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# Medical malpractice: Handling birth trauma cases

Birth trauma cases are the most difficult and expensive that plaintiffs' medical malpractice lawyers undertake. Multiple experts (often as many as eight or nine) are required. Defense lawyers assigned to these cases invariably are the "cream of the crop." An entire body of "medical" literature has been generated over the past 20-plus years for the sole purpose of exculpating doctors from liability. Litigation costs average well over \$100,000, and frequently exceed \$200,000.

Birth injury cases also present plaintiff lawyers with the opportunity to help those malpractice victims who, as a group, are most in need – brain-damaged children and their families. The events giving rise to liability typically occur over a short period of time and are emotionally compelling. The revisionist literature does not hold up under careful scrutiny. Economic damages, expressed in present value dollars, generally range from the mid-seven figures to the low-eight figures. On several levels, these cases represent the ultimate challenge for plaintiffs' medical malpractice lawyers.

## Case screening

Because of the devastating emotional cost to the family and enormous financial cost to the attorney of mis-selecting a birth trauma case, careful screening is essential. Screening begins with the initial client intake. The attorney or staff member performing the initial screening should, in a stepwise fashion, obtain the following information:

- When was the child born;
- Where (hospital, city, state) was the child born;
- Names of the delivery health-care provider and pre-natal provider(s);
- Apgar scores, if known;
- How long did the child remain hospitalized at birth;

- How long did the pregnancy go;
- Were there any problems noted prenatally;
- Mode of delivery;
- Length of labor;
- Any problems noted during labor;
- Has the child had seizures;
- How does the child's development compare with siblings, if any;
- Any family history of developmental, cognitive, motor or neurological problems;
- Has any health-care provider told the family the cause of the child's problems;
- Has the family been told that the child will have permanent problems; and
- What, if anything, does the family think might have been done wrong that caused the child's problem.

Assuming that the initial intake provides a basis for going further, the next step is to schedule an appointment with the child's parent(s). The parents should be requested to bring with them any medical records or documents relating to the case that are already in their possession. At the time of the initial meeting, authorizations to obtain medical records should be signed. At a minimum, the following medical records need to be obtained in connection with the initial case evaluation:

- All pre-natal records;
- The mother's complete hospital records for the admission that included labor and delivery;
- The fetal monitor strips (if these are not requested specifically, they will not be forwarded, since they are customarily kept separately from the medical chart);
- All hospital outpatient records for the mother during the pregnancy in question, along with the monitor strips, if any, pertaining to those visits;
- The baby's complete newborn admission hospital chart; and

- A "representative" sampling of the child's medical records after discharge from the hospital.

The next step is for plaintiffs' counsel to personally review all the medical records obtained. While a legal nurse consultant can be a very valuable resource in helping the attorney to navigate his/her way through the medical records and understand the significance of what is or is not there, there is no substitute for the lawyer's own review. Failing to familiarize himself/herself with the medical records places plaintiffs' counsel at a significant disadvantage when making initial contact with prospective experts and, subsequently, when discussing those experts' opinions regarding the case.

Before deciding to move forward on a birth trauma case, the lawyer should obtain credible favorable opinions from well-qualified experts on liability and causation. While an obstetrician may be able to express some opinions regarding causation, it is necessary at the outset of the case, to retain experts who will specifically address causation. For initial review purposes, this expert would most likely be a pediatric neurologist or neonatologist. Even if the negligence appears to be egregious, plaintiffs counsel could be making a very expensive mistake by not solidifying expert's support for causation before filing the case.

## Theories of liability

Liability may be based upon events that occur during one or more of the following time frames: Pre-natal; Intrapartum; or Neonatal.

A partial list of issues arising during each timeframe is set forth below.

### **Pre-natal:**

- Failure to properly screen for genetic defects;

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- Failure to properly calculate due date;
- Failure to diagnose and/or treat gestational diabetes;
- Failure to diagnose and/or treat properly pregnancy-induced hypertension;
- Failure to timely order/perform/interpret fetal ultrasounds;
- Failure to timely offer expanded AFP screening;
- Failure to timely offer/recommend amniocentesis;
- Failure to work up size disproportionate to date;
- Failure to diagnose interuterine growth retardation (IUGR);
- Inappropriate recommendation of vaginal birth after Caesarean (VBAC);
- Failure to properly manage post dates of pregnancy;
- Improper management of breech presentation;
- Improper management of twins/multiple gestation pregnancy.

**Intrapartum:**

- Failure to timely diagnose fetal distress;
- Failure to timely offer/perform Caesarean section;
- Failure to administer timely Group B Strep prophylaxis;
- Failure to monitor properly during VBAC;
- Improperly starting/failure to discontinue Pitocin;
- Failure to suspect/diagnose uterine hyperstimulation;
- Failure to appreciate/act on sinusoidal heart rate pattern;
- Failure to properly manage prolonged second stage of labor;
- Failure to properly manage shoulder dystocia;
- Improper use of vacuum extractor;
- Improper use of forceps;
- Failure to follow nursing chain of command;
- Improper management of umbilical cord prolapse;
- Improper management of placental abruption;
- Improper management of breech presentation;
- Failure to timely assemble neonatal resuscitation team.

**Neonatal:**

- Failure to properly resuscitate in delivery room;

- Failure to monitor;
- Failure to oxygenate/ventilate;
- Failure to timely transfuse;
- Esophageal intubation;
- Failure to timely obtain arterial blood gas;
- Failure to timely obtain CBC.

**Identifying the defendants and coverage**

It is particularly important in birth injury cases to identify and name all appropriate defendants, since individual defendants frequently lack sufficient insurance coverage to compensate the plaintiff's damages. For example, a physician may have been acting as an employee of a medical group at the time he/she provided negligent medical care. In some cases, the individual doctor and the group are covered by separate policies. In other cases, although both individual and group are covered under a single policy, the policy limit applies separately to each.

Interrogatories should be sent to the defendant hospital as quickly as possible, requesting identification by name and last known address of each person who provided care to mother and baby from the time of admission through the time of delivery. If there are potential issues regarding the adequacy of neonatal care, the same interrogatories should be asked as to the neonatal personnel during any portion of the neonatal hospitalization where the quality of care is in question.

All hospital and/or nursing policies and procedures that might be relevant should be obtained. Typically, there will be an index of the policies and procedures for labor and delivery. The index can be requested initially, and then a follow-up request for production should be sent requesting the specific policies and procedures that appear relevant. In some cases, there is a need to establish whether the hospital had a policy or procedure in place on a particular issue. In that event, the hospital should be requested to produce the specific policy or procedure in question, as well as the index.

The form interrogatories 4.0 series (insurance coverage) should be served early on as to each defendant. Identifying insurance coverage is important to know whether the coverage is ade-

quate. In addition, knowing the level at which excess coverage kicks in may be important in formulating settlement strategy.

**Experts**

All birth injury cases are multiple (five or more) expert cases. The types of experts needed vary depending upon the facts of the particular case. Since causation is usually disputed vigorously (see below), it is not uncommon to have as many as five experts from different specialties testifying regarding causation. The types of experts typically retained in birth trauma cases include some or all of the following:

- Obstetrician;
- Maternal/fetal medicine specialist/perinatologist;
- Labor and delivery nurse;
- Neonatologist;
- Neonatal nurse;
- Pediatric neurologist;
- Neuroradiologist;
- Placental pathologist;
- Neuropsychologist;
- Physical medicine/rehabilitation specialist;
- Life care planner; and
- Economist

**Overcoming the causation defenses**

The defendants invariably take the position that the baby's brain injury was due to undetectable events that preceded the onset of labor, and that nothing the defendants did, or failed to do, affected the outcome. The obstetrical literature has been systematically rewritten since the early 1980s for the express purpose of shielding obstetricians from liability. Much of the literature has little or no scientific validity. The most recent publication that the defense relies on was published in 2003 by the American College of Obstetrics and Gynecologists with the joinder of the American Academy of Pediatrics titled *Neonatal Encephalopathy and Cerebral Palsy, Defining the Pathogenesis and Pathophysiology* (hereinafter "2003 ACOG Task Force Report"). The report sets forth, in dogmatic fashion, criteria which are *required* in order to define an

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acute intrapartum hypoxic event sufficient to cause cerebral palsy. By defining four *essential* criteria that must be satisfied before an intrapartum hypoxic event can even be considered as a cause of cerebral palsy, the 2003 ACOG Task Force Report clearly seeks to minimize the number of birth injury cases in which the plaintiff will be able to meet his/her burden of proof on causation. In virtually every case, one or more defense experts will testify that the 2003 ACOG Task Force Report is “reliable authority” regarding the relationship between intrapartum events and cerebral palsy, thereby opening the door for defense counsel to cross-examine the plaintiffs’ experts at length regarding the report pursuant to California Evidence Code section 721(b)(3). In order to counter this potentially devastating defense, plaintiffs’ counsel must be thoroughly familiar with the entirety of the 2003 ACOG Task Force Report, including the cited references, and must make sure that plaintiffs’ experts are prepared for cross-examination based on the report.

For a comprehensive discussion regarding causation issues, please see *Overcoming the Latest Causation Defenses in Birth Injury Cases*, by Kenneth M. Sigelman, J.D., M.D., previously published by CAALA in *The Advocate*, Volume 31, Number 4, April 2004.

### Developing the damages case

The key disputed issues as to damages in birth injury cases are the following:

- (1) The extent of medical, nursing and therapeutic care, particularly the level of attendant care, that will be required over the child’s lifetime; and
- (2) The child’s life expectancy.

In every birth injury case, the plaintiff must present a life care plan that is complete, realistic and understandable by the jury. The defense will typically counter with a life care plan that costs far less than the plaintiffs’ plan because (1) a significant portion of the attendant care burden is assigned to the parents, (2) the level of attendant care is inadequate (for example, non-licensed attendants cannot administer medication), and (3) the defense experts, relying upon largely out-

dated literature, will project an extremely shortened life expectancy. The plaintiffs’ experts can cite more recent literature, including Plioplys, *Survival Rates of Children with Severe Neurologic Disabilities: A Review*, Seminars in Pediatric Neurology, Volume 10, Number 2 (2003), pages 120-129 and Plioplys, et al., *Survival Rates Among Children with Severe Neurologic Disabilities*, Southern Medical Journal, Volume 91, Number 2 (1998), pages 161-172 to prove a significantly longer life expectancy than that suggested by the defense.

Non-expert testimony regarding damages is at least as important as the testimony of the experts. While family members are often compelling witnesses in recounting the difficulties of caring for a disabled child and the ongoing adaptations that the entire family has to make, non-family members who are well-acquainted with the family situation (family friends, clergy, teachers, therapists, etc.) may carry greater weight with the jury because they are not interested parties. With regard to presenting a teacher or therapist as a witness, plaintiffs’ counsel must consider the fact that, inevitably, teachers and therapists who work with disabled children tend to think positively, sometimes to the point of painting an unrealistically rosy picture. The school and/or therapy records should be reviewed carefully, so that plaintiffs’ counsel will have a sense of how the testimony is likely to go before deposing or calling as a trial witness a teacher or therapist. With regard to therapists, an additional problem that must be considered is a possible relationship between the therapist and the defendant health-care provider.

As with any catastrophic injury case, demonstrative evidence is critically important in proving damages. “Day in the Life” video footage should be prepared so as to illustrate specific points raised in the testimony of expert and/or non-expert witnesses. Photographs and/or video footage of items in the life care plan (special equipment, residential facilities, etc.) should be used whenever possible in order to help the jury understand fully the purpose and importance of each item.

### Settlement strategies

Settlement strategies in birth injury cases often turn on the relative apportionment of liability among physician and/or midwife, and hospital, and to the respective insurance coverage. In a typical case, liability may be stronger as to the health-care provider (usually physician, but possibly midwife) who was managing the labor and delivery, but whose insurance coverage is inadequate to cover his/her proportionate care of the damages. Accordingly, it is imperative that (1) all of the details of coverage be elicited during discovery as stated above, (2) the liability case as to the hospital/labor and delivery nurse be worked up meticulously for more than simply “chain of command” issues, and (3) neonatal resuscitation issues also be explored carefully.

Where appropriate, a policy limit demand should be served on all individual physician and/or midwife defendants at the earliest opportunity. However, this should only be done after plaintiffs’ counsel has determined how to deal with the “empty chair” at trial.

Finally, since structured settlements are a part of the settlement of most birth injury cases, plaintiffs’ counsel should retain his/her own structured settlement consultant before entering into meaningful settlement negotiations.

### Motions in limine

Two key motions in limine are (1) to preclude evidence of potential benefits to be paid by Medi-Care, Medi-Cal, the Regional Center and other sources which are not within exceptions to the collateral source rule set forth in Civil Code section 3333.1, and (2) to preclude the testimony of an annuitist.

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The two motions can be accessed by clicking on the links below. They can also be found at [www.caala.org](http://www.caala.org) under *Advocate* magazine.