

— OBSTETRIC LITIGATION

Minutes That Matter

Obstetric Emergencies Under the New Federal Hospital Standards

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Obstetric cases are some of the hardest in medicine and in law. A healthy woman comes in to have a baby, and within an hour she's bleeding faster than anyone can replace it. The injuries are often permanent, the timelines are measured in minutes, and the families are left grieving at what should have been the best day of their lives.

What's new is the rulebook. In November 2024, CMS finalized the first federal hospital standards written specifically for obstetric services and obstetric emergency readiness. They're phasing in from 2025 through 2027, and they create documents and expectations that didn't formally exist before.

Two other facts sit behind this. First, access is shrinking. March of Dimes has reported that roughly a third of U.S. counties are maternity care deserts, with no hospital offering obstetric care and no obstetric clinicians. When labor and delivery units close, pregnant and postpartum women in trouble end up in emergency departments that don't see them often. Second, when state maternal mortality review committees look at pregnancy-related deaths, they keep concluding that most could have been prevented. CDC's review of committee data for 2017 through 2019 put the figure above 80 percent. Preventability is exactly what a lawsuit asks about.

WHAT THE NEW STANDARDS REQUIRE

Since July 1, 2025, every hospital and critical access hospital with an emergency department, whether or not it delivers babies, has had to keep protocols for obstetric emergencies, complications, and immediate post-delivery care that follow nationally recognized guidelines. It has to have the supplies and equipment to handle those emergencies, train relevant ED staff on the protocols every year, and have transfer protocols in place.

Since January 1, 2026, hospitals that provide obstetric services have had to meet a new obstetrical services standard. The service has to be organized and run to nationally recognized standards, integrated with the rest of the hospital, and supervised by qualified people. The hospital has to keep a roster of practitioners and their privileges. Labor and delivery rooms need a call-in system, a cardiac monitor, and a fetal Doppler or monitor, and there have to be protocols for obstetric emergencies and complications.

Starting January 1, 2027, obstetric services will need a quality improvement program that looks at outcomes by patient subgroup and runs at least one maternal health improvement project a year, along with regular training for obstetric staff that builds in what the quality data show.

For attorneys, the practical upshot is a list of things the hospital should be able to hand over: its obstetric emergency protocols, the ED readiness protocols, training records, equipment checks, transfer agreements, and the privilege roster. Whether those existed, what they said, and whether anyone followed them are all fair questions. How they bear on the standard of care in your jurisdiction is a legal question.

A FICTIONAL CASE

A woman has an uncomplicated vaginal delivery at a community hospital. About 90 minutes later her nurse finds the pad soaked, massages her uterus, and calls the physician. Over the next hour her heart rate climbs, she goes pale, and she gets anxious. Blood loss is charted as “estimated.” Blood is ordered, but it takes time to come up. By the time she gets to the OR she’s lost a great deal of blood, and she needs a hysterectomy. She lives, with lasting consequences.

RECOGNIZING HEMORRHAGE

ACOG defines postpartum hemorrhage as cumulative blood loss of 1,000 mL or more, or any blood loss with signs or symptoms of low blood volume, within 24 hours of birth, whatever the route of delivery.

The trouble is that people are bad at eyeballing blood. Visual estimates consistently come in low, which is why so many hospitals have moved to quantitative blood loss: weighing pads and measuring what’s collected. So one of the first things to ask is how her blood loss was measured, and whether that matched the hospital’s own protocol.

Vital signs can fool you too. Young, healthy women compensate well, and blood pressure may hold until very late. A rising heart rate is often the earlier warning. Some protocols use the shock index, heart rate divided by systolic pressure, to catch this. If the hospital used a maternal early warning system, did anyone apply it? Did it trigger? What happened next?

THE RESPONSE

The Alliance for Innovation on Maternal Health's safety bundles break hemorrhage care into readiness, recognition, response, and reporting. Most hospitals now use staged hemorrhage protocols that escalate as blood loss climbs, and massive transfusion protocols to get blood out fast.

The case lives in the timeline. When did someone first recognize excessive bleeding? When was the physician called, and when did the physician actually see her? When were the uterotonics given (oxytocin, methylergonovine, carboprost, misoprostol), and in what order? Was tranexamic acid considered? When did the protocol stage go up, and was massive transfusion activated? When was blood requested, released, and hung? When was the decision made to go to the OR, and when did surgery start?

Measure each gap against the protocol and against what her condition called for at that moment. A slow blood delivery might be a blood bank problem, a failure to activate the protocol, or a reasonable call based on what people knew then. You have to find out which.

SEVERE HYPERTENSION

Preeclampsia and its relatives can cause stroke, seizures, abruption, and organ damage. ACOG's guidance is to treat acute-onset severe hypertension, a systolic of 160 or higher or a diastolic of 110 or higher that persists on a repeat reading (usually within 15 minutes), with a first-line drug such as IV labetalol, IV hydralazine, or immediate-release oral nifedipine, as soon as reasonably possible and ideally within 30 to 60 minutes. Magnesium sulfate is used to prevent seizures in preeclampsia with severe features.

Every blood pressure should be in the record with a time, along with when the clinician was told and when the medication went in. Postpartum women need particular attention, because severe hypertension can show up days after delivery, often after they've gone home. What she was taught at discharge, and whether she was told when to come back, can matter a great deal.

WHEN SHE SHOWS UP AT AN ED WITHOUT AN OB UNIT

Under the 2025 standard, emergency departments have to be ready for this even if their hospital doesn't deliver babies. A woman a week postpartum with bleeding, a crushing headache, blurry vision, or trouble breathing may walk into the closest ED. Did it have obstetric emergency protocols? Had the staff been trained? What medications and blood were on hand? How was transfer handled? EMTALA's labor provisions apply as well.

THE RECORD GETS WRITTEN AFTER THE EMERGENCY

When a woman is hemorrhaging, nobody is charting in real time except, if the unit is well run, a designated recorder. Most of the narrative is written afterward. So build the timeline from every source that stamps its own time: the recorder's sheet or hemorrhage flowsheet, the MAR and the automated dispensing cabinet log, the blood bank's request, crossmatch, and release log, the anesthesia record and OR log, lab collection and result times, and the fetal monitoring strip in its native electronic format with its annotations.

Machine timestamps are usually more reliable than a note written hours later. Late entries aren't automatically suspect, but they can carry hindsight, so note when they were written.

STAFFING

AWHONN publishes nurse staffing guidelines for perinatal units, including closer ratios in the first hours after birth. They're professional guidelines, not federal law, though some states have their own requirements. How many patients did her nurse have when the bleeding started? Was a second nurse free to help? Was the physician in the building or driving in? Those facts can explain a delay without anyone having to assume one.

CAUSATION

Tying a deviation to the outcome takes a qualified specialist, often maternal-fetal medicine, obstetric anesthesia, or general obstetrics. Would earlier recognition have avoided the hysterectomy? Would faster treatment of the blood pressure have prevented the stroke? Some obstetric emergencies get worse despite everything going right, and a fast, protocol-driven response deserves as much space in the analysis as a delay does.

RECORDS WORTH REQUESTING

- The prenatal record and risk assessments
- The labor and delivery record, fetal monitoring in native format, and postpartum flowsheets
- MAR, dispensing cabinet logs, blood bank logs, anesthesia record, and operative report
- Labs with collection and result times
- The hospital's hemorrhage, hypertension, and obstetric emergency protocols in effect that day
- ED obstetric readiness protocols and training records, for ED presentations
- Staff training and competency files and equipment check logs
- Transfer agreements, transfer protocols, and the privilege roster
- Unit staffing assignments and census

SOURCES

- CMS, CY 2025 OPPS/ASC Final Rule (Nov. 2024), obstetrical services and emergency services readiness Conditions of Participation
- ACOG Practice Bulletin No. 183, *Postpartum Hemorrhage* (2017); ACOG Committee Opinion No. 767, *Emergent Therapy for Acute-Onset, Severe Hypertension During Pregnancy and the Postpartum Period* (2019)
- CDC, *Pregnancy-Related Deaths: Data from Maternal Mortality Review Committees in 36 U.S. States, 2017–2019*
- Alliance for Innovation on Maternal Health, Obstetric Hemorrhage and Severe Hypertension patient safety bundles
- March of Dimes, *Nowhere to Go: Maternity Care Deserts Across the U.S.* (2024)
- AWHONN, *Standards for Professional Registered Nurse Staffing for Perinatal Units*

This newsletter is for education only and isn't medical or legal advice or a clinical protocol. The case is fictional.

ABOUT LEXCURA CLINICAL INTELLIGENCE

Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have an obstetric emergency case and want the timeline rebuilt from every timestamped source and measured against the hospital's protocols and the new federal standards, we'd welcome the conversation.

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