Nice Guys Don't Always Finish Last

By Stephanie C. Hatchett, JD

As her gurney clattered toward the delivery room, Heather Carr[1] was excited about the birth of her second baby despite the need for a C-section. Her husband would be at her side during surgery, she was healthy, in a major hospital attended by her own obstetrician, and thus she had no fear. Once in the OR, spinal anesthesia was begun by CRNA Tyler Henry, a well-seasoned veteran with excellent skills. As the OB walked in, eyes smiling behind her surgical mask, Heather breathed a sigh of relief. A sigh, then nothing more…as Heather was suddenly unable to breathe. She had no voice, no way to gesture or call for help, and she began to panic. She believed death was imminent, and all she could think about was her husband being left alone to rear two young children. Totally immobile, tears began to flow and she silently screamed "I can't breathe! Help me! Somebody help me!"

CRNA Henry was carefully monitoring Heather's vital signs and noted the sudden spike in her blood pressure. Beads of perspiration and teary, wide eyes conveyed her distress, and he realized Heather had developed a high spinal with paralysis and arrested breathing. Henry immediately began to ventilate Heather by Ambu bag and soothingly reassured her that all was well. CRNA Henry considered various options to safeguard the safety of both Heather and her baby but hoped the spinal would reverse itself very quickly, avoiding intubation. A father himself, Henry recognized that administering Versed or intubating the patient would forever destroy this important moment for the Carr family; therefore, he chose to continue monitoring and "bagging" Heather so the delivery could proceed as planned. When the spinal still had not reversed some forty minutes later, CRNA Henry paged his supervising anesthesiologist, Dr. Stevens, to assist. Unfortunately, Dr. Stevens did not respond to the page for approximately thirty minutes. CRNA Henry continued ventilating the patient while both he and

Mr. Carr quietly assured Heather that all was well. When Dr. Stevens arrived, he chose to intubate the patient immediately. Heather delivered a healthy baby and neither suffered any medical harm from the anesthesia incident.

Heather recovered physically from childbirth but soon alleged permanent disability due to post-traumatic stress disorder, which she related to the delivery events. She engaged in mental health counseling somewhat sporadically. Suit was later filed, alleging negligence by Mr. Henry in performing the spinal block and failure to remedy the paralysis, and negligent supervision by Dr. Stevens. Mr. Carr alleged the family was required to hire a nanny or housekeeper to perform many of the activities that were formerly done by Mrs. Carr. Heather Carr admitted that she had mild "baby blues" or PMS type symptoms after the birth of her first child, but that it quickly resolved with one counseling session. In stark contrast to her testimony, medical records revealed Mrs. Carr received long term disability benefits after her first child's delivery due to severe postpartum depression. Rather than one counseling session, she actually required hospitalization and aid from a live-in caretaker for some months. In support of her disability claim after the first birth, Mrs. Carr had even written a letter regarding the devastating effect of depression; these and other records were presented to the jury during a three week trial (after a mediation attempt failed to reach a resolution).

Testimony presented by the defense included an instructor who was complimentary about the manner in which CRNA Henry responded to the crisis. The CRNA stated that less experienced persons would have intubated Carr immediately, but he would teach anesthesia students to handle the situation in exactly the same manner as did Henry. The plaintiff's expert testified that Mr. Henry was "trying to be a nice guy" but his failure to immediately intubate the patient put her and the baby at unnecessary risk. Dr. Stevens was faulted for not being present when the spinal commenced and for not responding immediately when paged. Both Henry and Stevens felt strongly that they had not violated the standard of care and did not waver throughout the lengthy trial.

In summary, a judgment call which results in a poor outcome does not necessarily equate to medical malpractice. High spinals can and do occur without negligence. A medical professional is judged not by the unexpected

result but instead by the standard of care, loosely defined as the action an ordinary, prudent professional with the same training and experience in a similar community would practice under the same or similar circumstances. The jury listened carefully to the evidence, agreed with the choices made by CRNA Henry, and returned a defense verdict in less than 45 minutes.

[1] All names and other identifying information from this factual situation have been changed to protect the parties' identities.
