physicians.

Similarly, some of the communication between Dr. C and Nurse A was not helpful to the defense of the case. It was clear from the nurse's notes that she was concerned about this patient, but Dr. C contended that the concern was not clearly communicated to her during the time she was home. It is noteworthy that, despite her apparent concern over the way Dr. C was managing the case, Nurse A never used the hospital's chain-of-command protocol.

Ultimately, the other providers seemed willing to place the blame on Dr. C, and a unified defense of the case was unlikely. Although a strong defense appeared to be available, the totality of the circumstances led Dr. C to request resolving the case through settlement.

An unfortunate postscript to this case is that, following its conclusion and one other case in which a payment was made on behalf of Dr. C, she was so distressed and disillusioned with the practice of medicine that she discontinued practicing and has not returned.[1]

Summary Suggestions

The following suggestions may be helpful to providers when they are remotely managing patient care and coordinating with other members of the care team:

- Clear communication between remote and onsite providers is essential. Accurately relaying all relevant facts, clearly stating any concerns, and precisely verifying all orders are critical elements of this communication.
- Adequate documentation of verbal conversations will minimize the likelihood of miscommunication between treating practitioners and provide the information needed to conduct a thorough review of the case's circumstances if necessary.
- Bedside providers should not hesitate to use their facility's chain-of-command protocol if they feel the patient is not receiving optimal care. The use of this protocol should provide a "second set of eyes" to review the case and arrange additional support if needed.
- Training in courses such as TeamSTEPPS® can be valuable in ensuring that an organized, complementary approach to patient care is occurring across the provider spectrum.[2]

Conclusion

The practice of medicine is complex and has many moving pieces that must interface properly to ensure optimal care. Sometimes failures happen not as a result of inadequate technical ability, but due to a breakdown in a basic element of care, such as communication, coordination, or documentation. Careful attention to these basics often can go a long way toward facilitating the optimal outcome everyone desires.

Endnotes

[1] "Litigation stress" is not an uncommon reaction by physicians to the rigors of the legal process during malpractice litigation, and it manifests itself in a variety of ways. MedPro-insured providers who are struggling with feelings of uncertainty, fear, or despondency during the litigation process are urged to talk to their MedPro claims managers or their defense attorneys. MedPro's booklet *Litigation Support: Maintaining Your Balance* and the website https://physicianlitigationstress.org/ also provide informative and supportive materials.

[2] TeamSTEPPS® is a teamwork and communication training program available through the Agency for Healthcare Research and Quality. To learn more, visit https://ahrq.gov/teamstepps.