Delay in delivery—mother and child die: $1.4M settlement

RESULTS OF ULTRASONOGRAPHY on January 8 identified placenta accreta and placenta previa in a woman at 36 weeks of gestation. On January 14, she was referred to a university medical center for treatment. Instead of scheduling a prompt delivery, the ObGyns sent her home with a plan to deliver her at 39 weeks. Nine days later, the mother collapsed at home. She was taken to a nearby hospital, where an emergency cesarean delivery was performed. She died after delivery. The baby was profoundly acidotic and asphyxiated and died 10 months later.

ESTATE'S CLAIM: The standard of care for placenta accreta requires delivery between 34 and 36 weeks of gestation. The mother died from a placental abruption and amniotic fluid embolism. Placenta accreta increases the risk of catastrophic hemorrhage. If delivery had occurred on January 14, both the mother and child would be alive.

DEFENDANTS' DEFENSE: The case settled before trial.

VERDICT: A $1.425 million Georgia settlement was reached. The settlement amount was limited by a damages cap unique to the defendant hospital.

Woman dies after robotic hysterectomy: $5M verdict

WHEN A 36-YEAR-OLD WOMAN underwent robotic hysterectomy, the gynecologist inserted a plastic trocar and sleeve through the patient's umbilicus to access the abdominal cavity at 7:30 AM.

The certified registered nurse anesthetist (CRNA) noted a significant abnormality in the patient's vital signs at 8:07 AM and administered medication and fluids to treat a suspected blood loss. When the patient's heart rate became extremely elevated at 8:25 AM, the CRNA administered another drug, which failed to bring the patient's heart rate down. At 8:37 AM, the monitoring machine could not record the patient's blood pressure. The CRNA informed the surgeon of the patient's condition. The supervising anesthesiologist was called; he arrived at 8:45 AM and determined that the patient was bleeding internally. He asked the surgeon if he could visualize any bleeding; the surgeon could not.

The patient's condition continued to deteriorate. At 9:05 AM, her blood pressure was still undetectable on the monitor. A Code Blue was called at 9:30 AM. Exploratory surgery and blood transfusions begun at 9:43 AM were not able to counteract the patient's massive blood loss. After cardiac arrest, she was pronounced dead at 11:18 AM.

ESTATE'S CLAIM: The surgeon was negligent in lacerating the left common iliac artery when inserting the trocar, and in not detecting the injury intraoperatively.

The anesthesia staff was negligent. The CRNA did not inform the surgeon until the situation was dire. A simple procedure could have been performed at any time to check the patient's hematocrit and hemoglobin levels, but that was not done until 9:30 AM. If the severity of the patient's condition had been determined earlier, blood transfusions and further treatment could have saved her life.

DEFENDANTS' DEFENSE: There was no negligence on the part of the surgeon or anesthesia team. The standard of care was met. Arterial laceration is a known risk of the surgery.

VERDICT: A $5,008,922 Illinois verdict was returned against all defendants except the CRNA.

Placental abruption not detected: $6.2M settlement

AT 24 WEEKS OF GESTATION, a mother presented to the hospital with premature contractions that subsided after her arrival. She was discharged from the hospital. The woman gave birth in her bathtub several hours later. The baby was 10 weeks premature. He suffered profound brain damage and has significant physical defects.

PARENT'S CLAIM: Neither the ObGyn nor the hospital staff appreciated that the mother was experiencing placental abruption. If diagnosed, treatment could have prevented fetal injury.

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.*

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PHOTO: SHUTTERSTOCK

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DEFENDANTS' DEFENSE: The case was settled prior to trial.

VERDICT: A $6.2 million New York settlement was reached.

A woman with MS becomes incontinent after surgery

A 43-YEAR-OLD WOMAN with multiple sclerosis (MS) underwent a hysterectomy performed by a gynecologic surgeon. During surgery, the patient's ureter was injured, requiring additional surgery. The patient is now permanently incontinent.

PATIENT'S CLAIM: During surgery, the surgeon constricted the ureter with stitches. A second surgery was needed to remove the stitches and reimplant the ureter. The second surgery left her permanently incontinent. Although incontinence is a known complication of the second surgery, the second surgery would not have been necessary if the surgeon had not injured the ureter during the first surgery. Incontinence was not a result of her MS as she was not incontinent before the second surgery.

DEFENDANTS' DEFENSE: There was no deviation from the standard of care. There was no stitching around the ureter. The ureter was damaged by kinking, which was addressed during the second surgery. Incontinence was a result of her MS.

VERDICT: A $700,000 South Carolina verdict was returned.

Child has brachial plexus injury: $2M award

A WOMAN WAS ADMITTED to the hospital for elective induction of labor. She gained a significant amount of weight while pregnant. During delivery, her family practitioner (FP) determined that vacuum extraction was needed but he was not qualified to use the device. An in-house ObGyn was called in to use the vacuum extractor. The FP delivered the baby's shoulders. The infant was born with a floppy right arm and later diagnosed with rupture injuries to the C-5 and C-6 vertebrae and permanent brachial plexus damage. She has limited range of motion in her right arm and shoulder.

PARENTS' CLAIM: The FP was relatively inexperienced in labor and delivery. He should not have ordered vacuum extraction because of risk factors including the mother's small stature, her significant weight gain during pregnancy, the use of epidural anesthesia, and induction of labor. Using vacuum extraction increases the risk of shoulder dystocia.

The FP improperly applied excessive downward traction on the fetus causing the infant to sustain a brachial plexus injury.

The FP did not notify the parents of the child's injury immediately after birth; he told them about the injury just before discharge.

DEFENDANTS' DEFENSE: There is no evidence in the medical records of a shoulder dystocia; "no shoulder dystocia" was charted shortly after delivery. No one in the delivery room testified to a delay in delivering the infant's shoulders. The mother's internal contractions caused the injury. The baby was not injured to the extent claimed.

VERDICT: The ObGyn who used the vacuum extractor settled before the trial for $300,000. A $2 million Illinois verdict was returned against the FP.

Bowel injury during robotic procedure: $6.25M settlement

A WOMAN IN HER LATE 60S reported minor urinary incontinence to her gynecologist. She underwent robot-assisted laparoscopic hysterectomy with a sling procedure for pelvic prolapse. During the sling procedure, the transverse colon was injured. The patient developed sepsis, requiring multiple attempts at surgical repair, including colostomy. The patient requires a permanent colostomy. She has a malabsorption disorder and needs frequent intravenous treatment for dehydration.

PATIENT'S CLAIM: The surgeon failed to properly control the robotic device, causing injury to the patient's bowel. The surgeon deviated from the standard of care by failing to convert from the robot-assisted laparoscopic procedure to an open procedure when complications arose. The injury was not properly treated before the surgeon closed the initial surgery, causing the patient to develop sepsis.

PHYSICIAN'S DEFENSE: The surgeon claimed that the injuries and resulting sepsis were the fault of other physicians and hospital staff. The case settled during trial.

VERDICT: A $6.25 million New Jersey settlement was reached.

Delay in treating infant in respiratory distress: $7.27M settlement

A CHILD WAS DELIVERED by a certified nurse midwife at a birthing center. At birth, the baby had a heart rate of 60 bpm and was in respiratory distress but there was no one at the

clinic qualified to intubate the infant. Emergency personnel were called but the infant remained in respiratory distress for 8 minutes. The baby experienced birth asphyxia with hypoxic ischemic encephalopathy resulting in severe cerebral palsy.

PARENTS' CLAIM: The birthing center was poorly staffed and unprepared to treat an emergency situation.

DEFENDANTS' DEFENSE: The defendants denied all allegations of negligence. The case was settled during trial.

VERDICT: A $7.27 million Pennsylvania settlement was reached.

Hydrothermal ablation led to genital burns

A WOMAN SAW AN OBGYN on October 2 to report menorrhagia. She had been treated for uterine fibroids with a Mirena intrauterine device and hydrothermal ablation. Another physician had suggested hysterectomy, which she declined.

When the ObGyn found that the patient had an enlarged uterus, he ordered ultrasonography and an endometrial biopsy. On follow-up, the ObGyn provided options of robotic hysterectomy or operative hysteroscopy with hydrothermal ablation. The patient chose hysteroscopy and the procedure was scheduled for December 28.

During surgery, an improper seal to the cervix around the hydrothermal ablation sheath was detected before heating the fluid. A tenaculum and 2 sponges were placed on the cervix to help form a seal and the fluid was heated for 4 minutes. The procedure was aborted when fluid was seen to be leaking again. Instruments were removed after a cooling period. The patient was discharged from the surgery center the same day with a prescription for oral hydrocodone bitartrate and acetaminophen for pain.

On January 4, the patient reported severe vulvar pain. The ObGyn found thermal burns on both labia with possible cellulitis. He prescribed silver sulfadiazine cream twice daily, levofloxacin 500 mg for 7 days, and warm-water soaks. When the patient called to report continued pain on January 7, the hydrocodone and acetaminophen prescription was renewed. On January 8, the ObGyn found continued evidence of labia and introitus burns with no signs of infection. The patient was told to continue taking the oral pain medication and to apply topical lidocaine gel and silver sulfadiazine cream.

Examinations on January 11, 17, 24, and 31 showed continued evidence of active healing. When new evidence of vulvar ulceration with inflammation and infection appeared, supportive care and antibiotics were given. On February 7, granulation tissue had developed at the introitus with continued healing.

On March 27, she saw a gynecologist for dyspareunia. The skin was healed but a tender band of scar tissue was noted at the burn site. She was referred for physical therapy and given estradiol vaginal cream.

On December 11, the patient reported dyspareunia and depression to the gynecologist, who prescribed medication for depression and referred her to counseling.

PATIENT'S CLAIM: The ObGyn was negligent in failing to maintain a proper seal around the hydrothermal ablation shield. The patient sustained second-degree burns to her genital area from the hot saline solution that leaked from the uterus. The injury caused lasting dyspareunia and depression.

PHYSICIAN'S DEFENSE: There was no negligence. Once the ObGyn realized that the seal was incomplete, the procedure was stopped and the fluid cooled before being released. Burns were treated within the standard of care.

VERDICT: A Texas defense verdict was returned based on a no-evidence partial summary judgment: neither the patient nor the expert witness supplied evidence to support the claims of gross negligence or exemplary damages against the ObGyn.

Was the spinal block given at wrong level?

A MOTHER WENT TO THE HOSPITAL in labor. Prior to cesarean delivery, she underwent an anesthetic spinal block administered by a CRNA. Initially, the patient reported pain shortly after the injection was performed until the block worked. The baby's delivery was uneventful.

In recovery a few hours later, the patient reported intense and uncontrollable pain in her legs. Magnetic resonance imaging revealed a fluid pocket on her spinal cord at the L1-L2 level. The patient has permanent pain, numbness, and tingling in in both legs.

PATIENT'S CLAIM: The CRNA failed to insert the spinal block needle in the proper location.

DEFENDANT'S DEFENSE: The CRNA contended that he complied with the standard of care. He claimed that the patient had an unusual spinal cord anatomy: it was tethered down to the L3-L4 level.

VERDICT: A $509,152 Kentucky verdict was returned.