Birth Injury: L & D Nurses Met Legal Standard Of Care, Court Finds No Negligence.

The parents sued their obstetrician, the on-call neonatologist and the hospital for damages.

Their lawsuit claimed the child's cerebral palsy was caused by negligence committed by the physicians and the hospital's labor and delivery nurses causing hypoxic brain damage right before the child's birth by cesarean section.

The jury awarded a $30 million verdict against the obstetrician but found no negligence by the neonatologist or the hospital's nurses.

The parents settled their $30 million verdict against the obstetrician for the $1 million limits of his malpractice policy. They also settled for $100,000 from the neonatologist's medical group in exchange for not pursuing an appeal against him.

The parents appealed the verdict in favor of the hospital to the Appellate Court of Illinois, but the Court affirmed the verdict and exonerated the hospital's labor and delivery nurses from negligence.

Admission / Nursing Assessment

The patient came in at 2:30 a.m. at full term, two days past her estimated due date. The plan was for vaginal birth after a prior cesarean. Her vital signs were taken, an IV was started for hydration, an external fetal heart monitor was started and her obstetrician was phoned. At 3:00 a.m. the fetal heart rate was 140 and the mother was dilated 3 cm. All signs were considered normal.

Amniotic Fluid / Meconium

Her obstetrician arrived at 3:15 a.m., ruptured her amniotic sac and started a fetal scalp monitor.

The amniotic fluid contained thick meconium, according to the court record. Following hospital policy, the nurses phoned the on-call neonatologist. The court said that is accepted practice within the legal standard of care for labor and delivery nurses whenever meconium is observed prior to delivery.

When the neonatologist arrived ten minutes later the fetal hear rate was still 145 beats per minute.

In a medical negligence case against a hospital based on vicarious liability for the conduct of the hospital's nurses, it is necessary for the patient to present expert testimony:

1. To define the legal standard of care for the nurses under the specific circumstances of the case, and

2. To establish that the legal standard of care was breached, and

3. To prove to a reasonable degree of medical certainty that the breach of the legal standard of care by the nurses was the proximate cause of the patient's injury.

The rationale for requiring expert testimony is that a lay person on the jury is not skilled in the practice of medicine and is, therefore, unequipped to evaluate professional conduct without the aid of expert testimony.

Nurses who have the appropriate educational and practice qualifications are accepted as experts on the nursing standard of care.

Medical cause and effect, however, in most instances requires testimony from a specialist physician as an expert witness.

APPELLATE COURT OF ILLINOIS
December 17, 2003

Low Fetal Heart Rate
Nurses Initiated Chain of Command

Around 4:30 a.m. the fetal heart rate dropped ominously to around 60. The nurses started standard nursing interventions including increasing the IV fluid rate, repositioning the mother on her side and starting oxygen through a face mask, which temporarily returned the fetal heart rate to baseline.

Then the fetal monitor stopped tracing altogether. A nurse listened and tried to count the audible signals while also trying to calibrate the audible signal for the fetus with the signal for the mother which she in turn verified with a wrist pulse.

The nurses called the labor and delivery charge nurse into the room to assess the situation. It was her responsibility, if it was warranted based on her assessment, to get things moving toward an emergency c-section regardless of what the obstetrician was thinking or doing.

The chart showed the supervisor was called at 4:40 a.m. and came at 4:57 a.m. The c-section was called at 5:00 a.m. and started at 5:28 a.m. The nurses got another scalp monitor working at 4:53 a.m. and it confirmed the fetus was in distress.

In court the nursing experts on both sides agreed the nurses acted properly by initiating the nursing chain of command. The question was whether the staff nurses acted quickly enough, an issue for which there is no precise standard. The judge and jury believed they did and held the obstetrician solely at fault for any delay.

The only questionable issue was whether the nurses should have presumed this baby was not at risk during the interval while a fetal monitor was not actually reporting usable data.

Cesarean Set-Up

The lawsuit alleged the nurses failed in their nursing responsibility to have the room, equipment and supplies ready in time once the cesarean was called. However, the court found no proof to back that allegation. **Bryant v. LaGrange Memorial Hospital, __ N.E. 2d __, 2003 WL 22965485 (Ill. App., December 17, 2003).**