Zweibach Women's Health

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To whom it may concern,

I have reviewed thirteen hospital charts of patients managed by Dr. Dinsmore in 2011. I have also reviewed the comments made by the external reviewer, Dr. Thomas E. Nolan M.D. Finally I have reviewed the conclusions of the investigating committee.

I am a Board Certified obstetrician gynecologist who has been in practice in Brandon, Florida for 28 years. I am currently on the medical staff of Brandon Regional Hospital. Over the years I have served as Ob/Gyn Department chairman, as well as participated on the Ob/Gyn Peer-Review Committee and the Perinatal Risk Committee. I have performed this review from the perspective of an Ob/Gyn physician in a community hospital, practicing conservatively, using ACOG standard of care guidelines.

I believe that the external reviewer's comments have been taken out of context for the community standard of care. They may be valid from an academic perspective, reflecting a "standard of care" required of physicians in training in an academic institution. I can see how his comments could be interpreted by non-Ob/Gyn physicians to result in Dr. Dinsmore's suspension. However, I believe that that interpretation is wrong.

It is the medical staff's duty to suspend privileges in order to protect patients from unsafe physicians, and/or to remove flagrant violators of the hospital's bylaws. Neither seems to be the case here. In reviewing these charts from a peer-review perspective I see areas for improvement, in particular as regards documentation, however I do not see poor medical judgement, poor medical management, nor poor surgical skills. I do not see poor outcomes, with the exception possibly of the baby with meconium aspiration. The Apgars for this baby were good, though, and meconium aspiration is thought to possibly occur prior to labor and/or delivery and is not necessarily avoidable by early delivery. The baby was transferred for NICU care, and apparently had a quick, successful recovery. Finally, I do not see flagrant violations of the bylaws.

Were the suspension only for documentation, then it might be similar to a suspension of admitting privileges such as is done for not completing medical records. <u>Physicians are not normally suspended from the medical staff for documentation issues.</u>

In reviewing these cases I find that Dr. Dinsmore had admission notes and operative notes on every case. Her operative notes included her pre-op rationale for the cesarean sections. Her handwritten notes were complete and exceptionally legible. Her prenatal records were very complete. Although she can be faulted for not regularly documenting during labor in written progress notes, and not having written pre-op notes, it is clear from the nursing labor notes that her patients were managed properly and safely. Her medical decisions were appropriate from an obstetric point of view.

The assertion that there is no insight into management decisions, timing and physician involvement, because there are no notes during the labor is an academic and/or legal premise which is misleading. It is obvious to me as a practicing Ob/Gyn physician reviewing the labor records and monitor strips that the doctor was following and managing the labors appropriately. The lack of a written note should not have been misconstrued so as to conclude that the doctor had no insight into how and why she was managing labor, and further should not have been used as a basis for suspending her medical staff privileges. She made the right decisions and had the outcomes to show it.

The reviewer in several cases felt the decision to perform cesarean section "should have been made sooner." One can often look back and come to such conclusions. However, that does not mean that they

were required to be done sooner. There was not a bad outcome in any of these cases. ACOG sets guidelines for the minimum hours required without cervical dilation to decide to do a cesarean section. To my knowledge there is not an exact rule as to after how many hours a cesarean has to be performed, in the absence of an abnormal fetal heart rate pattern. There are multiple reasons for a longer trial of labor before the decision is made to do a cesarean section.

In these cases Dr. Dinsmore demonstrates a conservative approach to managing labor, increasing pitocin slowly, and at times allowing more time before deciding to do a cesarean section than some might. I suspect she has a lower overall cesarean section rate than many other Ob/Gyn's due to this. Although she allows a longer trial of labor before calling a cesarean section,this was done within ACOG guidelines regarding fetal heart tracings. In every instance where there was a persistent Category III fetal tracing she did a timely cesarean section. She had good outcomes. I do not think it is appropriate to label this as below the standard of care and to bar this physician from the medical staff because she tried to give her patients a greater chance to have a vaginal delivery.

I have never seen a physician suspended from the medical staff for poor documentation when the care was appropriate and the outcomes were good. We have all worked for years with physicians who write sketchy and/or illegible notes. We don't discipline them unless poor medical care is provided. Dr. Dinsmore's documentation may have some room for improvement for medicolegal reasons, but it seems that a simple request that she include labor progress notes and pr--op notes before cesarean sections, would have accomplished that goal. Again, the outcomes show that she practices safe medicine.

The reviewer determined that there was a lack of documentation of VBAC consents. There were also comments regarding the appropriateness of the facility for VBAC's. First, I found that in every case there was VBAC counseling done in advance with documentation in Dr. Dinsmore's office charts and admit notes. However, neither the consents signed in the office nor a hospital VBAC consent were in the hospital charts. This is a hospital issue more than a physician issue.

Regarding VBAC's, in one case there was an "unknown prior c-section scar." Dr. Dinsmore appropriately challenged the reviewer who disagreed with this VBAC. In fact ACOG allows TOLAC (trial of labor after cesarean) with an unknown scar per ACOG Practice Bulletin 115, in August, 2010, which states "TOLAC is not contraindicated for women with previous cesarean delivery with an unknown uterine scar type unless there is a high clinical suspicion of a previous classical uterine incision. " There was no such suspicion here. In fact there was documentation to suggest otherwise.

I was surprised that the hospital did not have a VBAC consent for its VBAC patients. This and the questions raised about 24 hr. anesthesia and blood bank services to support the provision of VBAC services suggest that hospital administration, nursing and the medical staff should address these system issues to make sure VBAC is safely offered and the hospital is medicolegally secure. It isn't fair to fault the physician for system issues. If VBAC is seen as a concern then the hospital should develop a more comprehensive VBAC protocol.

In community hospitals, contrary to the reviewer's assertions, labor is managed directly by L&D nurses. The practicing Ob/Gyn physician relies on them to keep him/her apprised of the patent's status. Labor and Delivery nurses are generally well-trained to recognize abnormal fetal heart tracings. The non-Ob/Gyn investigating members may not be aware that fetal tracings are very dynamic as is the course of labor. Fetal heart tracings can be non-reassuring and then, with oxygen, positional changes, and decreasing pitocin, they may revert to become more reassuring. However, with decreasing pitocin the labor then slows down. When non-reassuring fetal heart tracings become persistent or worse, delivery is required. In the absence of these, though, labor is allowed to continue, pitocin may be restarted and overall there is a longer protracted course of labor. In looking back at some of these cases, there were periods of time where there were intermittent non-reassuring areas and labor was slowed by turning off the pitocin. Then pitocin was turned back on when the tracing looks good again. This results in time being added to the labor course until a point comes where the O/Ggyn feels sure that vaginal delivery will not happen and a c-section is ordered.

Several of Dr. Dinsmore's charts fall into this category. I do not believe these longer labors with intermittent abnormal fetal tracings were "below the standard of care." Again, there were no bad outcomes. Further, there is no instance in the chart where the nurses were worried about the baby, feeling it should have been delivered earlier and/or the doctor did not immediately respond.

In my experience the labor nurses are as focused as the doctors on having a good fetal strip. They are drilled on this They are certified and re-certified in reading fetal monitor tracings. If the reviewer's impressions are correct then were they not competent to recognize the doctor not acting in a risky situation? Surely their labor notes would reflect repeated calls and concern on their part. The truth is, more likely, they were aware of the need for careful surveillance and kept the doctor advised any time they had a concern. As the records reflect, the staff has done this quite well. Dr. Dinsmore, I believe, responded appropriately, whenever she was notified of worrisome fetal heart tracings. She knows her nursing staff.

As for using "oblique lie" to describe the position of the fetus at time of c-section when it failed to fit through the pelvis, this is not related to her clinical management of the patient in any way. Similarly, her use of the high risk pregnancy CPT code for "chronic renal disease" due to patient's history of kidney stones is irrelevant to patient's management. One can see where the academic Ob/Gyn would find this misuse of terms frustrating. It is inappropriate to conclude that this is clinically relevant and/or a reason for dismissal from the medical staff.

Specifically my conclusions in reviewing the cases of particular concern to the Credentials Committee are as follows:

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. Zweibach: Provider states her prenatal records are missing from the chart but that they document normal growth clinically and no evidence of macrosomia. They document the transfusion history. An ultrasound at term is not required for patients with gestational diabetes unless macrosomia is clinically suspected. She had a prior 8 lb. 6 oz. baby. She can be faulted for not having an EFW written in her admit note. However, there was an uneventful labor and delivery and a good outcome.

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. Zweibach: Pt. admitted for gestational hypertension, possible preeclampsia. As Pt. had labile BPs with 90 diastolics on and off the first 12 hours I feel it was reasonable to decide to induce at 38 weeks even though she did not meet criteria for preeclampsia. Once committed to induce, the induction was repeated each of three days. As the BPs normalized after the first day, the pt. could have been offered to go home or to continue induction. Either approach would have been reasonable. Dr. Dinsmore asserts the daily notes are missing from the chart. Patient continued the induction. Ultimately on the third day the patient did finally go into labor, failed to dilate in labor and had an indicated c-section of a 9 1-2 pound baby. Reviewer says there was no reasoning for c/s - perhaps since the labor record dates and times do not show up on the copies well and there is no pre-op note. But careful review of the labor record shows proper use of cervidil, pitocin, rupture of membranes and failure to dilate which resulted in the c-section. The op note reflects the pre-op indications for c-section. So, would it have been different if pt. was discharged to return in 2-10 days with a larger baby and high blood pressure, possibly with worsened preeclampsia?

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. Zweibach: Pt. had a long labor, managed conservatively. In general labor is managed by the nurses with the doctor following. Documentation is adequate. This pt. had pain management issues which slowed the progression of "intervention" to speed up the labor. The doctor could have been more aggressive with labor or calling a cesarean section sooner, but neither is required or below a standard of care as the fetus was stable. An IUPC probably would not have helped as pitocin was used probably maximally and backed down when contractions got too close. ACOG guidelines provide cutoff point for c/s but do not specifically require a c/s to be done after 2-3 hrs of no cervical change. Dr. Dinsmore's conservative approach has not had poor outcomes. It may contribute to a lower than average c-section rate which is generally thought to be desirable. Use of term oblique lie rather than "asynclitic" is irrelevant to pt's care. The use of Surgicel is advocated by some. The use of Type and Cross is a Labor and delivery issue, not a physician issue.

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. Zweibach: No pre-op or labor notes in the hospital chart, but op note says: "had 2 prolonged decelerations to the 90's lasting greater than 3 minutes and stat c/s called". In fact, the labor record shows intermittent decelerations earlier in labor, then a 5 minute deceleration just 5 minutes after vaginal exam showed 6 cms. So stat c/s was appropriate. Excellent outcome with Apgars 6/9. Management of post-op fever workup, antibiotics and ICU admission were already realized to be appropriate by Investigating Committee. The misuse of "oblique lie' actually refers to asyncliticism associated with cephalopelvic disproportion. Although the wrong word was used, her intent is apparent, and as I have said above, misuse of the word is irrelevant to the patient's care. Similarly, the use of "chronic renal" was where a CPT code for "pregnancy complicated by kidney disease" was used since the patient had kidney stones. Maybe not academically precise, but again, this had no bearing on the patient's care and should not be construed to imply that the doctor did not know what patient's renal disease history included. Procalcitonin has been reported useful in ER mangement of pts. with fever, so if Dr.Dinsmore used it in assessing her post-op patient with a fever she should, not be condemned.

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. Zweibach: Reviewer feels labor was too long. However, pt. had latent phase labor, then went from 4 cm to 9 cm in 6-7 hours which is normal. The patient was 9 cm for 4-5 hrs more when the c/s was called. Perhaps the c/s could have been called sooner but pitocin was decreased and increased in an attempt to maintain a good labor pattern which stretched out the time period. Pt. was monitored. The fetal tracings were fine. An IUPC is optional. It appears the pitocin was used maximally so it would not have made any difference. The lack of notes during labor and pre-op note is an opportunity for correction, but the doctor was clearly there and involved. Pre-op rationale was included in the Op Note. Decisions were appropriate. The nurses did not complain of being unable to reach the doctor. The baby was 9 pounds, 5 ounces with Apgars of 9/9. The Post Op course was excellent.

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. Zweibach: The 33 wk BPP was done at a one time clinic visit. BPP is an effective test of feto-placental function like the NST. The prenatal record does say LTCD. In any case, ACOG allows TOL with unknown scar per practice bulletin 115 (TOLAC is not contraindicated for women with previous cesarean delivery with an unknown uterine scar type unless there is a high clinical suspicion of a previous classical uterine incision.)

The decelerations were apparently when dilated and pushing, with patient imminently delivering, as patient was given meds by anesthesia to improve the heart rate. Generally if the poor fetal tracing was due to uterine rupture, contractions disappear and vertex no longer in pelvis. This was not the case. It appears that the doctor was at the bedside, likely encouraging pushing and rapid delivery in the face of fetal decelerations. One would not expect her to be at a nursing station writing notes.

As for uterotonics, in our practice we often give cytotec by verbal order in the immediate peripartum period when a nurse reports excessive bleeding. If the patient does not respond the doctor returns. A note may never be written addressing this specific interchange. Often the choices of medications are related to which ones the nurse may be able to administer quicker. Overall I think the case was excellently managed although a more detailed delivery note might have been helpful. There was a good outcome with Apgars of 7/9.

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. Zweibach: This patient was sick. Consultants were appropriately called. The tests questioned by the reviewer were ordered by the consultants. The Credentials Committee found the use of the consultants was OK. The reviewer questions the diagnosis, testing and treatment of the consultants and holds Dr. Dinsmore responsible to educate them. I believe this is beyond any discussion on the doctor's management of her patient which appears to have been appropriate.

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. Zweibach: No explanation given by reviewer as to "poor documentation." There is a VBAC consent with documented scar. There is an admit note at 9 PM and delivery at 3 AM. Uneventful labor so would not expect note during labor. Good outcome. Legible handwriting. I do not see any problems.

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. Zweibach: The clindamycin order seemed to be a communication error as it was ordered correctly by Dr. Dinsmore initially, then there is a verbal order for clindamycin 2 hrs later. There is an admit note at 7 PM. It appears that a cesarean section was called at 0930 the next morning with the intention of doing it several hours later. The op note includes the pre-op rationale which states that there were periods of minimal variability and lack of accelerations and failure to progress in labor. It is difficult to tell from the nurses notes and monitor strips when membranes were ruptured and how much pitocin was used and when. The doctor reports being advised of decreased variability by the nursing staff but no decelerations. The case appears to show room for improvement in documenting labor progress, possibly using an IUPC to document labor, and performing cesarean section more timely. Nevertheless, there was a long labor and it appears that pitocin was used to its best ability, so a cesarean section was done appropriately. Although there was a delay in doing the cesarean after the decision was made the fetal strip never became a category III strip mandating delivery right away and there was a good outcome for mother and baby.

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. Zweibach: The monitor strips are incomplete but per nursing labor notes, after the initial 2 minute decel following epidural and associated with vomiting, pt. had category II decels and progressed to complete and pushing within 3 hours. MD present during pushing and when decels were obviously repetitive and delivery was not imminent, which was a relatively short period of time, a stat c/s was done. Care was excellent as was outcome, Apgars 7/9. Lack of pre-op note can be faulted, but as the admit note was only 3 hrs earlier I wouldn't expect a labor progress note. The dictated Op Note included a "rationale for surgery."

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. Zweibach:

1. Strip was intermittently non-reassuring. Although the nurses told the MD, they did not communicate a sense of urgency or at least the MD did not perceive that. When called at 5:21 she came in within the required 30 minutes response time and called the c/s by 5:59. At that point, c/s could have been more urgent, given hospital and anesthesia limitations. The reviewer referred to the 30 minute rule.

2. The reviewer suggested amnioinfusion should have been done. This is controversial. In fact at Brandon Regional Hospital it is contraindicated by our neonatologist in the presence of thick meconium as they feel it will loosen the meconium and make it more likely to be aspirated.

3. It is very hard to tell what happened regarding use of pitocin during the labor due to poor legibility of the labor notes and lack of times on the monitor strips. Severe decelerations were intermittent, so pitocin may have been used on and off. Pitocin not documented except 3 mu at 6:50 pm, so it was likely not used extensively?

4. The Ob/Gyn is not expected to look below the cords. Lack of rationale for thrombophilia profile may be an item for discussion. The doctor ordered it as the cord blood seemed to clot quickly. This may be a documentation question, but <u>does not</u> reflect care below the standard of care.

5. It seems that there was some disconnect between the staff and the physician in reviewing and communicating the monitor strip and/or the use of pitocin. Nowhere do the nurses express concern that the doctor has not come. Probably they did not communicate urgency to the doctor. I think this case might be used to place focus on developing a better pitocin protocol and nurse education as well as review with doctor regarding when it is urgent and when it's not. This would be a good case for the hospital to review, along with the VBAC cases and request an ACOG review through ACOG's Voluntary Review of Quality of Care program. I don't think the issues are so simple as removing Dr. Dinsmore. I don't think that will solve the problems with monitor strips, VBACs and timely c-sections.

<u>Patient #12</u>

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 primary 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. Zweibach: Reviewer says VBAC should have been done 4 hours earlier. Facility, consent issues. Patient had VBAC consent done in office on 05/30/11, consent was provided, counseling documented on prenatal record as part of hosp chart. Dr. Dinsmore's admit note documents “approved for VBAC.” No consent on chart at all. Notes from NP at 23:00 (Dr. Dinsmore present) and at 01:30 with Dr. Dinsmore and again at 05:30 with note. Yes, the c/s could have been done earlier, but there was no fetal indication for urgency and no adverse outcome. As noted above, there is no requirement to do the c/s as soon as the cervix stops dilating, or “falls off the Friedman labor curve.” In fact, often the conservative doctor waits longer for the possibility that vaginal delivery might happen. This is encouraged by ACOG I believe. Also, in the real world, c-sections don’t always get done immediately, as long as the baby is OK. There may be another c-section tying up the OR, change of shifts, anesthesia issues, etc. The lack of a hospital consent and reviewer’s concerns about resources, 24 hr anesthesia and blood banking are criticisms of the facility not the doctor. The facility should probably have it's VBAC protocol reviewed/revamped. This was a good outcome for the 10-1/2 pound baby and it's mother.

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. Zweibach: Pt. came through ER and managed by midwifery service. Dr. Dinsmore consulted at time of difficult delivery. Dr. Dinsmore had admit note, labor note and delivery note. Reviewer does not explain what his documentation concerns are. It looks well documented to me.