

“It’s not bad people, it’s bad systems”



By Brent Kinney, J.D.

“It’s not bad people, it’s bad systems.” - Lucian L. Leape, MD^[1]

Samantha Taylor^[2] was a 33-year-old female who had been a patient of Main Street Obstetrics (MSO), a Maternal Fetal Medicine practice, intermittently since 2018. Prior to the birth at issue, Ms. Taylor gave birth to three children (2009, 2019, and 2020). MSO was involved in the 2019 and 2020 deliveries.

For the pregnancy at issue, Ms. Taylor was initially seen at MSO via a telehealth visit on April 13, 2021, by Daryl Cadeau, MD, a Maternal Fetal Medicine (MFM) specialist. Ms. Taylor was referred to MSO by her primary obstetrician, Antonia Garcia, MD, for IgA deficiency, asthma, short intervals between pregnancies, obesity, history of recurrent pregnancy loss, and recurrent urinary tract infections. Dr. Garcia’s employer, Local Obstetrics and Gynecology (LOG), had a relationship with MSO whereby MSO’s MFMs provided telehealth services for LOG’s patients who had high-risk pregnancies, which

reduced the number of out-of-town visits the patients needed to make.

In all, Ms. Taylor had a total of seven telehealth visits with three different MFMs at MSO. During the telehealth visit with MSO on October 13, Dr. Cadeau scheduled Ms. Taylor's induction for October 28 at Downtown University Hospital (DUH). On that same day, October 13, MSO faxed Ms. Taylor's medical records to DUH. Ms. Taylor's last telehealth visit with MSO was on October 20 with Margaret Washington, MD.

Ms. Taylor also had a Group B Streptococcus (GBS) culture test performed on October 20, which was ordered by Dr. Garcia. The GBS test resulted on October 22, and it indicated that GBS was detected. A fax confirmation sheet from Dr. Garcia's office indicates the GBS test result was successfully faxed to MSO on October 25.

Ms. Taylor presented to DUH on October 28 for the scheduled induction^[3], at which time she was reported as an unknown GBS status. Accordingly, a PCR test was performed, and it returned negative for GBS. Based on that result, Ms. Taylor was not given intrapartum antibiotics. The baby (K.T.) was delivered vaginally on October 29. The delivery appeared to go smoothly with APGARS of 9 and 9. The next day, unfortunately, K.T. was found unresponsive on her mother's chest. Aggressive resuscitation followed, but K.T. was diagnosed with, among other things, hypoxic ischemic encephalopathy, respiratory failure, seizure activity, and GBS sepsis. K.T.'s prognosis was poor at the time of discharge.

Over the following months and years, K.T. has received neurology, orthopedic, and cardiology care. K.T. has also received occupational, physical, and speech therapy. K.T.'s continuing diagnoses include spastic cerebral palsy, complex partial epilepsy, and swallowing dysfunction.

At this point, I am sure you are asking – if MSO received a fax with a test result showing that Ms. Taylor tested positive for GBS, then why was she reported as an unknown GBS status and why wasn't she given intrapartum antibiotics? The unfortunate reality is that MSO's system of handling incoming lab and test results had some glaring defects that became evident during the discovery phase of this case. Due to these defects, none of the MFMs at MSO were aware of Ms. Taylor's positive GBS test result at any time prior to her induction and delivery.

First, discovery revealed that when an MFM at MSO ordered a lab or test, the result was placed in the respective MFM's personal "bucket" and, if abnormal, it was marked "high." On the other hand, if the result was from a lab or test ordered by an outside provider, the result was filed as a "referral record" and assigned to the last MFM who saw the patient. However, MSO's system had no mechanism to alert or notify the MFM that a "referral record" had been assigned to him or her; instead, the MFM would not see the "referral record" until opening the patient's chart during the next office visit.

In this case, and pursuant to MSO's system, MSO's medical records clerk filed the GBS test result as a "referral record" and assigned it to Dr. Washington since she was the MFM who saw Ms. Taylor on October 20, the date of Ms. Taylor's last prenatal visit with MSO.

Since MSO's system did not provide for a mechanism to alert or notify Dr. Washington of this new "record referral" being assigned to her, she would not have seen it until accessing Ms. Taylor's chart during the next office visit. Unfortunately, Ms. Taylor did not have another office visit prior to the scheduled induction and delivery. Furthermore, Dr. Washington was not involved in Ms. Taylor's induction and delivery.

The other defect in MSO's system was that there was no mechanism for dealing with outside lab and test results received between the period of a patient's medical records being transmitted to the hospital and the scheduled delivery date. In this case, MSO transmitted Ms. Taylor's medical records to DUH on October 20. Five days later, MSO received the fax showing that Ms. Taylor had tested positive for GBS; however, there was no mechanism in place to have this critical test result transmitted to DUH since Ms. Taylor's medical records had been transmitted on a prior date. Even if the MFM supervising the induction and delivery had remotely accessed MSO's electronic medical records on October 27 or 28, it is unlikely the MFM would have seen the positive GBS test result since a "referral record" did not become a part of the patient's official medical chart until it was opened and reviewed by the MFM to whom it was assigned. Since Dr. Washington never opened and reviewed the "referral record," the GBS test result was never a part of Ms. Taylor's official medical chart at MSO.

This was a case in which there was no standard of care defense for MSO. This was a system failure by MSO that simply could not be defended. All defense experts agreed that, at the very least, MSO needed a process for channeling critical lab and test results to the immediate attention of an MFM. As Dr. Leape stated, "it's not bad people, it's bad systems." Ultimately, MSO settled before trial, as did Dr. Garcia and his employer, LOG.^[4]

^[1] Lucian L. Leape, MD was an American pediatric surgeon and academic, who became one of the world's foremost experts on preventing medical errors.

^[2] All names have been changed to protect the identities of the parties.

^[3] One of MSO's MFMs, who was not involved in any of Ms. Taylor's prenatal telehealth visits, supervised resident care of the induction and delivery in this case.

^[4] The main concern for Dr. Garcia and LOG is that they too did not send the positive GBS test result to DUH, and Dr. Garcia's medical records do not indicate that he discussed the positive GBS test result with Ms. Taylor.

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