

## Risk Management Review

### Improper Management of Pregnancy Results in Death of Mother and Impairment of Child

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#### INTRODUCTION

Every obstetrical case is complex, even when the mother is healthy. Subtle but significant changes can occur quickly. This interesting case from the Northwest illustrates a catastrophic outcome that resulted from a failure to recognize and respond to a patient's rapidly deteriorating condition.

#### FACTS

The patient was a 27-year-old nurse, gravida 4, para 3, who presented to the OB/GYN practice for management of her fourth pregnancy. Her previous three pregnancies had been uneventful; this pregnancy also had been uneventful through the first 36 weeks. On March 21, the patient presented for her last prenatal visit. At that visit, she had a blood pressure of 126/82 mmHg and weight of 212 lbs. Her cervix was dilated to 2 cm, she was 80 percent effaced/-2 station, and her urine was negative.

The office note for this visit, written by Dr. A, indicated that the patient's entire family had a "GI bug." Although the patient was not personally suffering from any nausea, vomiting, or other GI symptoms, she requested Phenergan<sup>®</sup> "in case she developed nausea and vomiting." The legal complaint alleged that she complained of fatigue at this visit; however, the patient record does not mention fatigue.

The following day, the patient spoke with Dr. B (another physician in the same practice) by phone. According to the record for this conversation, she indicated to Dr. B that she felt nauseated. She had tried drinking some Gatorade but was unable to keep it down. She again indicated that all of her children were similarly ill. Dr. B advised the patient to go to the hospital if she felt dehydrated.

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The patient did present to the hospital the following morning. At that time, Dr. B completed admission notes, which indicated a **3-day** history of nausea and vomiting (taking the date of onset back to at least March 21). Other hospital consultants' notes indicated a history of nausea, vomiting, and diarrhea for **1 week**. (The discrepancy regarding the onset of GI symptoms led to allegations of alteration of the March 21 office note.)

At the hospital, a fetal monitoring strip was obtained, which was nonreassuring. Shortly thereafter, an emergency cesarean section resulted in the delivery of a live baby boy. Because of poor respiratory effort, he was immediately transferred to a children's hospital, where he was intubated and received a dose of surfactant. He was able to be weaned to room air the following day. He was also started on antibiotics, which were discontinued after a negative culture.

The baby experienced neonatal seizures at the children's hospital, and he was started on phenobarbital. An ultrasound of his head and EEG were negative; however, an MRI showed a small intraventricular hemorrhage and extensive diffuse abnormalities of the cerebral hemispheres. The baby was discharged on April 9 and, with the phenobarbital, was seizure free. However, he had severe and permanent neurological deficits.

Because the mother had slightly elevated blood pressure, she had liver function and coagulation studies done as part of the delivery process. These studies showed liver abnormality and coagulopathy consistent with fatty liver of pregnancy. Her condition appeared to improve after consultation with several specialists and treatment with blood products. After showing improvement, she was discharged.

Approximately 1 week later, the patient presented with a fever, an elevated WBC, and tachycardia. She was admitted and followed by several physicians, including Dr. B. However, none of their notes indicate that a vaginal exam was ever performed, and none of the physicians stated a definitive diagnosis (which was ultimately determined to be endometritis).

On April 5 (approximately 2 weeks postdelivery), an infectious disease consultant ordered a CT scan because of concerns that a pulmonary embolus might be developing. The CT scan showed gas bubbles in the uterine lining. A radiologist recognized the seriousness of this finding and called Dr. C (another member of the OB/GYN group, who was on call) at 1a.m. to report this finding. After Dr. C received the call, he left Dr. B a voicemail message because Dr. B was to round on the patient in the morning.

Once the endometritis was identified, it was found to be resistant to antibiotics, and it caused portions of the uterus to become necrotic. However, the patient's coagulopathy and other conditions made surgical intervention very high risk.

After a discussion with Dr. B, the patient elected to have a hysterectomy. Postoperatively, she became hypotensive, arrested, and was successfully resuscitated. She arrested again the following day and, in accordance with her family's wishes, was not resuscitated. She died as a result.

A malpractice lawsuit was commenced against Drs. A, B, and C; a fourth physician in the practice; and the practice itself. With the consent of the doctors, the case was settled in the very high range, with defense costs also in the high range.

## DISCUSSION

This case involved several issues that made it challenging to defend. The first concern that the defense counsel identified was significant problems with the documentation. The office note for March 21 indicated that the patient did not have any nausea or vomiting; however, the hospital note (written on March 23) indicated nausea and vomiting (and possibly diarrhea) for a period of 3 days to 1 week. This disagreement led to persistent allegations of record alteration, which were never proven nor disproven because of the settlement of the case. Obviously, if these allegations had been proven, they would have had a negative impact on the defense.

Even if the allegations of record alteration were ultimately disproven, this case illustrates a potential weakness commonly identified in medical documentation — discontinuity. Most often, discontinuity occurs when a subsequent provider does not review what the previous provider has written, or when a hospital-based provider does not have access to the office notes.

Although the potential for inconsistency between office and hospital documentation cannot be eliminated, it is important for both office and hospital providers who are writing notes to review what has previously been written in the record. The discontinuity of the documentation in this case makes it difficult to definitively establish the patient's condition on March 21, and it also suggests a general disconnect amongst the healthcare providers.

The transitions of patient care, or handoffs, are the next point of concern in this case. A handoff is simply *any* transfer of patient care from one provider to another — from a full transfer of care to simply covering call for another provider. A handoff is one of the greatest points of risk in the continuum of patient care for one simple reason: the risk of miscommunication, which is a well-recognized predictor of errors that may lead to patient injury.

As is common with larger practices or care that involves transitions from office treatment to hospital treatment, this case had several handoffs of patient care. The first significant handoff occurred between Drs. A and B, from March 21 to

March 22. This handoff resulted in disagreement regarding the onset of symptoms. This is significant because some expert reviewers suggested that if the patient had symptoms on March 21, Dr. A could have ordered laboratory testing at that time. If the test results showed reason for concern, an induced vaginal delivery could have been commenced. The experts reasoned that taking these actions would have greatly lowered the risk of infection to both the fetus and mother.

The second significant handoff that occurred was between Dr. B and the other physicians who attended the patient when she returned to the hospital approximately 1 week after the initial discharge. It appears that none of the physicians performed a vaginal exam (which would have likely indicated an infection) — possibly because they were not communicating well as part of a comprehensive approach to the patient's care.

The final problematic handoff occurred between Drs. B and C, when Dr. C was covering call for the group. The radiologist thought the findings were serious enough to warrant a 1 a.m. call to Dr. C. Yet, Dr. C did not communicate the information to Dr. B directly, resulting in several hours of delay in follow-up care for the patient. Some of the expert reviewers felt that the delay may have been significant in the patient's overall deterioration.

Although some reviewers thought that this was just a very difficult and complicated case, there seems to have been opportunities to intervene sooner. If such intervention had occurred, the catastrophic outcome might have been avoided or at least mitigated.

## **SUMMARY SUGGESTIONS**

The following suggestions may help practitioners avoid miscommunication while transitioning patient care within a facility or across locations:

- Before writing in any patient chart, providers should review the notes that are already present.
- The provider who has primary responsibility for the patient should periodically review the patient's record to ensure it is complete and logical.
- Any significant disparities in the patient's medical record should be reconciled as soon as possible.
- Transitions of care (or handoffs) are inherently dangerous and should be handled with utmost caution. Well-defined policies and protocols for managing handoffs can be beneficial.
- Communication among providers, staff, and the patient/family is critical in avoiding errors.

## CONCLUSION

The delivery of medical care continues to be an imperfect science. However, careful attention to the process of healthcare delivery, including the nonclinical aspects, will enhance the likelihood of a favorable outcome and may reduce professional liability exposure.

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