University of California, San Francisco
Antepartum & Intrapartum Management

Defense of the Perinatal Brain Injury Case

University of California, San Francisco Antepartum & Intrapartum Management
June 10, 2010
San Francisco, California

David R. Lucchese, Esq.
Galloway, Lucchese, Everson & Picchi
Walnut Creek, CA

4 issues in 30 minutes

1. Are perinatal providers still the targets in malpractice cases?
2. Why are the settlements and verdicts in perinatal brain injury cases so large?
3. What are the most frequent theories of liability in these cases against perinatologists, obstetricians, certified nurse midwives and perinatal nurses? What can these professionals do to lower their risk of being sued, and losing if they are?
4. Can these cases be defended in a courtroom, or at least settled for as little as possible?

ARE PERINATAL PROVIDERS STILL THE TARGETS IN MALPRACTICE CASES?

YES!

- In the PIAA malpractice claims closed analysis, between 1985 and 2007, obstetrical claims ranked first among all specialties for the number of claims reported and the total amount of indemnity paid.
- Closed claims involving the brain-damaged infant had the highest average payment at $565,152.

ARE PERINATAL PROVIDERS STILL THE TARGETS IN MALPRACTICE CASES?
(cont’d.)

- Verdict Search each year publishes the top 100 top civil cases in the United States (all types):
  - 2004 – 7 of top 100 civil cases were perinatal brain injury cases, ranging from $23 million to $63 million.
  - 2005 – 7 of the top 100 civil cases were perinatal brain injury cases, ranging from $17 to $212 million.
WHY ARE THE SETTLEMENTS AND VERDICTS IN PERINATAL BRAIN INJURY CASES SO LARGE?

Although in California, general damages for pain and suffering are limited to $250,000, there is no limitation on the collection of economically-related injuries.
WHY ARE THE SETTLEMENTS AND VERDICTS IN PERINATAL BRAIN INJURY CASES SO LARGE? (cont’d.)

- Perinatal brain injury cases have high economic damages.

These cases involve injuries to babies who during their childhood and adulthood are usually severely disabled secondary to their brain injuries, requiring:
- extensive medical care
- expensive and constant assistive care for ADLs
- recovery for loss of their adult earning capacity

Medical and assistive care have some of the highest rates of inflation.
Because of extensive care, these children often have a relatively long life expectancy.
THE FACTORS IN THE ECONOMIC EQUATION

General damages for pain, suffering and loss of enjoyment of life, etc. = $250,000 (limited by Section 3333.2, Civil Code)

Economic damages – according to proof at trial

THE FACTORS IN THE ECONOMIC EQUATION - Economic Damages (cont’d.)

- Medical and assistive care costs:
  - Level of care needed – fee per hour (doctor, RN, LVN, CNA)  
  - Frequency of care required (# hours per day)  
  - Number of days per year service needed gives annual cost  
  - Estimated life expectancy of the child

THE FACTORS IN THE ECONOMIC EQUATION - Economic Damages (cont’d.)

- Loss of earning capacity - what the jury finds would have been the level of academic achievement of the child if not disabled; then a forensic economist applies US Bureau of Labor Statistics for the average work life earnings of persons with that level of education

DAMAGES - FOUR Y/OLD QUADRAPLEGIC $13.5M (PCV)

Male: 4 years old  
Condition: spastic quadriplegia  
Life expectancy: 56 years

ECONOMIC DAMAGES

Future (Present Cash Value)

- General Damages (past and future)  
  - Past: $250K  
  - 2% of Total Value
  
- $691K Med. Care  
  - 5% of Total Value
  
- $622K Med. Supplies  
  - 4% of Total Value
  
- $451K Education  
  - 3% of Total Value
  
- $105K House Modifications  
  - 0.1% of Total Value
  
- $8.0M Attendant Care  
  - 66% of Total Value
  
- $2.5M Loss of Earning Capacity 4 Yr. College  
  - 19% of Total Value

$250K
$0
$691K
$622K
$451K
$105K
$8.0M
$2.5M

5% of Total Value
4% of Total Value
3% of Total Value
0.1% of Total Value
66% of Total Value
19% of Total Value

In my own 30 + years of experience defending perinatal providers:
- Prenatally (mostly involving the perinatologist and the ob)
  - Diagnosing and treating gestational diabetes – causing later problems during delivery
  - Missing abnormalities in ultrasound tests
  - Diagnosis and treatment of preeclampsia
  - Management of post-date pregnancies
- Intrapartum
  - Induction and augmentation-related problems, including uterine tachysystole
  - Failure to diagnose a failure to progress and then section
  - Fetal heart rate interpretation – misinterpreting the maternal heart rate for the fetal heart rate
  - Fetal heart rate interpretation – failure to diagnose FHR pattern requiring immediate intervention for fetal intolerance to labor
  - Improper use of vacuum or forceps
  - Failure to diagnose and avoid a potential shoulder dystocia; or failure to properly resolve a shoulder dystocia
  - Failure in the face of a fetal indication for section to start the procedure in “a reasonable time” after the decision to section
  - Failure to continued FHR monitoring in the operating room
MOST FREQUENT LEGAL ISSUES (cont’d.)

- Intrapartum (cont’d.)
  - For CNMs: failure to follow hospital guidelines for interface with the "supervising physician," or need to transfer care
  - For L&D nurses: not following nursing protocols; failure to notify OB or CNM of significant abnormalities in the mother or fetus
  - Failure of the obs, and/or nurses to alert the nursery of potential problems for a soon to be delivered baby – so they will be present
  - Regarding resuscitation of the newborn, if needed: failure to have necessary staff present and failure to follow NRP guidelines in the resuscitation

HOW TO REDUCE RISK AND IMPROVE CHANCE OF DEFENSE

- Better documentation – the key to later explanation
  - This is constantly mentioned, but not always followed.
  - Especially needed if there is an emergency – should someone be a scribe, and document as if during a code.
  - Physician progress notes need to be more frequent during labor, an use a SOAP format; the plan is especially important if labor progress is slow.

HOW TO REDUCE RISK AND IMPROVE CHANCE OF DEFENSE (cont’d.)

- Shared understanding of FHR interpretation among providers
- Instill in providers the importance of teamwork and communication between providers on the maternal and fetal condition
- Have a higher awareness of potential danger during the second stage of labor

HOW TO REDUCE RISK AND IMPROVE CHANCE OF DEFENSE (cont’d.)

- Have drills for obstetrical emergencies, including shoulder dystocia; and/or have an OB rapid response team
- When a cesarean section is called make sure that everyone knows the indication, the rapidity at which the baby needs to be delivered, and have the section start as soon as the circumstances merit – continue monitoring the fetus
HOW TO REDUCE RISK AND IMPROVE CHANCE OF DEFENSE (cont’d.)

- If there is any belief the fetus may be depressed at birth, alert the nursery to have necessary resuscitators and care providers at delivery.
- If possible, cord blood gases should be obtained on every delivery, but for sure if the baby is at all depressed at birth; and, if the baby is depressed the placenta should be retained and examined.

PERINATAL BRAIN INJURY CASES CAN BE DEFENDED IN COURT, OR THE SETTLEMENT CAN BE SIGNIFICANTLY LOWERED, IF CERTAIN ELEMENTS ARE PRESENT (cont’d.)

- I have won most of the perinatal brain injury cases that I have tried in court or in arbitration.
- In my review of jury verdicts and settlements in other states there are many of these cases that are being tried in court, rather than settled, and many are being won as well.

PERINATAL BRAIN INJURY CASES CAN BE DEFENDED IN COURT, OR THE SETTLEMENT CAN BE SIGNIFICANTLY LOWERED, IF CERTAIN ELEMENTS ARE PRESENT

- There are some perinatal injury cases where truly the baby experienced peripartum hypoxic-ischemic brain injury and the totality of the facts make the case one that cannot be defended at trial. Those cases are settled – often for very significant amounts of money in the millions of dollars.

PERINATAL BRAIN INJURY CASES CAN BE DEFENDED IN COURT, OR THE SETTLEMENT CAN BE SIGNIFICANTLY LOWERED, IF CERTAIN ELEMENTS ARE PRESENT (cont’d.)

- There is a trend to try these cases if the content of the medical records can be opined by expert witnesses to demonstrate that the actions of the perinatal healthcare professionals were in compliance with the standard of care, and there also clinical evidence to support an expert witness opinion that the infant's brain injury did not occur during the intrapartum period.
CAUSATION

WERE THE ACTIONS BY THE DELIVERY TEAM THE CAUSE (SUBSTANTIAL FACTOR) OF THE BABY’S BRAIN INJURY?


“The human brain is susceptible to a wide variety of genetic, developmental, and acquired abnormalities and insults.”
The realm of low frequency, high severity…

- Prevalence of cerebral palsy is about 20 per 10,000 births.
- Incidence of neonatal encephalopathy attributable to intrapartum hypoxia is 1.6 per 10,000 births.
- The great majority of cerebral palsy is caused by factors other than intrapartum hypoxia.

The Effect of Demonstrable Evidence as the Basis for Causation Testimony

- Case: Schutte v. Dr. Green; perinatal brain injury; spastic quadriplegia; arbitrated when child was 9 years of age – totally dependant – $10 million PCV (a Carol Hyland special).
- Question: did 8 hours of high doses of pitocin cause hyperstimulation, decreased fetal profusion, terminal bradycardia and hypoxic-ischemic brain injury at birth?

Defense Causation Experts

Defense experts: (a) pediatric neurologist looks at 14 hour ultrasound of baby’s brain – showed the changes in the brain caused by hypoxic injury, but weeks before labor; and (b) placental pathologist who showed a blowup of slide of placental tissue which demonstrated structural changes in the villi – chorioangiosis (much increased number of blood vessels) that was caused by hypoxic injury weeks before labor.
Written ruling by arbitrators for defense (5/30/06):

“The arbitration panel is particularly impressed with the fact that the testimony of Dr. Machin and Dr. Barados on visible structural abnormalities, which they testified could not have occurred without a hypoxic injury preceding labor, was not disputed by plaintiff with contrary expert opinions in these areas….Accordingly, the majority of the panel finds that plaintiffs have failed to sustain their burden of proof either on the issues of causation or standard of care.”

References


References (cont’d.)

References (cont’d.)


References (cont’d.)