

CONFIDENTIAL REPORT
PREPARED FOR:

Attorney Name, Esq.

PRN Legal Nurse



Consultants

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Fact Sheet and Summary

Patient Information

Name: Carrie C Smith

Date of Birth: 03.21.1992

Date of Injury: NA

Date of Death: NA

Primary Care Physician: Albert Doe, PA

Treating Physicians:

- Dr. [REDACTED] – Obstetrics
- Dr. [REDACTED] - Obstetrics
- Dr. [REDACTED] – Maternal Fetal Medicine
- Dr. [REDACTED] – Emergency Room
- Dr. [REDACTED] – Maternal Fetal Medicine
- Dr. [REDACTED] – Pediatric Neurology
- Dr. [REDACTED] – Maternal Fetal Medicine
- Dr. [REDACTED] – Obstetrics
- Dr. [REDACTED] – Gastroenterology
- Dr. [REDACTED] – Maternal Fetal Medicine
- Dr. [REDACTED] – Obstetrics
- Dr. [REDACTED] – Obstetrics
- Dr. [REDACTED] – Obstetrics

Other Treating Providers:

- [REDACTED], CNM – Obstetrics
- [REDACTED], CNM - Obstetrics

Medical History

- Anemia

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- Anxiety
- Asthma
- Chlamydia trachomatis infection of lower genitourinary sites (2011, 2014)
- Depression
- Enlarged thyroid
- Previous cesarean section complicating pregnancy, childbirth, or the puerperium
- Unspecified disease of respiratory system (history of asthma with cold, has albuterol)
- Urinary tract infection (one in pregnancy)
- Varicella (disease child)
- History of syncope
- Murmur, heart
- Trauma
- History of pyelonephritis
- Yeast vaginitis
- Bacterial vaginosis

Surgical History

- Abdomen Surgery
- Appendectomy (4/2010)
- Cesarean Section x2 (2008, 2012)
- Foot Surgery (age 7 for removal of a needle she stepped on)

Possible Depositions and Reason

Name	Facility	Dates in Question	Reason

Records Reviewed

File Name/Designation	Relevant Pages	Total Pages
HOSPITAL	32	146
MEDICAL CENTER	19	85
TOTAL	51	231



Narrative Summary and Opinion

The following report is an analysis of the medical care received by Carrie Smith (CS).

The Facts

On December 31, 2022, CS was 19+ weeks pregnant and seen in OB triage for abdominal pain, nausea and vomiting. She was complaining of bilateral tightening lower quadrant pain, feeling like pressure on the inside of her c-section scar. Her workup was negative with the exception of dehydration; she was encouraged to try stretching, heating pads, warm bath, Tylenol PRN (as needed) and to increase hydration. Her nausea and vomiting had been an issue throughout the pregnancy, and she was taking Zofran as needed which had been previously prescribed.

On January 19, 2023, she was seen for a routine OB appointment, her anatomy US was normal. She was having some vaginal discharge consistent with yeast vaginitis and a prescription was given for fluconazole.

On February 7, 2023, was seen in OB Triage for dizziness, Braxton Hicks contractions, unable to eat, and nausea. She reported that she is just not hungry; struggles to want to eat, feels hungry but doesn't want to eat. Regarding contractions, she reported she had similar contractions in all her pregnancies but starting later by her recollection around 28-32 weeks. Preterm labor workup was negative, discussed options to address constipation, that her dizziness, weakness in legs, and fatigue most likely related to inadequate PO intake and strategies to maximize nutrient dense intake.

On February 9, 2023, she was seen for an OB problem visit. CS had pain perceived as contractions on and off for several days. She was seen in the hospital and was told she was having real contractions but was not dilating. She was most bothered by not being able to nourish herself or sleep well. She was offered magnesium to help with mild constipation and Ambien to assist with sleep, for which she accepted prescriptions. While in the pharmacy she had a near syncopal episode requiring admission to the hospital. CS reported contractions trigger lightheadedness and dizziness. An ECG, COVID/flu and Enema to rule out constipation, infection and cardiac etiologies of her symptoms. These were declined by CS. She was admitted overnight for IV (intravenous) hydration. CS was very frustrated with "contractions" stating she will "not leave until we make them go away". She was recommended fetal monitoring prior to discharge and declined this as well, stating "if you won't do anything to help me, then I don't need to do that. I'm going home."

On February 14, 2023, she was admitted to the hospital for overnight observation of contractions. She awoke the next morning complaining of more right upper quadrant pain than contractions therefore an ultrasound was ordered which showed biliary sludge, no stones. She requested an additional dose of Ambien for sleep, and some IV fluids as she was not drinking while asleep. Later that evening CS reported no contractions and was feeling well rested and overall better and stable for discharge. CS felt like she got a lot of questions answered that

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admission. Reviewed that biliary sludge can sometimes cause similar colicky pain as stones. Recommended low fat diet to help reduce frequency of symptoms.

On March 7, 2023, CS was seen at 29w0d for routine visit her hemoglobin had dropped continuously to 9.2 units at lowest, ordered IV iron infusions, plan was to order hemoglobin electrophoresis to rule out thalassemia. Her primary complaints were persistent nausea, rib pain, contractions, and general discomforts of pregnancy since second trimester. CS was physically and emotionally fatigued and frustrated by symptoms. She had tried various medications with minimal relief and preferred not to take medications “if they aren’t going to do anything”.

CS was admitted from 3.14.2023-3.21.2023 for worsening abdominal pain, was admitted, treated with IV opioids (Dilaudid) which improved pain but only transiently. Her evaluation there included a negative MRI abdomen/MRCP (Magnetic resonance cholangiopancreatography) and abdominal ultrasound, labs that were unrevealing (no evidence of pancreatitis, infectious etiology, genitourinary (GU) etiology). She had a gastrointestinal (GI) consult, felt possibly dyspepsia could be contributing but providers felt lower likelihood of gastric ulcer and not consistent with gallbladder etiology. CS discussed with physicians that often patients feel upper GI symptoms such as GERD or reflux during pregnancy and it is not uncommon to start a PPI [proton pump inhibitor]. She did not want to start the PPI, stating “I am not a guinea pig, I am nobody’s practice, I am sick of trying things.” Ultimately symptoms felt to be secondary to poor tolerance of uterine contractions/irritability. CS reported during her last pregnancy she was discharged to home on Percocet for the last few weeks of her pregnancy to get her to her c-section date. CS requested to be delivered now because she cannot handle this any longer. Discussed that preterm deliveries are not performed without an indication, and that there was not a reason to deliver her at that time. An exam could be done to reassess cervical change which she declined, at which point CS stated, “that’s fine if you won’t do it, I can find another doctor who will” and then requested to speak to nurse manager. CS became frustrated and did not like her suggested plan of care, at which time she requested Dr. McGonigle be fired from being her care provider. Her care was transferred from Women’s Healthcare Associates (WHA) to OB hospitalist service. CS requested IV pain medication despite oral pain medications being indicated as she was tolerating by mouth intake, she stated they do not work as fast as she is not tolerating intake by mouth. Dr. Hendrickson again stated that oral medications should be used, the patient informed the doctor that she was not honoring her wishes, and that “we can go around all night.” CS had IV Dilaudid ordered at 0.4 mg every 3 hours. A care conference was recommended at that time to set expectations around pain management and diagnostic workup. CS identified with social work that her mental health has suffered so much during this pregnancy due to the amount of pain she had been in and that multiple trips to hospital with no definitive answers that she desired early delivery. CS reported that she wanted her C-section now, she clarified that she does not want harm to come to baby however she was unable to live with that much pain and the negative effects on her whole family. CS reported that she felt heard by the team and advocated for but did verbalize fear of being cut off abruptly from medications and being sent home without a good follow-up plan/plan of care.

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During her consultation with Maternal Fetal Medicine (MFM), she reported she has been told the risks of prematurity before and she is willing to accept those risks. She felt that providers were prioritizing the health of the fetus over her health, and she was at risk staying in pain for 9 more weeks. CS was willing to talk to other doctors but would not accept additional medications without a sure diagnosis. On March 16, 2023, she declined fetal monitoring.

On March 17, 2023, in order to maintain pain management and alleviate patient's frustration Dilaudid was ordered at 1.5 mg IV every 2 hours. On March 18, 2023, Dilaudid 2mg every 1-1.5 hours was being given. Later CS was switched to 4mg Dilaudid by mouth with 2 mg IV push for breakthrough pain. Distraction techniques, walking on unit, visits outside, visits from friends and family, but CS was resistant. An inpatient pain management consult was requested. Pain medications again increased to Dilaudid 8mg by mouth every 4 hours with Dilaudid 1mg IV for breakthrough. Pain decreased to 6/10 that lasted <2 hours and patient able to get some sleep in between care. Pain management consult discussed treating patient as chronic pain management since symptoms were felt to be pregnancy/uterine/physiologic. Discussed using buprenorphine or methadone for pain management and not high dose opioids.

On March 19, 2023, CS requested to have her sister present to advocate for her, they shared the perception that care had been inadequate, primarily due to treatment of pain due to an unknown etiology with pain medicine. They felt that due to the failure of this treatment she should be delivered by c-section now. Conversation proved difficult as physicians were repeatedly interrupted and unable to completely answer their questions or offer insight. Felt her pain was due to uterine irritability and contractions and that narcotics are not working and should be discontinued. CS's mother visited later and Googled uterine irritability. She agreed with the diagnosis and proposed supportive measures like jacuzzi, a doula, and acupuncture. Decision made to try 15mg of oxycodone every 6 hours. She requested a day to decompress and process prior to discharge home. On March 19, 2023, CS stated that the current pain plan is not working and wanted to speak with the physician. During continued discussion with nurse, she made statement "I would terminate this pregnancy if I could." At this point CS requested her care be transferred back to WHA. A care conference was performed to set expectations for ongoing care from all of the WHA providers and discussed further treatment options which included delivery at 37 weeks unless a change in clinical scenario, no further use of IV or PO narcotics to treat uterine irritability, WHA has exhausted all diagnostic interventions to investigate her discomfort and recommend she seek a second opinion. CS and providers at PPMC all agreed that transfer of care to an alternate hospital system would be beneficial.

On March 22, 2023, at 31w3d CS presented her first prenatal visit with Hospital MFM after mutual dismissal from WHA, her prior OB provider. They discussed her abdominal pain affecting pregnancy (acute on chronic abdominal pain since 20 weeks (initially periumbilical, then uterine radiating to right/left upper quadrant and back). Felt it may be a poor tolerance of uterine irritability or Braxton Hicks contractions, adhesions may be contributing. She has multiple admissions for pain. Imaging done showed a negative MRI/MRCP, negative abdominal ultrasound (no gallstones, small amount of sludge), labs unrevealing (normal lipase, amylase, CMP [complete metabolic panel] and CBC [complete blood count]), GI

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consult who felt it could be functional dyspepsia, they advised a trial of PPI and hycosamine (CS declined). Additional supportive therapies offered (and declined): physical therapy, acupuncture, TENS unit, lidocaine patches, belly band support. Discussed trial of PO nifedipine, Vistaril, and twice weekly IVF. She declined the offer of additional medications to address withdrawal symptoms due to recent narcotics (clonidine, Zofran (has at home), Imodium). There was no life-threatening pathology to date on extensive work up. She was understandably frustrated with the lack of diagnosis and solution. She was worried about potential withdrawal, which she experienced after MVA last year, but was not currently having significant symptoms. During that visit after the abdominal exam, CS began experiencing abdominal discomfort that coincided with contractions that palpated moderately. Dr. Salati agreed with prior suggestions that she may be having significant discomfort from her Braxton Hicks contractions and possibly worse symptoms due to adhesive disease which is a diagnosis of exclusion. She could not rule out IBD [irritable bowel disease] or thrombotic etiology. CS was found to have a normal Hb electrophoresis and therefore did not have thalassemia.

On March 23, 2023, CS presented via ambulance to the hospital for nausea, vomiting, diarrhea and abdominal pain. She had not felt the baby move since the prior evening. She had reassuring fetal testing on admission with a reactive non-stress test. CS accepted a trial of Gabapentin for anxiety/pain, and Robaxin to address restless legs. Her abdominal pain was further investigated with a repeat abdominal US with dopplers which was normal. Her abdominal pain was thought to most likely be due to uterine irritability. She had a repeat growth/anatomy US done during the admission which unfortunately showed new ventriculomegaly that was not previously seen on anatomy US at 22w1d (1.18.2023). CS's first trimester genetic screenings for chromosomal abnormalities had been normal, tests were sent for CMV and toxoplasmosis prior to discharge, patient was not interested in amniocentesis. On March 28, 2023, she was seen in the MFM office for a routine visit. CS's contractions continued but were tolerable on nifedipine; mild headache but willing to tolerate to have decrease in contractions/pain. The plan was to continue current dose and weekly IV fluids, plan to deliver at earliest possible date helping with anxiety and frustration of difficult pregnancy. She stopped taking Robaxin as that was for withdrawal symptoms that have resolved.

On March 30, 2023, CS had a Fetal MRI completed. She discussed the results in the office with Hospital Maternal Fetal Medicine on April 3, 2023. Unfortunately, the MRI revealed a right sided grade 3 Intraventricular/Germinal Matrix Hemorrhage (IVH/GCH) as well as right sided frontal horn periventricular white matter and caudate head cysts suggesting prior parenchymal injury. Based on the literature, antenatal IVH with parenchymal injury has a significant risk of motor impairment, developmental delay, and seizures. They reviewed these risks in a general sense and discussion was deferred for a more in-depth discussion with Pediatric Neurology. CS expressed concern about her ability to care for a child with special needs. Options were reviewed that included termination of pregnancy in setting of significant anomalies, as well as expectant management. They also reviewed recommended evaluation for antenatal IVH/GCH. A large portion of cases have no identifiable risk factors. Twin

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gestation and fetal growth restriction are risk factors, neither of which applied to CS. Fetal bleeding diathesis is another known risk factor, and therefore evaluation for NAIT and hemophilia was recommended.

On April 5, 2023, CS met with Pediatric Neurology to discuss results of the abnormal fetal MRI. They discussed that a right-sided grade 3 intraventricular hemorrhage and right-sided frontal horn periventricular white matter and caudate head cysts seen on fetal MRI obtained at 32weeks 2days gestational age have an increased risk for left-sided hemiparesis, developmental delay, and possibly other neuro complications including seizures and posthemorrhagic hydrocephalus. CS was mostly quiet during the visit, whereas her mother had several questions regarding how the injury occurred and was informed that the imaging study alone would not be able to identify both when the injury occurred or cause with certainty. CS's mother appeared frustrated, stating correctly that in the United States African American women have higher rates of mortality and morbidity than most other ethnic populations which she attributed to systemic racism.

On April 5, 2023, CS again met with Maternal Fetal Medicine (MFM) to make arrangements for pregnancy interruption in the setting of the devastating new diagnosis of intraventricular hemorrhage. At that time, it was decided to do a KCI [potassium chloride injection] prior to repeat C-section. This is an injection directly into the fetuses' heart to stop it from beating. On April 6, 2023, CS was seen again in the Maternal Fetal Medicine office to finalize delivery planning. She expressed anger and frustration regarding the inability to explain why and when fetal IVH occurred. Again, reviewed that NAIT [neonatal alloimmune thrombocytopenia] and hemophilia testing may help provide an answer, but discussed that IVH [intraventricular hemorrhage] may also occur in the absence of any known risk factors. CS was firm on her decision for both KCI and repeat Cesarean section, although asked multiple times why KCI could not be administered after delivery to allow her to meet/hold a live infant. Dr. Kao reviewed that while feticidal injection is legal in the state of Oregon even in the 3rd trimester, the equivalent procedure in the neonatal period is certainly NOT legal in any state. She inquired why resuscitative care could not be withheld in order to allow the baby to pass away naturally; it was reviewed at length that at her current gestational age that survival (even long term) could be a possibility. She understood that alternatives to KCI are ongoing expectant management, parenting or to pursue adoption. Given fetal CNS (central nervous system) imaging and prognosis, however, she appeared certain that she would prefer KCI.

CS was seen for post-op follow up on May 22, 2023. At that time, she had established care with a counselor and a support group to help her through her grief and loss of both her baby and her grandfather. She did present shortly after her last visit to a suicide crisis center because she was having passive thoughts of self-harm but was discharged home. CS did not do NAIT or hemophilia testing and deferred this testing but would consider if she had another pregnancy. Discussed options for future pain management planning. Dr. Salati acknowledged that her history is somewhat unique and that she does not have a substance use disorder or chronic pain but has demonstrated a very high physical tolerance for opiate medications when she has needed it to treat acute pain. A goal was made of having her establish care with a provider who can assist in making future pain plans so that expectations are aligned between

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the patient and the future providers. It was suggested that she establish care with Dr. Kea Parker at Richmond Clinic as a PCP (primary care provider) experienced with addiction medicine. CS was amenable to this plan.

Legal Nurse Discussion and Opinion Based on the Medical Records Provided

CS began experiencing abdominal pain at 19+ weeks gestation. Her workup was negative except for dehydration. She was given recommendations on helping with pain as it was associated with round ligament pain, which occurs at this stage in pregnancy as the uterus becomes larger.

CS continued to have problems with nausea, which she experienced throughout her entire pregnancy and was prescribed Zofran, which is a medication that is safe in pregnancy. In February she noticed and feel Braxton Hicks contractions, which she reported having in all of her pregnancies but did not experience until later, around 28-32 weeks. These are contractions that while uncomfortable do not cause cervical dilation and can continue throughout pregnancy. She continued to have problems with adequately hydrating and constipation which can make these contractions worse. She had multiple admissions for IV hydration and monitoring of the contractions. She did at certain times during these admissions decline fetal monitoring.

On February 14, 2023, she was admitted to hospital for overnight observation of contractions, but in the morning was complaining of more right upper quadrant pain and an ultrasound was ordered that showed biliary sludge and discussed this can cause similar colicky pain as stones.

On March 7, 2023, at 29w0d she continued to complain of persistent nausea, rib pain, contractions, and general discomforts of pregnancy since the second trimester. CS was physically and emotionally fatigued and frustrated by symptoms. She had tried various medications with minimal relief and preferred not to take medications “if they aren’t going to do anything.”

On March 14, 2023, CS was admitted to the hospital for worsening abdominal pain. Her evaluation there included a negative MRI abdomen/MRCP and abdominal ultrasound, labs that were unrevealing (no evidence of pancreatitis, infectious etiology, GU etiology). A gastroenterology consultation was performed, and they felt dyspepsia could be a contributing factor. Ultimately symptoms felt to be secondary to poor tolerance of uterine contractions/irritability. During her last pregnancy CS was on Percocet for the last few weeks until the delivery date due to similar discomfort. She was treated during this admission with high doses of IV and PO opioid medications, Dilaudid and Oxycodone respectively. She was originally ordered smaller doses of these medications, however requested larger doses as felt that they were not helping with her pain at the lower prescribed doses. These are both safe for use in pregnancy for short periods of time. CS requested IV medications where PO medications were appropriate because they did not work as fast as IV medications. These were only used for the week that she was in the hospital and did not pose a long-term negative effect on the patient or the fetus. CS also requested to be delivered during this admission and when the provider explained there was not a clinical indication, she fired her and the group from participating in her

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care for the remainder of the hospitalization. A pain management consultation discussed treating CS as chronic pain management since symptoms were felt to be pregnancy/uterine/physiologic. Discussed using buprenorphine or methadone for pain management and not high dose opioids. The decision was made to transfer her care back to the original provider group that she fired and no longer use IV or PO narcotics to treat uterine irritability. They had exhausted all diagnostic interventions to investigate her discomfort and recommended that she seek a second opinion. CS up to this point had declined supportive therapies such as physical therapy, acupuncture, TENS unit, lidocaine patches, and belly band support.

CS started care with a new provider on March 22, 2023, when she transferred to Hospital Maternal Fetal Medicine. They discussed that there was no life-threatening pathology to date on extensive work up. She was frustrated with the lack of diagnosis and solution. Dr. Salati agreed with prior suggestions that she may be having significant discomfort from her Braxton Hicks contractions and possibly worse symptoms due to adhesive disease which is a diagnosis of exclusion. She could not rule out IBD or thrombotic etiology. CS agreed to trial PO nifedipine, Vistaril, and twice weekly IV fluid infusions.

On March 23, 2023, CS accepted a trial of gabapentin for anxiety/pain and Robaxin to address restless legs when she presented to the hospital via ambulance for nausea, vomiting, and diarrhea in addition to abdominal pain. Her abdominal pain was further investigated with a repeat abdominal ultrasound with dopplers which was normal. She had a repeat growth/anatomy ultrasound done at this time that unfortunately showed new ventriculomegaly that was not seen on previous anatomy ultrasound at 22w1d (1.18.2023). CS's first trimester genetic screenings for chromosomal abnormalities had been normal, tests were sent for CMV [cytomegalovirus] and toxoplasmosis prior to discharge, CS was not interested in amniocentesis. An amniocentesis is a prenatal test that takes amniotic fluid from around the baby in the uterus. This fluid is tested to see if the baby has certain health conditions, or in this case possibly explained IVH. During follow up appointment on March 28, 2023, contractions continued but were tolerable on nifedipine; mild headache but willing to tolerate to have decrease in contractions/pain. The plan decided upon was to continue current dose and weekly IV fluids, deliver at the earliest possible date helping with anxiety and frustration of difficult pregnancy. Robaxin had already been stopped as that was for minor withdrawal symptoms that resolved.

On March 30, 2023, a fetal MRI was completed to follow up the new ventriculomegaly found on US [ultrasound] completed around March 23, 2023. The MRI revealed a right sided grade 3 Intraventricular/Germinal Matrix Hemorrhage (IVH/GMH) as well as right sided frontal horn periventricular white matter and caudate head cysts suggesting prior parenchymal injury. Based on literature, antenatal IVH with parenchymal injury has a significant risk of motor impairment, developmental delays, and seizures. CS expressed concern about her ability to care for a child with special needs. Options were reviewed that included termination of pregnancy in setting of significant anomalies, as well as expectant management. A large portion of cases of IVH/GCH have no identifiable risk factors. Fetal bleeding diathesis [a tendency to suffer from a particular

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medical condition] is a risk factor, and therefore evaluation for NAIT and hemophilia was recommended, for which the patient declined and did not have testing performed.

On April 5, 2023, CS met with pediatric neurology to discuss results of abnormal fetal MRI. They discussed that the results have an increased risk for left-sided hemiparesis, developmental delay, and possible other neuro complications including seizures and posthemorrhagic hydrocephalus. CS then met with Hospital MFM to make arrangements for pregnancy interruption in the setting of the devastating news of intraventricular hemorrhage. She therefore decided on a KCI injection prior to repeating C-Section. CS again had a discussion that IVH may occur in the absence of known risk factors (twin gestation, fetal growth restriction, NAIT and hemophilia.) She asked why KCI injection could not be performed post-delivery (feticide injection is legal in Oregon, the equivalent in the neonatal period is NOT legal in any state). CS asked why resuscitative care could not be withheld in order to allow the baby to pass naturally; it was reviewed with her at length that at her current gestational age that survival (even long term) could be a possibility. She understood the alternatives to KCI were ongoing expectant management, parenting or to pursue adoption. Given fetal CNS imaging and prognosis, she appeared certain that she would prefer KCI. CS delivered via repeat C-section on April 7, 2023.

It is our nursing opinion, to a reasonable degree of medical certainty, that all care provided to CS was appropriate during pregnancy. Her decision to end her pregnancy was one that she made after discussions with Maternal Fetal Medicine and Pediatric Neurology regarding the intraventricular hemorrhage that her fetus has suffered in-utero and concluded that she was not capable of caring for a child with special needs. CS additionally had issues with abdominal pain during her pregnancy, which was treated with opioid medications until a diagnosis of exclusion could be made. Once it was determined that the abdominal pain was not GI related and felt to be poor pain tolerance in relation to uterine irritability and Braxton Hicks Contractions, opioid medications were stopped as those are not going to improve pain, and alternative medications that can lessen or stop these was used (nifedipine). At no time was there a life-threatening condition that required CS to terminate her pregnancy to save her life.

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Opioid Agonist	Parenteral Dose, IV, SC, IM	Oral Dose	PO:IV	Duration of Action, h
Morphine	10 mg	30 mg	3:1	3-4
Morphine, long-acting (Avinza, Kadian)	-	30 mg	-	12
HYDROMorphone (Dilaudid)	1.5 mg	7.5 mg	5:1	2-3
OXYcodone (Oxecta)	-	15-20 mg	-	3-5
OXYcodone, long-acting (OxyContin)	-	20 mg	-	12
HYDROcodone (Vicodin, Lortab)	-	30-45 mg	-	3-5
OXYmorphine (Opana)	1 mg	10 mg	10:1	3-6
OXYmorphine, long-acting (Opana ER)	-	10 mg	-	12
Codeine	-	180-200 mg	-	4
Fentanyl*	0.2 mg (200 mcg)	-	-	2
Methadone**	-	-	-	-

CS received both Dilaudid IV [intravenous] and PO [by mouth] during her admission to the hospital. The table above explains dose via oral or IV dosing and the amounts as well as duration of action [length of time medication is effective]. CS received IV Dilaudid 1.5mg every hour prior to being transitioned to PO Dilaudid. Later CS was switched to 4mg Dilaudid by mouth with 2 mg IV push for breakthrough pain. This did not help with discomfort, so CS was titrated to 8mg PO every 4 hours and 1 mg IV push for breakthrough pain. These doses are appropriate and within standards of care when dealing with chronic pain. CS also had a pain management consult to find the best way to treat her pain in the safest way possible while using opioid medications. These medications did not work, so the patient agreed to trial of Oxycodone 15mg PO every 6 hours, which is also an appropriate dose and timing based on information provided in table above. Once it was determined her abdominal pain was not related to a disease process that can be treated with opioid medications [GI related, pancreatitis, biliary colic] these medications were discontinued which was also the appropriate standard of care.

Reference from: <https://emedicine.medscape.com/article/2138678-overview>

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Recommendations

Please schedule a call with our LNC after you review to discuss this case.

1. Medical Record Retrieval:

Please have your firm request the medical records listed below:

Record Type and Date	Facility	Date Requested	Date Received
Medication administration records- to show dosed narcotics and amounts given	Providence		
Operative report from C-section	Hospital		
Final Autopsy report of Fetus	Hospital		

2. Expert Location and Screening:

Obstetrics
Fetal Neurology

PRN Legal Nurse Consultants can help find and facilitate experts for your case.

3. Possible Defenses:

- For chronic pain, practice goals include strategies to avoid or minimize the use of opioids for pain management, highlighting alternative pain therapies such as nonpharmacologic (e.g. exercise, physical therapy, behavioral approaches), and nonopioid pharmacologic treatments. CS refused all treatments other than opioid pain medications.
- The hospital provided standard care for anyone presenting to the hospital pregnant with abdominal pain. They did all appropriate imaging and being that during her admission CS complained that the pain had changed from more contraction to right upper quadrant pain, while evaluating a gastroenterological cause for this pain, they treated her with the appropriate pain medications. It was determined previously that the patient has an unusually high physical tolerance to opioid medications. She experienced a similar issue with pain management following a prior car accident and required a prescription for Percocet in a prior pregnancy to remain comfortable until delivery date.
- CS frequently became frustrated in the hospital when physicians tried to treat her with different medications and routes for her pain. They did however continue to provide safe care to her, and listened to her wishes, which was to be treated with opioid pain medication.
- CS frequently mentioned that this pregnancy was very emotionally and physically

Commented [TP8]: add in this section EVERYTHING that the hospital will use to debunk the case! Summarize her quotes and give quick bullet points as to how standards of practice/care were met for any state.

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taxing her due to her discomfort and requested delivery stating, “that’s fine if you won’t do it, I can find another doctor who will” and fired a physician from her care. During continued discussion with nurse, she made statement “I would terminate this pregnancy if I could.” Once CS found out that her infant had suffered an IVH in utero, CS expressed concern about her ability to care for a child with special needs. Options were reviewed that included termination of pregnancy in setting of significant anomalies, as well as expectant management. CS was firm in her decision regarding terminating her pregnancy and proceeding with delivery.

4. Research and Summarization of Authoritative Literature:

Medications given to the patient included Flexeril, Vistaril, Oxycodone, Fentanyl, Morphine, Dilaudid, Zofran, Gabapentin, Robaxin and Hyoscyamine.

Table 1. FDA Drug Risk Classification

Category	Description
A	Controlled studies in humans show no risk to the fetus
B	No controlled studies have been conducted in humans; animal studies show no risk to the fetus
C	No controlled studies have been conducted in animals or humans
D	Evidence of human risk to the fetus exists; however, benefits may outweigh risks in certain situations
X	Controlled studies in both animals and humans demonstrate fetal abnormalities; the risk in pregnant women outweighs any possible benefit

Source: References 4-7.

Flexeril- Pregnancy Category B: Reproduction studies have been performed in rats, mice and rabbits at doses up to 20 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to FLEXERIL. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

https://www.accessdata.fda.gov/drugsatfda_docs/label/2003/017821s0451b1.pdf

Vistaril - Hydroxyzine, when administered to the pregnant mouse, rat, and rabbit, induced fetal abnormalities in the rat and mouse at doses substantially above the human therapeutic range. Clinical data in human beings are inadequate to establish safety in

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early pregnancy. Until such data are available, hydroxyzine is contraindicated in early pregnancy. https://www.accessdata.fda.gov/drugsatfda_docs/label/2014/011459s048%2C011795s025lbl.pdf

Oxycodone - Teratogenic Effects - Pregnancy Category C There are no adequate and well-controlled studies in pregnant women. OXYCONTIN should be used during pregnancy only if the potential benefit justifies the risk to the fetus. https://www.accessdata.fda.gov/drugsatfda_docs/label/2015/022272s027lbl.pdf

Fentanyl - US FDA pregnancy category: C: Animal reproduction studies have shown an adverse effect on the fetus and there are no adequate and well-controlled studies in humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks. <https://www.drugs.com/pregnancy/fentanyl.html#:~:text=US%20FDA%20pregnancy%20category%20C,pregnant%20women%20despite%20potential%20risks.>

Dilaudid - US FDA pregnancy category: Not Assigned. Risk Summary: There are no available data to inform a drug-associated risk for major birth defects and miscarriage with this drug; prolonged use of opioids during pregnancy can result in physical dependence in the neonate. <https://www.drugs.com/pregnancy/hydromorphone.html>

Morphine – Pregnancy Category C No formal studies to assess the teratogenic effects of morphine in animals have been conducted. It is also not known whether morphine can cause fetal harm when administered to a pregnant woman or can affect reproductive capacity. Morphine should be given to a pregnant woman only if clearly needed. https://www.accessdata.fda.gov/drugsatfda_docs/label/2011/202515s0001lbl.pdf

Zofran - US FDA pregnancy category: B Animal reproduction studies have failed to demonstrate a risk to the fetus and there are no adequate and well-controlled studies in pregnant women. <https://www.drugs.com/pregnancy/ondansetron.html>

Gabapentin - US FDA pregnancy category: Not assigned. Risk Summary: There are no data on the developmental risks associated with use of this drug in pregnant women; in animal studies, developmental toxicity was observed at doses estimated to be similar or lower than those used clinically. <https://www.drugs.com/pregnancy/gabapentin.html>

Robaxin - US FDA pregnancy category: C https://www.accessdata.fda.gov/drugsatfda_docs/label/2003/011011Orig1s070s071lbl.pdf

Hyoscyamine - US FDA pregnancy category C: Animal reproduction studies have shown an adverse effect on the fetus and there are no adequate and well-controlled studies in



humans, but potential benefits may warrant use of the drug in pregnant women despite potential risks. <https://www.drugs.com/pregnancy/hyoscyamine.html>

Braxton Hicks contractions are sporadic contractions and relaxation of the uterine muscle. Sometimes, they are referred to as prodromal or “false labor” pains. It is believed they start around 6 weeks gestation but usually are not felt until the second or third trimester of the pregnancy. Braxton Hicks contractions are the body’s way of preparing for true labor, but they do not indicate that labor has begun or is going to start. [NBK470546](#)

During active labor, contractions are powerful, last for 60 seconds or longer, and occur in regular intervals. In contrast, Braxton-Hicks or false labor contractions begin around the second or third trimester of pregnancy, are irregular, less intense, and usually stop with activity or rest.

IU [irritable uterus] contractions fall somewhere in between the two. They are typically more intense than Braxton-Hicks contractions but do not reach the same level of intensity as true labor contractions. Unlike Braxton-Hicks contractions, IU contractions do not respond to activity or rest, meaning they do not go away or become less frequent with activity level or position changes.

Although IU is a common condition, it can cause concern and become uncomfortable and even painful.

However, there are a few things a person with IU can do to help manage their symptoms:

- Staying hydrated
- Reducing stress, where possible
- Resting and avoiding overexertion
- Eating small, frequent meals
- Avoiding trigger factors, such as caffeine and spicy foods
- Avoid lifting heavy objects
- Practice relaxation techniques, Lamaze breathing or meditation

Doctors may also recommend nifedipine (Procardia) to help manage IU. CS’s physicians did in fact do this once it was determined that her pains were not caused by anything other than uterine irritability, poor pain tolerance, and physiological. This standard of care would have been given to any pregnant woman once it was determined this was the cause of pain.

<https://www.medicalnewstoday.com/articles/uterine-irritability#coping>