Systemic Lupus Erythematosus: L & D Nurses, Physician Faulted For Mismanagement Of High-Risk Delivery.

The nineteen year-old obstetric patient had been diagnosed at age nine with systemic lupus erythematosus.

A perinatal medical group specializing in high-risk cases followed her pregnancy almost to term without complications.

She was admitted to the hospital for one day at near term for a flare-up of her lupus. Her rheumatologist agreed with her ob/gyn's plan to induce labor.

Four days later she came back to the hospital already in spontaneous labor. She was admitted to the labor and delivery unit and a monitor was started which showed reactive tracings with good variability.

At 1:00 a.m. the next morning she was dilated 8 cm, 90% effaced and at minus two station. An epidural was started for pain management. Finding the monitor tracings normally reactive, the labor and delivery nurse started Pitocin at 1:30 a.m.

An hour later the labor and delivery charge nurse ruptured the membranes and obtained clear liquid.

At 4:45 a.m. the on-call perinatologist came in and examined the patient. She was fully dilated so he instructed her to start pushing. The perinatologist saw some late decelerations on the monitor but was not concerned.

Nurse Saw Late Decelerations Stopped/Started Pitocin

A few minutes after the perinatologist left, the labor and delivery nurse lowered the Pitocin, then stopped it altogether after a few more minutes, being concerned about the late decelerations appearing on the fetal heart monitor.

An hour later, however, the nurse re-started the Pitocin for another forty-five minutes, then turned it off again.

At this point the facts are disputed. If the lawsuit had not settled but had gone to trial the nurse would have testified she did report to the perinatologist when she stopped the Pitocin both the first and second times.

The family's lawyers, on the other hand, were prepared to argued that the nurse believed the perinatologist was aware of the situation based on his exam at 4:45 a.m.

The nurse saw no need to report to him again and did not report again before she left at the end of her night shift.

When the day nurse came on duty between 7:00 and 7:30 a.m. she was immediately concerned about the monitor strips but the night shift nurse told her the perinatologist knew about it and was in the process of deciding what to do.

The day-shift charge nurse finally did call the perinatologist at 8:00 a.m. He called for a cesarean. There was further delay of almost an hour getting the medical team together at the hospital for the procedure.

The infant was delivered by cesarean at 9:01 a.m. with poor Apgars and now has cerebral palsy.

High Risk Pregnancy

The labor and delivery nurses, the lawsuit alleged, should have been more vigilant with a high-risk patient.

Systemic lupus erythematosis can result in a smaller than normal placenta which puts the fetus at risk for hypoxic labor complications. The nurses should have communicated more consistently to the patient's physician.

The hospital was faulted for the hour-long delay in starting the cesarean, albeit after more delay already attributable to the labor and delivery nurses and to the perinatologist in calling for the cesarean in the first place.

The $8,200,000 pre-trial settlement of the family's lawsuit filed in the Superior Court, Los Angeles County, California was reported on condition that the identities of the patient, physicians, nurses and hospital be kept confidential. **Confidential v. Confidential, 2008 WL 2020372 (Sup. Ct. Los Angeles Co., California, May 1, 2008).**