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Via hand delivery

October 3, 2011

Dr. Thomas Carson,
Chairman, Credentials Committee
Helen Ellis Memorial Hospital
1395 South Pinellas Avenue
Tarpon Springs, Florida 34689

Re: Credentials Committee Meeting vis August 19th Precautionary Suspension

Dear Dr. Carson,

I received your letter dated September 23, 2011 without an attachment. The attachment regarding the thirteen (13) cases was received last week. On August 19, 2011, without the benefit of any written notice, Bruce Bergherm told me that I was subject to an immediate precautionary suspension. Notably, I had just left the operating room and was not allowed to either complete that operative note or provide my then inpatients with any further care. I was not permitted to return to the hospital and could not complete the delinquent charts you commented upon. I will, however, make every effort to complete these medical records.

For the purposes of this meeting I reviewed the thirteen (13) obstetrical cases you identified. I reviewed both the inpatient medical records provided to my attorney, Adam S. Levine, and my corresponding office records. In addition to my review of these thirteen cases, my attorney reviewed the medical records with an independent expert familiar with our local practice. In addition to being an attorney, Dr. Levine is board certified by the American Board of Medical Specialties in Obstetrics and Gynecology and Reproductive Endocrinology and Infertility in addition to being certified by the American Board of Quality Assurance and Utilization Review Physicians. In fact, a United States District recognized Dr. Levine as an expert in Obstetrics and Gynecology.

Below you will find general comments applicable to all the records reviewed as well as comments specific to each case. I will be happy to discuss any or all of them with your committee. Despite your reviewer's comments, neither Dr. Levine nor I believe that any of these cases demonstrated care outside the prevailing standard of care. Further, it is my understanding that the external reviewer was formerly the chairman of an Ob/Gyn Department at an academic tertiary care hospital in a different state. His practice is likely not similar to that in our community. I understand and share your concerns about past biases and economic competition; however, the reviewer appears not to have practiced general Ob/Gyn in a solo-practice at a

community hospital. In addition to my views and those of my experts, attached to this letter as appendices, are copies of publications from peer-reviewed medical journals and the American College of Obstetrics and Gynecology that support the medical care that I provided.

I was encouraged by the former Chief Executive Officer of Helen Ellis Memorial Hospital to relocate my practice to this hospital. Over the past year, I significantly increased our obstetric volume. Last year I accounted for fifty eight (58%) of all obstetric deliveries at our hospital. I do wish to remain in practice here but feel that I have been unfairly treated. I will readily admit that my documentation, like that of the vast majority of my peers, can improve. However, the medical care I provided has been within the standard of care and has resulted in good outcomes. Also attached to this letter are statements and letters, many from the patients whose care has been criticized here.

General Comments

1. **Standard of Care** – The reviewer frequently commented on either deviations from or medical practice below the standard of care. What the reviewer completely failed to address was: 1) what the actual standard of care was; 2) what standards he was applying as a baseline; and 3) who actually violated the standard of care. Frequently, the standards the reviewer used appear to be either more stringent or in opposition to those espoused by the American College of Obstetrics and Gynecology. The standard of care is, by necessity, a wide standard that accounts for many different types of practices. The practice of medicine in an academic teaching institution is far different from that in a community hospital. Violating the standard of care generally requires that a physician practice far outside the community's standards. Statistically, if one were to evaluate all medical practices as a bell curve, the standard of care would be that 95% under the bell curve and including the upper 2.5% of outstanding care. That 2.5% at the bottom of the bell curve would be outside the standard of care.

2. **Documentation** – The reviewer frequently commented upon documentation concerns. However, each of the medical records contains all the component parts that a physician is generally responsible for including a history and physical examination, appropriate physician consents, signed physician orders, appropriate progress notes, appropriate delivery notes, post-partum notes and any necessary operative notes and discharge summaries. Additionally, I provide Labor and Delivery with copies of each patient's prenatal evaluations and laboratory work. The medical records generally satisfy AHCA and JCAHO medical record keeping requirements along with those set forth in the Helen Ellis Memorial Hospital (HEMH) Rules and Regulations and Bylaws. The reviewer commented that he wanted me to more carefully document my reasoning and plans of care. This is most common in academic training institutions where interns and residents are learning to care for patients. Generally, physicians in private practice may or may not document their individual thoughts and plans of care but nowhere is this required.

3. **Labor Philosophy** – The reviewer commented that I was not aggressive enough. However, the reviewer fails to realize that pregnancy and labor are not disease processes.

Rather, they are natural processes. There are no requirements that one be overly aggressive. If a patient is making progress and there are no other indications requiring immediate delivery, there is no reason to rush anything. Additionally, the reviewer must understand that patients do not necessarily do either what we tell them or what is right. In the absence of an immediate need for delivery, if a patient neither desires nor consents to a cesarean delivery or more aggressive use of pitocin, there is no need to force the issue. Further, few if any judges will order a cesarean delivery against a mother's will. The reviewer also accused me of wasting resources and spending too much money on patients – however the reviewer also suggested that I use other, expensive resources like internal fetal monitoring. If contractions and the fetal heart rate can be monitored reasonably well externally, the use of internal monitoring is not necessary.

4. **(Birth Center)** – I do not have a formal arrangement with them. I do provide them with the opportunity for me to consult on some of their patients antenatally. Generally, they refer their patients to whatever hospital and whatever doctors are on call that are closest to their patients.

5. **Vaginal Birth After Cesarean** – I recognize that I am one of the few physicians that allow this opportunity for patients. I do require that any patient requesting a VBAC undergo prenatal counseling by me. I also do not permit my patients to labor at home. Further, when a VBAC is in labor, HEMH is informed, I remain immediately available and there is always an operative suite on standby. My VBAC practice mirrors that recommended by the American College of Obstetrics and Gynecology.

6. **Surgicel** – Adhesion formation after cesarean delivery is reasonably common. Surgicel is generally used to promote hemostasis. I use it to maintain hemostasis over the uterine incision at the time of cesarean delivery. Surgicel is bactericidal. Surgicel has not been demonstrated, in any study, to increase or promote adhesion formation. In fact, Surgicel is made from the same material as Interceed, an adhesion prevention barrier used surgically. The only difference is the materials weave. Without being physically present the reviewer cannot and should not comment on the need for any material to promote hemostasis at surgery. Post-operative studies examining adhesion formation after cesarean delivery generally document no difference in adhesion formation in patients with primary repair of the bladder flap, placement of surgical or just fascial closure.

7. **Type and Cross** - Helen Ellis Memorial Hospital has had a Type and Cross as part of the routine admission pre-printed Obstetric Orders since before I ever delivered any patients in Pinellas County. Several months ago I tried to change my pre-printed orders and make the routine type and cross into a type and screen. Because of the administrative changes, these alterations never appear to have happened. In some cases I did not mean to order a Type and Cross but really wanted a type and screen – if at all. However, it should be clearly understood that in pregnancy, forty percent (40%) of cardiac output goes to the uterus. Obstetric hemorrhage can very rapidly result in severe morbidity and mortality. Patients with prior histories of hemorrhage will benefit from having blood immediately available. Because obstetric hemorrhage is never planned and because labor

and delivery runs 24 hours a day, every day, having blood available when there may be less than perfect lab and blood bank coverage is necessary.

Specific Case Comments

Patient # 1

20-year-old gravida 2 para 1 with gestational diabetes and macrosomia undergoing an induction at 39 6/7 weeks gestation.

HEMH EXTERNAL REVIEWER: *The intrapartum management of this patient met the standard of care, however, the documentation was poor.*
Estimated fetal weight and ultrasound determinations were not performed and or documented on the medical record and is below the standard of care.

On admission, a type and cross for 2 units was ordered; In the prenatal records it was noted that Dr. Dinsmore delivered the patient in the past and had to transfuse her. Documentation concerning prior delivery was poor and reasons for transfusion were not explained.

DR. DINSMORE COMMENTS:

1. The reviewer commented about poor documentation without specifically stating what, if anything was poor or missing. In point of fact, pursuant to AHCA and JCAHO requirements as well as the Helen Ellis Rules and Regulations for Medical Staff, my portion of this chart is complete. I signed my orders and verbal orders, I completed and signed a history and physical examination, I completed and signed labor progress notes, post partum notes, etc. I also completed a delivery note, and a post-partum note and discharge. Please see my documentation notes above.
2. The medical records provided contain records, pages 22 and 23, that belong to another unrelated patient.
3. My prenatal records are missing from this chart. My prenatal records are provided for all patients and should be part of the medical record. My prenatal records will contain the patients' prior significant history.
4. My prenatal records document normal growth by exam and no macrosomia. Ultrasound determinations in the late third trimester are inaccurate and not necessarily required.

Patient #2

32-year-old gravida 2 para 0 at 37 3/7 weeks gestation with gestational hypertension receiving prenatal care from (birth center) transferred for evaluation and induction of labor secondary to gestational hypertension who underwent a primary cesarean delivery. Notably, this patient had a longstanding renal disorder and only possessed one (1) functional kidney.

HEMH EXTERNAL REVIEWER: *Several aspects of this do not meet the standard of care. This patient did not have preeclampsia by any criteria, such as blood pressure, proteinuria. Edema can be varying and has been discarded as a diagnostic criterion. Uric acid, while helpful in some cases may be elevated by diet alone. Since she never has seen the patient, admitting for laboratory and 23-hour observation may have been useful in this case, with normal amniotic fluid and protein, she should have been discharged. The use of NST's is unreasonable and I have never seen it ordered every three hours. Beyond the lack of an indication for induction, the use of Pitocin is unusual and below the standard of care. The admission note was inadequate in justifying the induction, and the lack of at least daily notes with a patient being actively managed for delivery with uterotonic agents and the lack of any reasoning for proceeding with a cesarean section is below the standard of care.*

DR. DINSMORE COMMENTS:

1. The reviewer stated that several aspects did not meet the standard of care without clearly documenting which aspects as noted above in general comments.

2. The reviewer commented only about preeclampsia without recognizing that preeclampsia is only one of a wide variety of disorders related to gestational hypertension. A patient does not require the diagnosis of preeclampsia to be delivered. Rather, the American College of Obstetrics and Gynecology generally recommends early delivery for pregnancies complicated by any of the hypertensive disorders of pregnancy.
3. The reviewer commented about poor documentation without specifically stating what, if anything was poor or missing. In point of fact, pursuant to AHCA and JCAHO requirements as well as the Helen Ellis Rules and Regulations for Medical Staff, my portion of this chart is complete. I signed my orders and verbal orders, I completed and signed a history and physical examination, I completed and signed labor progress notes, post partum notes, etc. I also completed a delivery note, and a post-partum note and discharge. Please see my documentation notes above.
4. This patient was admitted on April 15, 2011 with a documented blood pressure at 1640 of 143/79. Over the next 5 days hypertension was documented in the patient's vital signs at a minimum of every 8 hours. This medical record appears to be incomplete and does not indicate the several days the patient was evaluated before she was delivered.
5. This patient only possessed a single kidney. The reviewer fails to notice this or comment upon it. All of the normative data regarding preeclampsia or hypertensive disorders in pregnancy were generated based on women with two (2) normal functioning kidneys prior to pregnancy. Treating this patient was necessary because in the event that severe micro vascular damage occurred as a result of the hypertensive disorder, it may not have been as reversible in this patient as it would have been with a patient with two (2) kidneys.
6. This patient's uric acid was 6.4 on April 14th, and it rose to 6.7 on April 15th. Despite the reviewer's comments, uric acid has long been considered a predictor of preeclampsia and the other hypertensive disorders of pregnancy.
7. At 38 weeks gestation the American College of Obstetrics and Gynecology recommends delivery for those pregnancies complicated by hypertensive disorders.
8. Evaluation of fetal status is necessary and NST are the standard way of evaluating fetal status – here the reviewer noted that NSTs were unreasonable but in a later case the reviewer said that a BPP was unreasonable and an NST should have been done.
9. With regard to induction, pitocin has long been used for induction and it is not clear why the reviewer comments otherwise.

Patient #3

23-year-old gravida 1 para 0 at term who underwent a primary cesarean delivery for arrest of dilation and descent.

HEMH EXTERNAL REVIEWER: *This patient should have been checked for dilation by 2200 and when it was determined that she had a desultory labor, an IUPC placed to determine the strength of contractions and if inadequate, augmented and after several hours, undergo a cesarean section. There is no documentation in the medical record on how this patient's labor was managed. Again the use of "oblique lie" as an indication for cesarean section is a misuse of terminology.*

The use of the Surgicel on the surgical site adds expense and probably increases scarring at the superior junction of the bladder flap, making future dissections at cesarean delivery difficult. The management of labor is below the standard of care. The use of a type and cross adds to expense and ties up those units for 48 hours in most hospitals; this should only be used if the probability of a transfusion is close to 90%. The overall management is below the standard of care, with ongoing poor documentation.

DR. DINSMORE COMMENTS:

1. In this patient's case, we were unable to increase the pitocin because the patient reported significant pain.
2. The reviewer commented about poor documentation without specifically stating what, if anything was poor or missing. In point of fact, pursuant to AHCA and JCAHO requirements as well as the Helen Ellis Rules and Regulations for Medical Staff, my portion of this chart is complete. I signed my orders and verbal orders, I completed and signed a history and physical examination, I completed and signed labor progress notes, post partum notes, etc. I also completed a delivery note, and a post-partum note and discharge. Please see my documentation notes above.

3. I utilize Surgicel during cesarean deliveries because it reduces bleeding and improves hemostasis. The reviewer is incorrect for several reasons:
    a. Surgicel is bactericidal.
    b. Adhesions are common following cesarean delivery but no data is published that reports increased scarring at repeat cesarean delivery.
    c. Without being physically present to observe the operative site, it is unreasonable for any reviewer to comment on the use of a hemostatic agent applied intraoperatively.
4. I ordered a type and cross instead of a type and screen. Our standing orders used to be for a type and cross and I have been working to change them to a type and screen.
5. My patients choose to see me because of my labor philosophy – I am not overly aggressive and do not rapidly increase pitocin or proceed to cesarean section with undue haste. Labor is a natural process. In the absence of an indication for immediate delivery, there is no need to abrogate a patient's wishes or desires for labor.
6. The reviewer requested an intrauterine pressure catheter, but I did not believe this was necessary because if the patient did not progress in labor, I would have ordered a cesarean delivery. The routine use of IUPCs are not necessary according to the ACOG guidelines.

Patient #4

20-year-old primigravid patient at 39 2/7 weeks with a history of asthma who underwent a primary cesarean delivery and who spiked a post-operative temperature of 103.5.

HEMH EXTERNAL REVIEWER: *There is no evidence of fetal intolerance to labor and cervical exam documentation by the physician was not provided. The cause of a postoperative fever, especially in a morbidly obese patient who has had an anesthetic and is not ambulating well according to the nurses' notes is atelectasis. In the initial radiology report atelectasis was suggested in the left lower lobe. The physical exam performed was rudimentary. This case falls beneath the standard of care on multiple levels.*

The term "chronic renal" has no meaning or explanation, nor was any laboratory data obtained. The patient did not have an indication for a cesarean section by the fetal monitoring strips. I doubt the infant was an oblique lie, because this is not usually found in a prima gravida. To order antibiotics without seeing the patient is unacceptable. An obese patient lying on her back with chest wall compression with gravid breasts in the immediate postoperative time frame is atelectasis until proven otherwise. The antibiotic choice when the patient was transferred to ICU is for endomyometritis, not pneumonia. A procalcitonin level is inappropriate in this clinical scenario. The medical documentation and care is below the standard.

DR. DINSMORE COMMENTS:

1. The reviewer commented about poor documentation without specifically stating what, if anything was poor or missing. In point of fact, pursuant to AHCA and JCAHO requirements as well as the Helen Ellis Rules and Regulations for Medical Staff, my portion of this chart is complete. I signed my orders and verbal orders, I completed and signed a history and physical examination, I completed and signed labor progress notes, post partum notes, etc. I also completed a delivery note, and a post-partum note and discharge. Please see my documentation notes above.
2. The reviewer incorrectly documents "no evidence of fetal intolerance to labor." In fact, I was called at 0239 to evaluate this patient. I came to Helen Ellis and remained because of the prolonged fetal heart rate deceleration that ultimately recovered sufficient for this patient to continue laboring. Over time, while I was physically present, the decelerations began again and I diagnosed fetal stress sufficient to require a cesarean delivery.
3. At the cesarean delivery for fetal stress, the documented APGAR scores were 6 and 9. The rapid recovery indicates a respiratory acidosis that was resolved following delivery.
4. This patient possessed a history of respiratory compromise with moderate asthma and reactive airway disease. When her temperature went to 103.5 I felt that this temperature was neither consistent with the mild fevers of either breast engorgement or atelectasis. My physical examination revealed decreased basilar lung sounds and with an oxygen saturation of only 93% and a pulse of 134 and a respiratory rate of

24, I felt that this patient required more surveillance than that routinely available on post-partum. Given her compromised respiratory status, I believed that this patient would benefit from admission to the ICU.

5. It is my understanding that the HEMH external reviewer is a former department chairman from an academic medical center in Louisiana. When one does not have residents and interns and one has a patient with a high, spiking fever, and while one is in transit to the hospital itself, it is eminently reasonable to begin antibiotics and stop them if they are not necessary. I ordered antibiotics for endomyometritis.
6. Post-partum fevers are common. The reviewer correctly documents common causes such as atelectasis. However, atelectasis generally only gives mild temperature elevations such as 101. Breast engorgement can also cause fevers. Too, these are generally less than 101. Again, I documented chronic renal because elsewhere in the same note I documented chronic renal lithiasis.
7. Laboratory determinations generally pose only a negligible threat to patient safety. I ordered a procalcitonin because the Obstetric literature suggests that that it is a good marker for sepsis.

Patient #5

23-year-old gravida 3 para 0 at term for induction of labor who underwent a cesarean delivery for failure to progress.

HEMH EXTERNAL REVIEWER: *Induction at 40/3 weeks is reasonable, but allowing the active phase of labor to last for 14 hours until a decision to do cesarean section is below the standard of care. The level of obstetrical involvement is below the standard of care, both in interventions and documentation. Consideration of labor obstruction by fetal macrosomia was never considered. Documentation of uterine activity via IUPC for adequacy of uterine contraction is absent. Essentially, the role of the obstetrician in the care of this and other patients seems to be delegated to nursing until they get the physician involved. The use of Surgicel on the uterine incision is well explained above.*

DR. DINSMORE COMMENTS:

1. The reviewer commented about poor documentation without specifically stating what, if anything was poor or missing. In point of fact, pursuant to AHCA and JCAHO requirements as well as the Helen Ellis Rules and Regulations for Medical Staff, my portion of this chart is complete. I signed my orders and verbal orders, I completed and signed a history and physical examination, I completed and signed labor progress notes, post partum notes, etc. I also completed a delivery note, and a post-partum note and discharge. Please see my documentation notes above.
2. The reviewer's facts are incorrect. Active labor is defined as the presence of regular uterine contractions causing an increased dilatation and effacement of the cervix when the cervix is at least four (4) centimeters dilated. In point of fact, this patient was not in active labor until 2200. At 0445, six (6) hours and forty five (45) minutes labor she was nine (9) centimeters dilated and completely (100%) effaced. The time elapsed is not 14 hours but 6.75 hours of active labor – something completely well within the normal range. The latent phase of labor is before 4 centimeters dilated and can last an extended period of time. Cervical dilatation is only delayed when greater than two hours elapse without change – or the progress from 4 centimeters to 9 centimeters, as here, could have been 10 (ten) hours.
3. The American College of Obstetrics and Gynecology Practice Bulletin #49 challenges the use of intrauterine pressure catheters (IUPCs)
4. The American College of Obstetrics and Gynecology Practice Bulletin #49 also challenges the "2 hour rule."
5. The use of both an intrauterine pressure catheter and a fetal scalp electrode are not necessary if external monitoring will provide adequate data.
6. Although I may rely upon the nursing staff too much, unlike academic medical centers, nurses at private hospitals possess far more independence and ability to care for laboring patients than those in academic centers.

Patient #6

23-year-old gravida 2 para 1 at 39 2/7 weeks gestation with mild gestational hypertension for vaginal birth after cesarean delivery.

HEMH EXTERNAL REVIEWER: *I am confused why a BPP was performed @ 33 weeks, rather than a NST, and then no further fetal testing done despite continued elevated B/P's. A trial of labor for a vaginal birth after cesarean mandates that the previous uterine scar is documented by some means or a note that it was discussed with a medical records person at the hospital. This patient had her child in New York by the medical records and the scar is not documented, only that she had gestational diabetes and the indication for surgery was failure to progress. The estimated fetal weight is not documented. There is no documentation why a diagnosis of transient pregnancy induced hypertension is considered. The most common etiology of fetal distress with late decelerations is most likely epidural anesthesia with maternal hypotension, especially in patients with pregnancy-induced hypertension.*

This was not addressed in a timely fashion with fetal distress during a VBAC, and a cesarean section must be considered. The patient should have at least been moved to the OR in anticipation of performance of a cesarean section. It was pure luck that this infant had enough fetal reserve not to become hypoxic at birth. The provider was involved in the care, but there is no documentation present as to her thought or her decision making process, and her reasons for intervening or not. Finally, it is unclear why the advanced uterotonic agents were used, (usual cause is uterine atony), and the way they are used is not logical – an oral agent at the same time as an IM injection, which was proceeded by a 3rd line agent. No documentation exists in the records I received as to why the medications were used. This case falls below the standard of care on multiple grounds.

DR. DINSMORE COMMENTS:

1. The reviewer commented about poor documentation without specifically stating what, if anything was poor or missing. In point of fact, pursuant to AHCA and JCAHO requirements as well as the Helen Ellis Rules and Regulations for Medical Staff, my portion of this chart is complete. I signed my orders and verbal orders, I completed and signed a history and physical examination, I completed and signed labor progress notes, post partum notes, etc. I also completed a delivery note, and a post-partum note and discharge. Please see my documentation notes above.
2. The reviewer is examining charts from both this patient's inpatient stay as well as her outpatient evaluation. In point of fact, a biophysical profile provides much more information related to fetal well-being, size and position than a fetal non-stress test does.
3. I ordered the biophysical profile that was questioned as part of an outpatient triage visit, the remainder of the triage chart is missing.
4. The reviewer comments on elevated blood pressures that were normal on repeat testing in the prenatal records.
5. I did a VBAC counseling with this patient on January 28, 2011.
6. Pursuant to the American College of Obstetrics and Gynecology, although the risk is lower with a prior low –transverse uterine incision, a trial of labor after cesarean (TOLAC) is acceptable if the uterine scar type (transverse or vertical) is unknown.
7. The reviewer appears to be using a much older, and unused classification of uterotonic agents. Modern obstetrics recognizes no 1st, 2nd, or 3rd line agents to prevent maternal hemorrhage. In pregnancy and immediately post partum, the gravid uterus receives approximately forty percent (40%) of total cardiac output. This can lead to rapid and fatal hemorrhage. Because of the severe risk of maternal hemorrhage and death, physicians should use whatever medications are immediately available in treating a potential hemorrhage while preparing to go to the operating room if a hysterectomy should become necessary.
8. I determine estimated fetal weight at each prenatal visit by examination and a Leopold's Maneuver. If necessary, and I think the weight is outside normal, I will order an ultrasound – such as a BPP with EFW. Here there was no gestational diabetes and the fundal height growth was normal so there was no reason to expect an overly large baby.
9. This patient did in fact have clear documentation of mildly elevated blood pressures with a negative urine dip for protein.

Patient #7

37-year-old grand multipara high-risk pregnancy with advanced maternal age and preterm labor admitted with preterm premature rupture of membranes who delivered within 24 hours and was diagnosed by a cardiologist consultant with post-partum cardiomyopathy.

HEMH EXTERNAL REVIEWER: *The obstetrician should have some working knowledge regarding normal physiological changes of the early post partum state to advise the consultants. The patient had mild hypertension in the third trimester (140/89 @ 29 weeks and 141/92 @ 33/6 weeks), but that is not documented in the H &P. On post partum day #1, the patient was noted to have "hypertension" (actual levels not noted in the physician's note). The echocardiogram findings are consistent with some level of hypertensive cardiac disease, but can be found with preeclampsia and hypertensive disorders of pregnancy. The patient was started on a usual regiment for cardiomyopathy, which is probably an overtreatment. Why was a renal ultrasound, abdominal ultrasound, and a lipid profile ordered in this post partum patient?*
The documentation, care, and use of consultants in this case were below the standard of care.

DR. DINSMORE COMMENTS:

1. The reviewer commented about poor documentation without specifically stating what, if anything was poor or missing. In point of fact, pursuant to AHCA and JCAHO requirements as well as the Helen Ellis Rules and Regulations for Medical Staff, my portion of this chart is complete. I signed my orders and verbal orders, I completed and signed a history and physical examination, I completed and signed labor progress notes, post partum notes, etc. I also completed a delivery note, and a post-partum note and discharge. Please see my documentation notes above.
2. The reviewer is absolutely wrong. I felt that this patient had a problem and I obtained a consultation. After an appropriate evaluation, that consultant made a diagnosis and a plan of care. While I generally do not have any issues discussing maternal physiology with a cardiologist, I am not a cardiologist and rely on my consultant's expertise in areas with which I am not an expert. There are absolutely no reasons why either an internal medicine physician or a cardiologist on staff at HEMH would be incapable of accurately diagnosing peripartum or post partum cardiomyopathy, mild pulmonary hypertension, diastolic dysfunction and/or a hypertensive crisis.
3. This patient's blood pressure was normal on repeat testing.
4. The renal ultrasound, abdominal ultrasound and lipid profile were ordered by my consultant and were not likely to result in any harm to our patient.
5. Maternal cardiomyopathy complicating pregnancy results in an excessive morbidity and mortality rate.

Patient #8

32-year-old gravida 4 para 1 at 41 2/7 weeks gestation for vaginal birth after cesarean delivery.

HEMH EXTERNAL REVIEWER: *Within the Standard of Care. However, documentation concerns remain.*

DR. DINSMORE COMMENTS:

1. The reviewer commented about poor documentation without specifically stating what, if anything was poor or missing. In point of fact, pursuant to AHCA and JCAHO requirements as well as the Helen Ellis Rules and Regulations for Medical Staff, my portion of this chart is complete. I signed my orders and verbal orders, I completed and signed a history and physical examination, I completed and signed labor progress notes, post partum notes, etc. I also completed a delivery note, and a post-partum note and discharge. Please see my documentation notes above.

Patient #9

21-year-old primigravid patient admitted in spontaneous labor at 41 2/7 weeks gestation who underwent a primary cesarean delivery for non-reassuring fetal testing.

HEMH EXTERNAL REVIEWER: *This case is below the standard of care on several levels. First, the lack of documentation of adequacy of labor and lack of timely intervention because of a very disturbing monitoring strip. For the sake of brevity, the same problems on the use of laboratory, (type and cross), Surgicel and obstetrical terminology continue. The use of Clindamycin for GBS prophylaxis without penicillin allergy is questionable, (and in some hospitals gives poor coverage). Additionally, there is essentially no documentation on the obstetrician's thought process or approach to this patient.*

DR. DINSMORE COMMENTS:

1. The reviewer commented about poor documentation without specifically stating what, if anything was poor or missing. In point of fact, pursuant to AHCA and JCAHO requirements as well as the Helen Ellis Rules and Regulations for Medical Staff, my portion of this chart is complete. I signed my orders and verbal orders, I completed and signed a history and physical examination, I completed and signed labor progress notes, post partum notes, etc. I also completed a delivery note, and a post-partum note and discharge. Please see my documentation notes above.
2. The reviewer frequently comments on my thought process and approach. While this is common in residency training programs, this is less common and not part of the standard of care for private practice physicians who have graduated from residency training programs. I will agree that I can and should document more but this lack of documentation did not result in substandard care.
3. The reviewer commented on a very disturbing monitor strip. Unfortunately, in communicating with me, the nursing staff consistently documented this strip as being category I or II with reassuring fetal well being.
4. As I stated previously, I need to depend less on the nursing staff and document more frequently.
5. This patient received appropriate group b strep prophylaxis for Helen Ellis.
    a. In fact, the Clindamycin was changed to penicillin after two doses had been given.
    b. Helen Ellis' preprinted orders document the use of Clindamycin as a first line agent when ampicillin is contraindicated.

Patient #10

24-year-old gravida 3 para 0 who was admitted in active labor and underwent a primary cesarean delivery for a partial placental abruption and meconium stained amniotic fluid.

HEMH EXTERNAL REVIEWER: *This case is below the standard of care. The latest an intervention should have been considered was by 17:30 and a cesarean delivery performed earlier. There is no documentation or explanations for the late decelerations and category III tracings in the medical record provided. Prior to going home for the evening, the provider should have checked on the patient and reviewed the tracing, specifically after nurses called to discuss.*

DR. DINSMORE COMMENTS:

1. The reviewer commented about poor documentation without specifically stating what, if anything was poor or missing. In point of fact, pursuant to AHCA and JCAHO requirements as well as the Helen Ellis Rules and Regulations for Medical Staff, my portion of this chart is complete. I signed my orders and verbal orders, I completed and signed a history and physical examination, I completed and signed labor progress notes, post partum notes, etc. I also completed a delivery note, and a post-partum note and discharge. Please see my documentation notes above.
2. The medical record provided is not complete. The fetal tracing is not from when the patient was actually in labor. The fetal monitor strip is missing

3. At 1730 this patient was vomiting, the vasovagal reflex associated with this can cause transient placento-fetal insufficiency resulting in transient fetal decelerations. I cannot review the actual fetal heart strip because it was not provided.
4. The notes document a two-minute variable deceleration after placement of the epidural – this is common especially when the laboring patient is not provided with a sufficient intravenous bolus of saline before epidural placement.
5. The documentation of the strip noted category II variable decelerations and a prolonged deceleration at 1919 when the patient was 9 centimeters dilated. The patient desired to wait but we proceeded with cesarean delivery when the decelerations remained
6. At cesarean delivery at 2016, I noted the presence of a maternal abruption.
7. The placental pathology reveals evidence of long standing meconium – thus it is not likely that sooner intervention would definitely be of benefit in this case.

Patient #11

28-year-old gravida at 41 3/7 weeks gestation with prenatal care at (Birth Center) transferred in labor with meconium stained amniotic fluid.

HEMH EXTERNAL REVIEWER: *Severe variable decelerations early in labor requiring additional maneuvers, likely caused by oliohydramnios, but not considered: No amnioinfusion performed. No placement of fetal scalp electrode until 7 hours later.*

At 09:20 the physician noted 7 cm dilation, 90% effacement, -1 station which is compatible with active labor. At 13:30 the physician noted 6-7 cm dilated and static at 90% effaced, -1 station. This indicated active phase arrest requiring cesarean section at 13:30. In this patient oxytocin was contraindicated due to severe decelerations of FHR. Fetal Heart Monitoring continued to evolve to more ominous patterns; recurrent prolonged decelerations, intermittent late decelerations, and the presence of intermittent complex decelerations, which does not support that the fetus was tolerating labor and a cesarean section was indicated. At the decision to proceed with cesarean section for fetal distress, the ACOG 30 minute rule should have been observed. The physician documented to proceed with cesarean section at 18:02. The incision was documented at 19:15 with delivery at 19:18.

At the time of cesarean section it was noted the patient had an "oblique lie" this would be highly unusual. There was a lack of description of where meconium was found in relationship to the baby's vocal cords. There is no rational for the thrombophilia work up, which has no diagnostic value in the recently delivered patient because of the dynamic relationship of clotting parameters in the immediate post partum patient. This falls below the standard of care on medical reasoning and documentation.

DR. DINSMORE COMMENTS:

1. The reviewer commented about poor documentation without specifically stating what, if anything was poor or missing. In point of fact, pursuant to AHCA and JCAHO requirements as well as the Helen Ellis Rules and Regulations for Medical Staff, my portion of this chart is complete. I signed my orders and verbal orders, I completed and signed a history and physical examination, I completed and signed labor progress notes, post partum notes, etc. I also completed a delivery note, and a post-partum note and discharge. Please see my documentation notes above.
1. The reviewer correctly points out that both the American College of Obstetrics and Gynecology and the American Academy of Pediatrics joint guidelines for laboring patients requires that from the time the Obstetrician determines with the patient that a cesarean delivery is indicated until the time the baby is physically removed from the uterus should be no longer than thirty (30) minutes. In this case I was physically present on Labor and Delivery but there were external delays in being able to proceed to the operating room that were out of my control related to anesthesia.
2. I do have a tendency to use some phrases out of habit that are not technically correct. For example, I document an oblique lie to generally refer to a malpresentation of the fetal vertex such that a cesarean delivery was indicated.

3. In this case, my documentation could have been more detailed and frequent. However, the placental pathology indicates long-standing meconium and my record keeping will not have had an impact on outcome. One of my shortcomings is being too reliant on the nursing assessment of fetal heart tracings and their reporting of those monitor tracings to me.
4. I ordered the thrombophilia evaluation because I thought it was indicated given the unusually rapid nature of blood clot formation in the umbilical cord.
5. Amnioinfusion is not required to be within the standard of care or routine practice anywhere in the United States at this time, or any past time. The use of amnioinfusion was an academic construct that was theoretical in nature that never provided the benefits it was intended to create.
6. Use of a fetal scalp electrode is not without risk to the baby. If the external monitor was sufficient to determine the fetal heart rate pattern, a fetal scalp electrode was not necessary.
7. In 2011, and in the vast majority of the past twenty (20) years, the Obstetrician is responsible for the mother not the baby – Obstetricians do not generally visualize baby's airways or determine whether meconium is below the cords – this is something that neonatologists and their nurse practitioners do.

Patient #12

31-year-old gravida 2 para 1 with spontaneous rupture of membranes at 40 2/7 weeks gestation who received prenatal care at (birth center) with a prior cesarean delivery who attempted a home birth before being transferred for a cesarean delivery.

HEMH EXTERNAL REVIEWER: *The trial of labor after cesarean is known to have multiple risks; the most catastrophic is uterine rupture in 1% of patients. It should not be done in a center that does not have 24-hour anesthesia coverage and adequate blood-banking facilities. There is no evidence in the prenatal or hospital record on previous cesarean section scar or counseling on VBAC. This patient should have probably been sectioned 4 hours before it was performed and additionally this is a macrosomic infant. The patient was type and crossed prior to surgery, which is an unnecessary task and expense. This case falls below the standard of care on medical documentation, timely intervention and poor utilization of resources.*

DR. DINSMORE COMMENTS:

1. This patient underwent an extensive counseling about the risks, benefits and alternatives of vaginal delivery after cesarean delivery (VBAC) on May 30, 2011. At the time of that counseling, I reviewed this patient's prior operative note and determined that she had a prior low transverse uterine incision. All these papers were provided with the patient's prenatal records to labor and delivery at Helen Ellis Memorial Hospital.
2. Pursuant to the American College of Obstetrics and Gynecology guidelines (Practice Bulletin #115), the reviewer's comments requiring "24 hour anesthesia and adequate blood banking facilities" only belong to the reviewer and appear nowhere in the American College of Obstetrics and Gynecology guidelines. However, the American College of Obstetrics and Gynecology does require that a physician be present in case of the need for immediate cesarean delivery – in all cases, I am immediately available to any patient undergoing a VBAC.
3. While this patient was in labor, this patient refused routine or frequent cervical examinations (see Nursing admission notes).
4. I personally counseled this patient, that a repeat cesarean delivery might be necessary but the patient adamantly declined a repeat cesarean delivery for anything but fetal distress. In retrospect, I should have documented these conversations with the patient more carefully.
5. I was not personally aware that this patient was in labor until her presentation on Labor and Delivery. I do not have a formal arrangement with any midwifery centers – I do, however, consult with their VBAC patients and recommend that any high-risk pregnancies be transferred to me.

Patient #13

26-year-old primigravid patient receiving prenatal care at (birth center) that was sent to Dr. Dinsmore for evaluation on 8/9/2011 for evaluation of a post-dates pregnancy at 41 4/7 weeks gestation. The patient had a mildly elevated blood pressure and normal fetal testing and was admitted to HEMH for evaluation and delivery.

HEMH EXTERNAL REVIEWER: *Within the Standard of Care. However, documentation concerns remain.*

DR. DINSMORE COMMENTS:

1. The reviewer commented about poor documentation without specifically stating what, if anything was poor or missing. In point of fact, pursuant to AHCA and JCAHO requirements as well as the Helen Ellis Rules and Regulations for Medical Staff, my portion of this chart is complete. I signed my orders and verbal orders, I completed and signed a history and physical examination, I completed and signed labor progress notes, post partum notes, etc. I also completed a delivery note, and a post-partum note and discharge. Please see my documentation notes above.

Please contact me if I can provide you with any further information or assistance.

Best wishes,

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Mahnee L. Dinsmore, M.D.