Introduction

The Born Emergency

My phone rang at 5:30 on Friday evening. I answered with excitement, expecting to hear the good news that my niece Sam had her baby. Instead, it was one of those moments that you will never forget where you were. I was standing in my kitchen surrounded by my kids, anxiously waiting to hear about Cousin Sam.

I answered my phone, and in the middle of my typical long, drawn-out, "Heeeeey," was my sister, Sam's mother, hysterically crying. She just kept repeating, "The baby crashed, the baby crashed." I ran outside, away from my kids, so they could not hear their aunt Kelly. In her broken voice, she told me they had rushed Sam out of labor and delivery to the operating room to do an emergency cesarean section. The baby's heart rate had abruptly dropped and was not coming back up.

This was the scenario in many legal baby cases when a mistake was made; they typically end with an emergency C-section. The families from the cases rely on the delivery team to guide them and help safely deliver their baby. When

a mistake occurs or the team misses something, the claim is that they did not deliver the baby in time. Having scrutinized years' worth of such cases, I had become all too familiar with the frantic chaos that engulfs the labor and delivery room as the delivery team races against time to deliver a healthy infant. It was at that moment that I could not help but wonder if the same heart-wrenching scenario that frequently played out in legal baby cases was now unfolding during Sam's labor and delivery.

As I listened to my sister crying over the phone, I sat outside silently, staring at the ground. In my head, I went from legal analysis to human analysis. I started thinking of all the families I had talked to over the years in my baby cases—the tears pouring from their eyes when they relived the day their baby was born. I understood how these families felt for the first time in all these years. It brings a feeling of helplessness as you realize that no decision now will change the past. All you can do is hope and pray that your baby will be okay.

As I continued to sit on the phone listening to my sister sob, I started to replay everything that had happened in the past 24 hours. Sam had already been lucky and made life-changing decisions to get her where she was that day.

I went back to the first phone call on Thursday night, March 17th. My sister called me to say Sam was not feeling well. She was 38 weeks pregnant and had been sick for the past couple of days. She was dehydrated, tired, and not feeling well from the stomach flu. My sister was calling to ask me whether I thought Sam should go to an IV lounge to hydrate

versus going to the hospital for an IV. My niece had been sick a couple of times that winter, so she was trying to avoid being around sick people during the last weeks of pregnancy. While I could understand the rationale behind the question, through my eyes, there was a more critical issue. I explained to my sister that they needed to go to the hospital for one primary reason: they could check on the baby and make sure she was doing okay. Mom and baby are connected, so if the mom is not doing well, it is essential to ensure her baby is.

Sam headed to a small local emergency room and got her IV, but they did nothing to check on the baby. She asked the nurse if they had a fetal monitor to check her baby's heart rate and see how she was doing. Your baby is inside you, and the only way they can talk to you is through their heart rate *(see Chapter 2)*. However, this was a small local emergency room with no fetal monitors.

Sam asked another critical question that we would later learn would ultimately change the course of the night, her pregnancy, and her life: "Where can I go to have my baby checked out?" She explained to the nurse that she mainly came to the emergency room to have her baby put on a fetal monitor. The nurse contacted another hospital where Sam could have the baby checked and let them know she was on her way.

Approximately 45 minutes later, Sam arrived at the hospital. She went to the triage area, and they started the fetal monitor. The nurses and doctors were immediately concerned about her baby's heart rate. They did some further

testing with an ultrasound, which was also concerning. The doctors and nurses advised Sam that they wanted to admit her to labor and delivery.

Now that it was time for the baby to come, it was decision time. They offered Sam a C-section or an induction with Pitocin to deliver vaginally. Sam wanted a vaginal delivery, which meant a Pitocin induction.

It was now 2:50 in the morning, and my phone was going crazy. "Gina, are you awake? Sam has been admitted to the hospital, and they are concerned about the baby."

"Are you awake?"

My phone was on "do not disturb," and I was asleep. Minutes later, a loud sound came through my room and startled me. The noise was like a *whoosh*, and my heart was racing when I woke up. I looked over and asked my husband what that noise was, but he was sound asleep. While lying in bed wondering about the sound, I looked over, and my phone lit up for a brief second; another text from my sister said, "Please, call me."

I called my sister, who was at the hospital with Sam. She told me that the delivery team was concerned about the baby and that they were inducing Sam. I was concerned about the plan; to be frank, I did not like it. I explained, "If the baby is not doing well, then she will likely have a hard time during labor."

Labor is tough on babies. Contractions squeeze the baby and temporarily decrease their oxygen. While this is a normal part of labor and babies are made to handle contractions,

they may not be able to handle the stress of contractions if they are already struggling.

I continued to explain that there are so many unknowns, as the baby is inside Sam and cannot be physically assessed or examined. The baby's lifeline is the umbilical cord and the placenta; even the condition of those is not known until delivery. In Sam's case, we knew the baby was struggling inside for some reason, but no one knew why. Following the analysis to my sister, I told her the baby did not need any more stress, and if Sam had a C-section, she would be holding her baby in about 30 minutes.

That morning, I could not figure out if my sister had poor communication skills or if my niece was being stubborn, but she wanted no part of a C-section. With no other choice in sight, I shifted gears from the C-section to the thought of a Pitocin induction. This was hard; I am not a fan of Pitocin. It is the most common factor in legal baby cases. When I get a new baby case at the firm, the first words I typically read are, "Mom is being induced with Pitocin." Through my legal eyes, I had seen the bad outcomes from Pitocin since my first case in February 2003. The only good news was that the lessons I had learned from Pitocin inductions gone wrong would now help me prepare my family.

I designated my sister as the baby advocate. She was responsible for ensuring the baby was doing okay during the induction. The first step was a crash course on reading the baby's heart rate. This would be key during the induction. If the baby was not tolerating the contractions, it would be

clearly demonstrated in her heart rate. (*see Chapter 9*) Next, she was to oversee the contractions and ensure the baby had adequate time to rest and recover before being squeezed again by the next contraction.

Then I explained that since this is a Pitocin induction and the baby already had a concerning heart rate, it is imperative that the most accurate and reliable fetal monitor be used to watch the baby's heart rate and contractions. I explained the difference between an internal monitor that attaches to the baby's head and an external monitor that is placed on the mom's belly. An internal monitor is the more accurate method and should be placed as soon as possible. *(see Chapter 8)*

Next, I told her to ask the nurse to tell her every time she increased Pitocin and to keep track of how much Pitocin was running through the IV. It is easy to do; they usually start at one milliunit and go to twenty milliunits. The nurse will increase it by one or two milliunits every time, which can be every 30 minutes or so. The nurse should make sure Sam is comfortable with the increase. If the contractions were adequate and Sam was dilating, there was no reason to increase it. In many legal baby cases, it is the higher Pitocin dosages that can lead to problems for the mom and her baby.

My next question for my sister: "Do you like Sam's delivery team?"

The team at the hospital was excellent and very well-liked by my niece and the family. After the delivery, Sam would tell me, "I loved my nurse, Caila." That is important; the families

in legal baby cases often relay unpleasant experiences with their nurse or doctor. You should get a warm fuzzy feeling from your delivery team, and you should trust them. They are the most important part of your labor and delivery. They will help guide you and bring your baby safely into this world.

Throughout the morning and afternoon of March 18th, I received videos and text messages of the baby's heart rate. It was okay, but it had dropped a few times. Everyone was watching it very closely, and they kept the Pitocin dose low to avoid stressing the baby more than they had to. There were more conversations about Sam having a C-section. However, Sam wanted to push forward with vaginal delivery, and the doctors were okay with continuing the induction. I was on edge; everyone was on edge. We just wanted the baby to be here safely. She would be the firstborn in the next generation of our family.

Then, just like that, I was back at the 5:30 p.m. phone call that landed me outside on my porch. I was still listening to my sister cry as we anxiously waited to hear about the baby. Then a glimpse of hope, as I could hear a nurse coming into the room to talk to my sister. They put me on speaker-phone as my very upset sister announced she was talking to her attorney, who was a baby lawyer. While I rolled my eyes and shook my head back and forth, I could hear the calm voice of the nurse. She explained that the baby's heart rate improved in the operating room, and the new plan was to use forceps to help deliver the baby. My sister asked me if it was a good plan, and I reiterated what the delivery team already

knew: the baby needed to be delivered as soon as possible. The nurse left the room and would come back after the baby was born.

My sister stopped crying; it was the hope we had been praying for—a sigh of relief that I can never explain with words. We said our goodbyes, as there were other calls to make. My sister would call me back after she knew more about the baby. I went back into the house as my kids stared quietly at me. My daughter finally asked, "Is everything okay with Sam?"

I responded, "I think so, but we all need to pray." After waiting some time, we finally got that call; our baby girl was going to be fine. Today, she is a healthy and happy little girl.

This experience was a close call that scared me and my family. Though we were fortunate that it ended with a healthy baby girl, I have witnessed the other side of close far too many times in legal baby cases. These are the heart-wrenching stories where families were just one decision or a few minutes away from a healthy baby, only to find themselves on the wrong side of a close call due to a mistake or oversight during childbirth.

On March 18th, while I tried my best to give my family important information over the phone, it was too late in the game. I was 1100 miles away from Sam that day. The realization that I may not be around for the birth of my grandchildren set in. I knew it was time to write down what I had learned from the last two decades of analyzing legal baby cases. Once I switched gears from attorney to author with

the purpose of helping families have the safest possible labor and delivery, it became apparent that there was much more to learn from these cases than I could have imagined. Finally, this book was born.