

Know Your Pitocin Policy, Lawyer Advises

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LAS VEGAS — From a legal standpoint, your hospital guidelines for the preparation and administration of Pitocin are a double-edged sword in the case of a bad birth outcome, Stephen Crandall advised at a conference on fetal monitoring sponsored by Symposia Medicus.

"If you have a policy in place, you better have meant it," said Mr. Crandall, a Mayfield Heights, Ohio-based plaintiff's attorney who specializes in health care law.

During court depositions in trials involving a bad birth outcome, he said, nurses frequently describe their hospital's Pitocin (oxytocin) policy as "just a guideline," Mr. Crandall said. "We hear that all the time." If a Pitocin policy is in place but not followed, "it's a difficult road" to say that there was no deviation from the standard of care, he added.

The other problem he sees is that nurses and other members of the labor and delivery team are unaware that a Pitocin policy exists in their institution. In some court

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cases, he said, "we take a nurse's deposition and we ask her things about the Pitocin policy in place. They don't even know what the policy is. That can't happen. Nine times out of 10, the nurses that we depose don't know what they

should know. It's very difficult to defend a case like that."

A second common area of medicolegal risk is poor charting and communication among members of the labor and delivery team, said James Kelley, a plaintiff's attorney who practices in the same firm as Mr. Crandall. "If you see potentially concerning signs or an absence of reassuring signs from a nursing standpoint or a physician standpoint, you have to take action," Mr. Kelley said. "If you make a call, you have to document that call. Remember the context: Most states allow 19 years for a child to file a lawsuit. If it's not in the chart, you're not going to remember [that call by the time the case goes to trial]. And I can assure you that who you say you called and told about what went wrong isn't going to remember that call either, if it's not in the chart."

If you're reading worrisome signs from the electronic fetal heart rate monitor, "document your interaction with that strip, whether you're writing on the strip or entering it on computer-generated strips," he added. "Make a note that you looked, that you palpated the contractions, or [that the electronic fetal monitor] wasn't giving you a reassuring sign as an external monitor. Palpate [the contractions]. Tell us what you find. Were they mild? Moderate? What kind of relaxation was there?"

Mr. Crandall added that without documentation of your actions in a case of la-

bor and delivery that resulted in a bad outcome, "you really have no plan [of care]. And if you have no plan, it's difficult for defense lawyers to defend you," he noted. "The other problem with a lack of documentation that benefits the plaintiff's side is that it leads to finger-pointing" among physicians, nurses, nurse-midwives, and other members of the labor and delivery team.

A third key area of medicolegal risk involves chart alteration. The bottom line?

Don't do it. "If you alter the medical record after there's a bad outcome, you have just created what we like to call verdict accelerant," Mr. Kelley said. Medical record alteration "takes a very noble profession and 'villanizes' it in a courtroom. Regardless of how bad or how good your care is, [changing medical records is] indefensible."

Mr. Crandall warned that people who alter charts eventually get caught, because other areas of the medical record often

conflict with what they wrote. Also, "there are very talented document analysts who can show when you wrote what," he said.

He concluded that a good lawyer "can defend anybody who is attentive to the patient's need and has a clear medical record, regardless of the outcome. As long as they can show us the basis for that, we've never had a problem in a courtroom," he said.

"It's when that chart is inconsistent, unclear, or absent that it becomes open season on the plaintiff's side." ■

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