Unnecessary laparotomy: $625,000 award

A WOMAN IN HER 20S reported cramping and rectal bleeding to her ObGyn. Pelvic and rectal examinations were normal. Her family physician's exam and a gastroenterologist's rectal exam and colonoscopy were all normal. A radiologist (Dr. A) identified a 3-cm by 6-cm mass on transvaginal ultrasonography. A computed tomography (CT) scan read by another radiologist (Dr. B) confirmed the mass. After receiving the radiologists' reports, the ObGyn told the patient that she had a small tumor that needed immediate removal. No mass was found during exploratory laparotomy.

Three years postsurgery, after trying to conceive, the patient underwent exploratory laparoscopy to evaluate her fallopian tubes. A surgeon found significant pelvic adhesions occluding the left fallopian tube. He lysed the adhesions and resected the left fallopian tube.

PATIENT'S CLAIM: The patient sued the ObGyn and both radiologists, alleging that the unnecessary surgeries resulted in reduced fertility.

Postoperatively, the ObGyn told the patient that the surgery, performed for "nothing," was the radiologists' fault, and that she would have no trouble conceiving. He later blamed her fallopian tube damage on a diagnosis of chlamydia that was successfully treated years earlier with no evidence of reinfection.

The ObGyn disregarded Dr. A's recommendation for a CT scan with rectal contrast; instead he ordered oral contrast. The ObGyn also ignored Dr. B's recommendation for magnetic resonance imaging (MRI).

The mass misidentified by the radiologists was described in 2 different places on the anterior wall of the bowel, both outside the purview of a gynecologist. Given the uncertain diagnosis, referral to a general surgeon was mandated; exploratory laparotomy was not indicated. The ObGyn never referred the patient to a general surgeon for evaluation or sent records or films to the surgeon whom he claimed to have consulted before surgery. The general surgeon denied that any such discussion occurred. The surgeon's first contact with the patient occurred when he was called into the operating room because the ObGyn could not find a mass; the patient was under anesthesia and her abdomen was open.

DEFENDANTS' DEFENSE: The ObGyn claimed that he had developed a plan with the general surgeon before surgery: if the mass was a uterine fibroid, he would remove it, but if the mass was mesenteric, the surgeon would operate.

The ObGyn was justified in performing surgery based on the patient's complaints and the radiologists' findings.

The radiologists contended that, since neither of them expressed certainty, both requested further studies, and neither suggested surgery, their treatment was consistent with the standard of care.

VERDICT: A $625,000 Pennsylvania verdict was returned, finding the ObGyn 100% liable.

Brachial plexus injury: permanent disability

AFTER CONCERNING TEST RESULTS, a woman went to the hospital for induction of labor. During vaginal delivery, a shoulder dystocia was encountered. The baby was born within 60 seconds using the McRoberts maneuver and suprapubic pressure. The ObGyn charted mild shoulder dystocia.

The child has decreased mobility of his left arm. MRI studies and surgical findings confirmed brachial plexus rupture and avulsion at C5–C7. Despite nerve grafting, the child has a significant disability to his left arm and shoulder.

PARENT'S CLAIM: The ObGyn negligently applied excessive lateral traction, improperly used lateral traction as a maneuver, and instructed the mother to continuously push.

PHYSICIAN'S DEFENSE: Shoulder dystocia was properly diagnosed and resolved using standard maneuvers. Traction and pushing are needed during shoulder dystocia management to determine whether the maneuvers are successful. Brachial plexus injuries can occur because of the normal forces of labor and delivery.

VERDICT: An Illinois defense verdict was returned.

Both ureters injured during TAH

A 49-YEAR-OLD WOMAN UNDERWENT total abdominal hysterectomy (TAH)

These cases were selected by the editors of OBG Management *from* Medical Malpractice Verdicts, Settlements, & Experts, *with permission of the editor, Lewis Laska (www.verdictslaska.com). The information available to the editors about the cases presented here is sometimes incomplete. Moreover, the cases may or may not have merit. Nevertheless, these cases represent the types of clinical situations that typically result in litigation and are meant to illustrate nationwide variation in jury verdicts and awards.*

PHOTO: ISTOCK

for removal of a uterine fibroid performed by her gynecologist and a surgical assistant. The patient had limited urine output immediately after surgery, no urinary output overnight, and abdominal pain. The gynecologist ordered a urology consultation. A CT scan showed bilateral ureteral obstruction; an interventional radiology study confirmed a blockage due to severance of both ureters. A nephrostomy was performed and, 6 weeks later, the ureters were reimplanted.

PATIENT'S CLAIM: The severing of both ureters was a negligent surgical error. While the risk of injuring a single ureter is a recognized complication of TAH, it is unacceptable that both ureters were severed.

DEFENDANTS' CLAIM: Standard of care was met: bilateral ureteral injury is a known risk of TAH. Before surgery, the patient was fully informed of the risks and signed a consent agreement. There was no intraoperative evidence that the ureters had been damaged. The injuries were detected as soon as medically possible and timely and successfully treated.

VERDICT: An Illinois defense verdict was returned.

Failure to detect breast cancer: $21.9M verdict against radiologist

A WOMAN WENT to a diagnostic imaging service for ultrasonography (US) after an earlier US was suspicious for a breast mass. She had a history of left breast pain and swelling that had been treated with antibiotics. The radiologist interpreted the second ultrasound as showing no masses; he noted skin thickening and a lymph node abnormality.

Nine months after initial US, the patient had a breast biopsy performed in another state. She was diagnosed with stage 3 breast cancer.

PATIENT'S CLAIM: The radiologist failed to properly interpret the findings of the second ultrasound.

PHYSICIAN'S DEFENSE: The radiologist contended that he was not liable because the technologist failed to place the transducer over the breast lump. The first US films were not provided for comparison.

VERDICT: A $21.9 million Florida verdict was returned.

Mother claims PTSD after twin's stillbirth

EXPECTING TWINS, a 23-year-old woman at 33.5 weeks' gestation reported pain. The ObGyn noted that her cervix was 4-cm dilated, 1 twin was in breech position, and that labor had begun. He recommended that the patient go to the hospital for cesarean delivery but told her that she could go home, shower, and gather her belongings first. When the mother arrived at the hospital 2.5 hours later, the fetal heart-rate (FHR) monitor indicated that one twin's heart was not active. An emergency cesarean delivery was performed. One twin was safely born, but the other died.

PARENT'S CLAIM: The ObGyn failed to properly address the onset of labor. The twin died because of compression of the umbilical cord. If the mother had gone directly to the hospital, FHR abnormalities would have been apparent and timely intervention could have been taken.

The stillbirth caused the onset of severe emotional distress in the mother leading to posttraumatic stress disorder (PTSD). She had extensive counseling. Her psychologist reported that the patient also suffered from complex grief disorder.

PHYSICIAN'S DEFENSE: The ObGyn's actions did not cause the injury. The twins' hearts were monitored at the last prenatal examination and were normal. It was appropriate for the ObGyn to allow the patient to return home before going to the hospital; the situation was urgent but not emergent. The stillbirth resulted from chorioamnionitis, a microscopic condition that is difficult to detect. A pathologist confirmed the diagnosis after examining the placenta.

The extent of the patient's grief was contested. An expert psychiatrist reported that complex grief disorder is not a recognized medical condition, and that, upon his examination, the patient did not exhibit PTSD symptoms.

VERDICT: A New York defense verdict was returned.

Vesicovaginal fistula after hysterectomy

A 39-YEAR-OLD WOMAN with a history of 4 cesarean deliveries and an enlarged fibroid uterus underwent TAH. She subsequently developed urinary incontinence.

PATIENT'S CLAIM: The ObGyn used an inappropriate dissection technique to remove the uterus, causing a bladder injury. He also sutured the vaginal cuff to the bladder, causing the formation of a vesicovaginal fistula. Repair surgeries were unsuccessful and the patient now is permanently incontinent.

PHYSICIAN'S DEFENSE: The standard of care was met. The patient had a preexisting bladder weakness due to the size of her uterus and prior surgeries. The bladder injury is a known complication of the surgery. The vaginal cuff adhered to the bladder due to postsurgical scarring or fibrosis.

VERDICT: A Michigan defense verdict was returned. ●