Claims Lessons

Title: Lack of Midlevel Supervision Contributes to Shoulder Dystocia Claim.

Facts: A 29-year-old female patient G2, P1 presented with a past history of shoulder dystocia in her first delivery. Her EDC (estimated delivery date) was 4/24/04. At her next prenatal visit on 4/5/04, she was seen by a CNM (certified nurse midwife). At that time she weighed 226 lbs, and the clinical assessment estimated the fetal weight to be over 8 lbs.

The patient was admitted on 4/13/04 at 6 AM for pitocin induction. The attending OB physician (Dr. "A") examined her at 8 AM, then turned the induction over to the CNM and left the hospital.

At 11:30 AM, Dr. "A" signed out to his partner, Dr. "B", due to a family emergency. Dr. "A" allegedly asked Dr. "B" to cover the call from 2 PM until he returned the next morning. However, Dr. "A" did not advise the patient, CNM or hospital nursing staff of his emergency. In contrast, Dr. "B" claims that Dr. "A" asked that he assume the call coverage only at 4 PM, so Dr. "B" left the hospital to go to a previous social commitment.

The patient's labor progressed uneventfully until 2:05 PM when she began pushing, and the CNM noted shoulder dystocia. The CNM attempted to contact Dr. "A" but the doctor didn't respond to cell phone calls or return pages. The CNM then made three attempts to turn the baby, and finally delivered the posterior arm by reaching under the axilla and sweeping the arm over the chest.

The baby delivered rapidly after this maneuver. The female infant weighed 9 lbs. 10 ozs. The shoulder dystocia complication caused severe Erb's Palsy. Documentation confirmed that the patient intended the CNM to deliver the baby, but she had specifically requested that Dr. "A" be immediately available since she had a shoulder dystocia history.

Risk Management Commentary & Advice:

1. **Delivery arrangement**s. Dr. "A" failed to comply with delivery arrangements given the fact that the patient was high risk for shoulder dystocia. If a physician promises to be present during the delivery, or immediately available, then either he or another physician should be present. Since this patient was high risk, the physician should have been primarily responsible for her delivery, not the CNM.
2. **Communication breakdowns**. Verbal handoffs and orders increase the potential for miscommunication and errors. Both doctors differed on whether call was to begin at 2 or 4 PM. A change in call status should be communicated to both staff and the hospital to ensure that a physician can be reached. If verbal

orders must be given, then the receiver should be asked to repeat back the order, instructions or coverage summary.

3. **Midlevel staff supervision**. The supervising physician must utilize collaborative practice agreements, monitor the midlevel staff for competency, and ensure that the midlevel staff follows the protocols as written.
4. **Midlevel staff compliance**. The CNM needs to follow the agreed treatment plan, call and update the attending during the induction and document the telephone calls in the medical record. When the CNM encountered the problem, she attempted one call to the attending physician and decided to attempt delivery without placing a stat page for any physician in the hospital to come to the delivery.
5. **Conflicting testimony**. A student CNM observing the delivery hurt the defense when she contradicted the testimony of the delivering CNM. Be aware of anyone present during treatment or delivery and whether it is appropriate to have the individual present during an emergency situation.

Disposition: This case settled for a substantial amount.

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