Meconium Aspiration/Asphyxia: Nurse Held Responsible For Delayed Cesarean Delivery.

The obstetric physician settled out of court for $950,000. The case went to trial only against the hospital, as the labor and delivery nurse's employer. The jury ruled the baby's damages were $5.2 million, with the physician 57% at fault and the nurse 43% at fault.

As the courts in Missouri do the math in a situation like this, the hospital was held liable for $2.2 million in damages, that is, 43% of $5.2 million, with no further liability placed on the physician beyond his out-of-court settlement.

The Missouri Court of Appeals approved the breakdown of fault and the total amount of damages. The damages were intended to compensate the child for the albeit short lifetime of special care she would need. The child was sightless, speechless, deaf and unable to control her limbs or swallow, due to cerebral palsy related to perinatal hypoxia and ischemia stemming from meconium aspiration.

Nursing Negligence
Oxygen Mask

Before any fetal distress was apparent, the physician ordered five liters of O_2 by mask. That was four hours after the mother's water broke. She had become well dilated and wanted to start pushing.

The nurse had difficulty getting the strap on the mask to stay put around her head, and just forgot about it.

With hindsight the court believed that the nurse ignoring the O_2 contributed greatly to fetal hypoxia, even though it did not seem critical to the nurse at the time.

Monitor Tracings

Three minutes after the physician stepped out of the room believing all was going well, the fetal heart rate dropped to a non-reassuring level, and the nurse actually marked it on the monitor strip.

However, the nurse did not turn the mother on her side, did not put on the oxygen mask, did not increase the O_2 and her IV fluids, did not tell her to stop pushing and waited ten to fifteen minutes to go get the physician.

The baby was injured by prolonged lack of oxygen during birth.

The jury attributed it, at least in part, to the fact the nurse did not promptly ask the physician to return when she noticed abnormal monitor tracings, did not promptly turn the mother on her side and did not ensure that the mother was wearing her oxygen mask.

The physician came back into the room and tried to force a vaginal delivery with a vacuum extractor, while the heart rated dropped further.

As indicated above, the jury ruled the physician's negligence in doing that rather than calling for a cesarean was 57% the cause of the baby's injuries.

Day-In-The-Life Videotape
Of Baby's Nursing Care

The hospital's attorneys argued it was prejudicial to the hospital for the jury to view a day-in-the-life video in court about the profoundly injured baby. They claimed it aroused too much emotional sympathy from the jurors and motivated them to bring in a large verdict.

The baby needed constant specialized nursing care, including a ventilator to breathe, a feeding tube in her nose and a catheter to remove bodily wastes, frequent suctioning, daily physical therapy and medications to relax her stiffness and control her seizures.

The court ruled that a day-in-the-life video about the baby's nursing care was an acceptable means for the family to prove to the jury that the baby deserved a substantial verdict. **Long v. Missouri Delta Medical Center, 33 S.W. 3d 629 (Mo. App.,**

Fetal Heart Tracings: Court Faults Nurse, Did Not See Abnormality Or Call Physician.

After noticing decreased fetal movements in her thirty-sixth week, the mother talked to her obstetrician.

Her obstetrician told her to go to the hospital's labor and delivery unit if she did not feel four or five movements every twenty to thirty minutes.

She followed her physician's advice and went to the hospital. At the hospital an external fetal heart monitor was started.

From the outset the readings were abnormal, but the nurse failed to note it or chart it or report it to the physician, until all activity stopped, an ultrasound was done and fetal demise was pronounced.

A non-reassuring fetal heart tracing mandates immediate medical attention.

The physician may elect to do acoustical or other fetal stimulation or an ultrasound or may just call a cesarean right away.

But it all depends on prompt notification from a competent and vigilant labor and delivery nurse.

COURT OF APPEALS OF MINNESOTA, 2001.

The Court of Appeals of Minnesota ruled there was nursing negligence by a hospital employee.

The court also ruled it was no defense the autopsy revealed a true umbilical knot. The possibility of something like that being present would be just another reason why careful strip monitoring is essential, the court indicated. **Demgen v. Fairview Hospital, 621 N.W. 2d 259 (Minn. App., 2001).**