CLM CLAIMS & LITIGATION MANAGEMENT ALLIANCE™

ADVANCING ETHICS, COOPERATION AND EDUCATION

CLM 2015 Medical Legal Summit
June 3, 2015 in Chicago, IL

Birth Injury Claims: How to Effectively Evaluate, Defend, and Resolve these Catastrophic Claims

I. Introduction

Obstetrical brain damage cases are challenging for the defense. The injured party, a newborn baby, is the most defenseless and sympathetic of potential plaintiffs. The recoveries in these cases are often quite high. Damages include the cost of maintaining the child for the remainder of her life, as well as noneconomic damages such as the loss of enjoyment of life, pain and suffering, mental anguish and loss of filial consortium. This presentation will provide an overview of the litigation statistics, standard of care and causation issues, claims and risk management issues and tools that can be used to decrease indemnity payments.

Statistics

Litigation of claims involving neurologic birth injuries consistently result in some of the largest jury verdicts and settlements. In 2012, the **average** jury award for poor obstetric and neonatal outcome exceeded $3,000,000.[1] Many verdicts, however, far exceed that amount:

- CT: **$58.6m** verdict against hospital and obstetrician (May 2011)
- FL: **$35.2m** verdict against hospital (June 2008)
- MD: **$21m** verdict against hospital and obstetrician (May 2010)
- NY: **$77.4m** verdict against hospital (May 2009)
- PA: **$78m** verdict against hospital (May 2012)
- MI: **$144m** verdict against hospital (October 2011)
- NY: **$130m** verdict against hospital (April 2013)

Understanding Hypoxic Ischemic Encephalopathy

Neonatal Encephalopathy is a "clinically defined syndrome of disturbed neurological function in the earliest days of life in an infant born at or beyond 35 weeks of gestation, manifested by subnormal level of consciousness or seizures, and often accompanied by

[1] Jonathan Muraskas, Lindsay Ellsworth, Eric Culp, Gretchen Garbe and John Morrison, *Risk Management in Obstetrics and Neonatal-Perinatal Medicine*, Complementary Pediatrics, 2012, at 269.

difficulty with initiating and maintaining respiration and depression of tone and reflexes."[2] Hypoxic Ischemic Encephalopathy is a subtype of neonatal encephalopathy for which the etiology is considered to be limitation of oxygen and blood flow near the time of birth. In layman's terms, hypoxic ischemic encephalopathy is a condition in which the brain does not receive enough oxygen, which can occur during a difficult labor and delivery.[3] The newborn's body can compensate for brief periods of depleted oxygen, however if the event lasts for over a five-minute period of time brain tissue is destroyed.

Hypoxic ischemic events can result in long-term damage which manifests itself in a variety of impairments. The impairments can include epilepsy, developmental delay, motor impairment, neurodevelopmental delay, cerebral palsy and cognitive impairment. These impairments can take years to surface, which drastically impacts the defense of the case.

II. Defending and Assessing these Claims

In order to succeed in a medical negligence claim, the plaintiff must prove: the applicable standard of care the physician or nurses were required to adhere to, deviation by the physicians or nurses from the standard of care, and that the deviation from the standard of care proximately caused the infant's brain damage.

Plaintiffs' prove the case by making a variety of arguments. The baby should have been delivered sooner, a C-section should have been performed, or that the physicians and nursing staff engaged in improper fetal monitoring.

Fetal Heart Rate Monitoring

The key piece of evidence in almost all birth injury claims is the external Fetal Heart Rate Monitor. Fetal Heart Rate Monitoring is commonly used to assess fetal well-being during labor by assessing the rate and rhythm of the fetal heartbeat. As we have come to learn over the years, the interpretation of the monitoring strips is subjective and varies from provider to provider.

As a result, a Fetal Heart Rate tracing should be interpreted in the context of the overall clinical circumstances, and categorization of a tracing is limited to the time period being assessed. A Fetal Heart Rate tracing may move back and forth between categories depending on the clinical situation and management strategies employed. The presence of accelerations reliability predicts the absence of fetal metabolic academia. The absence of accelerations does not, however, reliably predict fetal academia. Moderate variability reliably predicts the absence of fetal metabolic academia at the time it is observed.

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[2] American College of Obstetricians Gynecologists, Executive Summary: Neonatal Encephalopathy and Neurologic Outcome 123:896-901 (Obstet Gyencol., 2d ed. 2014).

[3] www.cerebral-palsy-faq.org

In recent years, and in effort to standardize the interpretation of Fetal Heart Monitoring, the obstetric community has developed a three tier interpretation system.[4] This system has become more prevalent in the practice of obstetrics and maternal-fetal medicine. For claims and litigation management, this interpretation system gives the defense more clear definitions, interpretation and research guidelines to defend the subjective, and often times unsupported, opinions of Plaintiff's experts.

Category I is a normal tracing.[5] It is strongly predictive of normal fetal acid-base status at the time observation.[6] The standard of care is for physicians and nurses to continue treatment in a routine manner.[7]

Category II is an indeterminate tracing. [8] It is not predictive of abnormal acid-base status.[9] When classified as a Category II, it means that there is not enough evidence to label the tracing as Category I or Category III.[10] The standard of care calls for evaluation and continued fetal surveillance and reevaluation.[11]

Category III is abnormal. It is predictive of abnormal fetal acid-base status at the time of observation (10 minutes span on tracing).[12] The standard of care calls for prompt evaluation and efforts to expeditiously resolve the abnormal Fetal Heart Rate pattern.[13] Nursing interventions includes the provision of maternal oxygen, change in maternal position, discontinuation of labor stimulation and treatment of maternal hypotension.[14]

Expert testimony in this area is key. The critical issue typically becomes whether the health care provider acted within the standard of care in his/her decisions with respect to what the fetal strips showed at that time. Plaintiff will use the fetal strips to argue that the health care provider did not respond to the distress in a timely manner. Plaintiff's experts argue that once fetal stress is evident, an emergency C-section is the only viable option. Defendants can counter with the drawbacks and concerns that accompany performing a C-section. C-sections during active labor are associated with increased risks such as hemorrhage, infection, thromboembolic events, and air or amniotic fluid embolization.

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4 George A. Macones, MD et. al., *The 2008 National Institute of Child Health and Human Development Workshop Report on Electronic Fetal Monitoring: Update on Definitions, Interpretation, and Research Guidelines*, 37 JOGNN, no. 5, 2008, at 510.

5 *Id.* at 513.

6 *Id.*

7 *Id.*

8 *Id.*

9 *Id.*

10 *Id.* at 514

11 *Id.*

12 *Id.*

13 *Id.*

14 *Id.*

Causation Defense

Plaintiffs also use fetal monitoring strips as evidence that the defendant obstetrician could have prevented the newborn from suffering brain damage had the obstetrician timely performed a C-section. The three categories described above can help to determine whether an acute hypoxic ischemic event was possible.

Category I or II Fetal Heart Rate tracing, with APGAR scores of 7+ at 5 minutes, normal umbilical cord arterial blood, or both is not consistent with an acute hypoxic-ischemic event.[15]

Category II Fetal Heart Rate pattern on presentation, lasting 60 minutes plus with persistently minimal or absent variability, lacking accelerations, even in absence of decelerations is suggestive of a previously compromised or injured fetus.[16]

Category I Fetal Heart Rate pattern on presentation that converts to Category III is suggestive of a hypoxic-ischemic event.[17] Additional Fetal Heart Rate patterns that develop after a Category I Fetal Heart Rate pattern on presentation which are suggestive of intrapartum timing of hypoxic-ischemic event include: tachycardia with recurrent decelerations and persistent minimal variability with recurrent decelerations.[18]

In addition to Fetal Heart Rate monitoring, other tools are available in the neonatal medical record to assist in the defense of these claims. The child's record can help determine if there are signs consistent with an acute intrapartum event. Unfortunately, time for this presentation does not allow for a full discussion and analysis of each. However, when evaluating the child's medical records, you and your experts should look to the umbilical cord blood gas, placental pathology, neuroimaging (MRI, CT's), lab tests (nucleated red blood cells) and the presence of multi-system organ failure. By doing a detailed analysis of the child's records, you can define the type and timing of an alleged birth injury, and more effectively defend these claims.

III. The Claims Perspective and Effective Risk Management

The number of claims is steady, but the number of *large* claims is increasing. The big claims are getting bigger. Bad states are getting worse, but the good states are getting tougher as well. Top tier plaintiffs' firms are getting more aggressive and demanding more. Certain insureds are more anxious and thus more likely to overpay. With the prospect of higher settlements and verdicts, we are now seeing more lower tier firms taking on birth injury cases that have been rejected by the upper tier firms. These firms, without a true understanding of these cases, are forcing cases to trial that otherwise would not proceed with the hopes of making a name for themselves.

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15 *See* American College of Obstetricians Gynecologists, *supra* note 2.
16 *Id.*
17 *Id.*
18 *Id.*

Drivers/Consequences

Top plaintiffs' firms are demanding a premium and second tier plaintiffs' firms seek to emulate the top firms. Bad cases are becoming more difficult to settle for the usual amounts. Cases that would have been settled in the past are being tried, resulting in more large verdicts. This has created increased anxiety among providers, and potential for panic-based decisions. Moreover, this has caused tension between insureds and their insurers.

Holding the Line

On the big cases, it is not business as usual. It is increasingly difficult to manage the litigation and decrease costs. The claims personnel and their counsel have to prepare for trial, not settlement. An evaluation must be done early on to determine which are the right cases to try. By getting the right experts on board early to review the medical records, meeting with your insureds and getting a good handle on the extent of the injury and damages, you can assess your risk moving forward.

By building a partnership between the insured, insurer and counsel, a plan can be put in place to effectively manage a claim. Do not make your insured the easy target, leave that to someone else.

Implement and Enforce Policies and Procedures

As previously discussed, the fetal monitoring strips are an integral part of litigation in the birth trauma context. It is imperative that there are policies and procedures which outline the monitoring of fetal strips. The policies should include information regarding what the fetal strips need to show for the nurses to notify the doctor, how often they should be checking the fetal strips, and what information on the fetal strips they should be documenting. However, when formulating such policies, keep in mind the clinical decisions that have to be made by healthcare providers based on each individual patient. Avoid making these policies too restrictive and mandatory.

Avoid the Spoliation Claim

Fetal monitoring strips are often used as evidence during trial. This means the hospital needs to preserve the fetal monitoring strips. In one circumstance, a hospital's negligent loss of fetal monitoring strips warranted striking its answer in medical malpractice based on spoliation of evidence. The court reasoned that the fetal monitoring strips were the most critical evidence to determine fetal well-being at the time of treatment, and in evaluating the conduct of health care providers with regard to obstetrical management.

IV. Structured Settlements

Generally

The use of a structured settlement allows a stream of payments in the future which prevents a lump-sum award at the present time. The defendant typically purchases an annuity from a life insurance company. It is beneficial to both parties. For the defendant, the primary advantage is that the cost of the annuity is significantly less than the settlement amount. As to the plaintiff, it ensures that the child will continue to receive money over time.

The Use of Substandard Lives

The plaintiff's medical records should be submitted to one or more insurance carriers that specialize in substandard lives. The insurance carriers then submit the medical records to physicians who have experience with medical histories in such cases and statistics they maintain on similar cases. The doctors provide estimates as the range of probable life expectancy. The insurance carrier then makes a quotation on the cost of an annuity in the case.

V. Affordable Care Act

With the passage of the Affordable Care Act, many Americans have access to medical care not otherwise available. The argument Plaintiffs have often made in birth injury cases, through their life care planners and economists, is that the Plaintiffs are entitled to receive privately paid medical services to avoid the reliance on government aid, which comes at a cheaper price. The Plaintiffs argue that there is no guarantee that the Plaintiff will continue to receive those benefits. However, with the passage of the Affordable Care Act, the Plaintiff's argument may be moot. There has not been sufficient practical experience to evaluate the affect the Affordable Care Act has had on the value of these claims. Moreover, the Constitutionality of the Act is still in question, making its usefulness in the defense of these claims in flux at this point. Regardless, it is a tool that should continue to be used by the defense.