MedPro Group
a Berkshire Hathaway company

Risk Management Review

Incomplete Patient History Results in Inadequate Obstetrical Care and Birth Trauma

Theodore Passineau, JD, HRM, RPLU, FASHRM

Introduction

An often-repeated phrase today is “the devil is in the details.” Unfortunately, this tragic obstetrical case illustrates how true this statement can be.

Facts

Dr. L was an experienced, board-certified obstetrician/gynecologist (OB/GYN) who practiced for several years in a multiphysician practice located in a major city. The patient–mother was a 27-year-old Caucasian female who made her first presentation to the practice on December 7 of Year 1 for pregnancy confirmation. Her husband was also present. They indicated they were interested in a “natural” birth experience.

In response to questions from Dr. L, the patient–mother’s other significant response to Dr. L’s questions was having what she described as a “miscarriage” during her previous pregnancy (which was handled by a different medical practice). Her due date was July 13 of Year 2.

On December 21, Dr. L’s partner, Dr. C, saw the patient–mother for the “obstetrical history visit.” During this visit, Dr. C reviewed a history form that the patient–mother had completed. The form read: “Is this your first pregnancy? If no, any previous complications?” In response, the patient–mother wrote, “1 miscarriage.” On the same form, she circled “yes” to the question “Have you, the father of the baby, or any other family member, ever had . . . stillborn or more than one miscarriage?”

Dr. C noted the patient–mother’s prior “miscarriage,” assuming this was a first trimester spontaneous abortion. Neither she nor Dr. L questioned the patient–mother any further about it. However, her “miscarriage” had been a fetal demise occurring at Week 19 resulting from a placental abruption.

The patient–mother rotated through the group for her prenatal care; neither Dr. L nor Dr. C saw her again for her prenatal care.

On February 23 of Year 2, an ultrasound indicated a hematoma on the placenta. Another ultrasound taken in March indicated that the hematoma was still present, but it was decreasing somewhat in size. No further action was taken.

On June 17 of Year 2 at 7 p.m., the patient–mother presented to the co-defendant hospital with complaints of painless bleeding that started at 6 p.m. The blood had saturated a pad. Dr. J, another member of the group, saw the patient–mother. At that time, she was 36 weeks, 2 days. She had no cramping or pain, the fetal heart rate was reactive, and there were a few contractions.

Dr. J examined her and noted a “small amount of dark blood in the vault,” but no active bleeding. The cervix was fingertip dilated and thick. After completing his examination, Dr. J discharged the patient–mother home, with instructions to return for symptoms of labor, rupture of membranes, bleeding, fever, or decreased fetal movement.

At 11:45 p.m. the next day, the patient–mother returned to the hospital with a complaint of vaginal bleeding since 11 p.m. The labor and delivery (L&D) nurse noted a small amount of red bleeding on a barrier pad, and smears of blood appeared on the patient–mother's inner thighs. No clots were evident.

Dr. L saw the patient–mother at 12:34 a.m. There was a slow trickle of blood in the cervix, and her hemoglobin level was 13. Dr. L arranged for admission and advised the patient–mother of the potential need for a C-section. The patient–mother again vocalized her desire for a natural vaginal delivery.

At 1:35 a.m., Dr. L reviewed the fetal heart monitoring (FHM) strip. Oxygen was administered for late decelerations, intravenous fluids were increased, and the patient–mother was positioned on her left side. Dr. L felt the patient–mother could continue to labor for a while.

At 2:10 a.m., Dr. L again reviewed the strip but took no further action. At 3 a.m., there was moderate bloody show, and the patient–mother continued having contraction pain. Shortly thereafter, a small gush of blood with two nickel sized clots emerged. Dr. L was notified about the patient–mother’s condition and that she was still undecided on an epidural versus natural birth.

At 3:15 a.m., nursing staff contacted Dr. L again to evaluate the patient–mother for questionable decelerations. At 3:17 a.m., he reviewed the FHM tracing and evaluated the patient–mother. He noted a couple of decelerations that had normalized; nevertheless, he determined they needed to move to delivery and advised the patient–mother.

At 3:24 a.m., to increase the likelihood of a natural delivery, Dr. L ruptured the membranes, and an internal electronic fetal monitor (EFM) was placed. The fluid appeared clear with some blood from the vagina mixing on the pad. The shift manager asked whether to call a pediatrician for the delivery; Dr. L thought they could monitor the baby and decide later. At 4:11 a.m., Dr. L was again at bedside. At 4:10 a.m., a prolonged deceleration had occurred, and he decided to move to a C-section.

It took 12 minutes to move the patient–mother from the L&D room to the operating room. During transport, the EFM was removed. The C-section proceeded without a pediatrician present; however, immediate resuscitation of the infant was necessary, which the hospital neonatal intensive care unit nurses conducted. The resuscitation included intubation, more than 30 minutes of chest compressions, and six doses of epinephrine. Apgar scores were 0, 0, 2, and 1.

The infant was diagnosed with respiratory failure, metabolic acidosis (cord pH was 6.77/-24 arterial and 6.64/-27 venous), hyperglycemia, and seizures at birth. He was ultimately diagnosed with severe hypoxic ischemic encephalopathy with no prospect for improvement. The infant required 24/7 care (including oxygen, a suction machine, feeding pump, nebulizer, and a cough assistance machine) and had a life expectancy of 10 to 25 years.

The defense's placental pathologist's subsequent analysis of the placenta was very informative. She observed a 9 cm, full thickness infarct in the placenta without collateral flow. Beneath the infarct was dead tissue and clotted blood. The infant's hematocrit was 82, the highest level the pathologist had ever seen. This made the blood extremely viscous, thus impeding its flow. The pathologist opined that the abruption had started several days before delivery, culminating in a complete abruption just prior to delivery.

A medical malpractice lawsuit was brought against Drs. L and C, the hospital, and three L&D nurses. With the doctors' consent, the suit was settled by means of a payment in the high

range on behalf of the physicians, with defense costs also in the high range. A separate payment in the high range was made on behalf of the hospital and nurses.

Discussion

Although this case is horribly tragic, it is not complicated. If a risk management professional conducted a root cause analysis, the critical error would likely be identified as the failure to adequately investigate the previous "miscarriage" as part of the history taking. If this prior event had been properly identified, presumably there would have been much closer surveillance of the patient–mother throughout the pregnancy.

This case brings two things about patients into sharp focus. First, many patients are poor historians. Whether through anxiety, distraction, failing memory, or other factors, they may fail to inform the provider of major historical information. In this case, it is noteworthy that the practice did not attempt to secure a copy of the patient–mother's treatment records from the first pregnancy; those health records would certainly have contained documentation about the abruption and its unfortunate sequelae.

Second, many patients have very limited medical knowledge. Common medical occurrences are frequently mischaracterized by laypersons. If Dr. C had explored the circumstances of the earlier "miscarriage" a little further, she might have recognized that something more significant had occurred. For instance, if she had inquired as to what week in the pregnancy the event had occurred, she would have recognized that it was not a first trimester event.

It is also noteworthy that, in her interview of the patient–mother, Dr. C assumed that the previous event had been a (not uncommon) first trimester miscarriage. As we all know, wrong assumptions are a common contributor to miscommunication in all aspects of interpersonal relationships.

We can only speculate as to the significance of the hematoma that was identified on the ultrasounds taken in February and March, but it is probably safe to say that the hematoma would have been closely monitored if the providers had known of the previous abruption.

The fact that the patient–mother rotated through several different providers during her prenatal course (never seeing Drs. L or C again until the time of delivery) was not necessarily advantageous. Each new provider she saw was "starting from scratch" with her, and it is not known how thoroughly each reviewed her health record before that encounter. The

likelihood of identifying this misunderstanding about the miscarriage was diminished, since each visit was—in effect—a new patient encounter.

Regarding the birth events, two highly credentialed OB/GYN experts reviewed this case. One expert felt he could support Dr. L's management of this birth; the other expert felt he could not support it because he thought that Dr. L should have delivered the baby by C-section no later than 2 a.m., which was arguably supported by our placental pathologist's findings.

This left the defense team in a quandary; if the nonsupportive expert's position was reasonable (which it appeared to be), it was likely that plaintiff's experts (who were also highly credentialed) would take a similar position, which a jury could easily accept.

When a jury of laypersons is confronted with opposing arguments regarding highly technical medicine — with well-credentialed experts making the arguments — they sometimes just disregard the standard of care issue and focus on what they can understand — the damages. This is just human nature, but it can complicate matters. In this case, it was a major concern given the severity of the damages, and it is one of the reasons that settlement was viewed as a viable option.

Summary Suggestions

The following suggestions may be helpful when assembling a comprehensive patient history in a multiphysician practice:

- Obtain and adequately review patients' health records before their appointments for pertinent information, whether seeing them for a new condition or as part of serial treatment. With new patients, a review of health records from previous providers can be very beneficial.
- Recognize that the health history provided by the patient may contain errors and/or be incomplete.
- When interviewing a new patient regarding their health history, avoid making assumptions. Gather thorough information about the patient's history of the present illness/condition, past medical history, family medical history, and personal/social history.
- Use open-ended questions when interviewing the patient and follow them up with questions that provide greater specificity.

- When seeing a patient for serial visits — to the extent possible — try to have patients see the same provider to enhance communication. Especially in large, multiprovider practices, every effort should be made to provide consistent, attentive care.

Conclusion

In a busy practice, streamlining processes often can increase efficiency. However, devoting sufficient time and attention to formulating a detailed patient composite will minimize the potential for an avoidable error, benefiting both the patient and practice.