## Labor and delivery mismanaged, child has CP: $30.5M award

**WHEN A 34-YEAR-OLD WOMAN** saw her ObGyn at 35 weeks' gestation, she was found to have gestational diabetes mellitus (GDM). No additional testing was ordered.

Two days later, the mother reported decreased fetal movement; she was admitted to the hospital for continuous fetal heart-rate (FHR) monitoring, and a maternal-fetal medicine (MFM) specialist was consulted. The mother was not placed on FHR monitoring until 2 hours after admission. Three hours after admission, the MFM, by phone, recommended further testing and later, cesarean delivery.

The child was found to have spastic quadriplegic cerebral palsy, profound developmental delays, a seizure disorder, and cortical blindness.

**PARENT'S CLAIM:** The child's injuries were due to mismanagement of labor and delivery. The MFM prescribed ultrasonographic biophysical profiles, but they were not performed until 2 hours after ordered. There were 3 ultrasonography (US) technicians at the hospital when the mother was admitted: 1 was on break, another was performing other tests, and the third was not notified because the hospital's computer system was down. When test results were unfavorable, the MFM recommended emergency cesarean delivery. An earlier delivery could have prevented the child's injuries.

**DEFENDANTS' DEFENSE:** The infant's injuries were a result of her mother's failure to keep her GDM under control.

**VERDICT:** A $30,545,655 Georgia verdict was returned.

## Blood vessels injured during trocar insertion: $8.7M verdict

**A 26-YEAR-OLD WOMAN** went to the emergency department with periodic pelvic pain. The attending ObGyn ordered exploratory laparoscopic surgery. When a resident physician inserted the trocar, the right common iliac artery and vein were injured. The patient started hemorrhaging and required a laparotomy to repair the injury. Postsurgery, the patient's bowel began to swell; the wound was kept open for drainage, requiring an additional procedure for closure. She remained in the intensive care unit for several weeks. She has a large abdominal scar and reports chronic abdominal pain. She is at risk for further complications, including bowel obstruction, because of abdominal adhesive disease. She lost her job and struggles to maintain her daily life.

**PATIENT'S CLAIM:** The resident was negligent in performing trocar insertion during laparoscopic surgery by inserting the trocar too far into the abdomen. The attending ObGyn did not supervise the resident properly. There is nothing in the patient's medical records to indicate that she had abnormal anatomy. The woman's life is in turmoil after what was supposed to be a routine procedure.

**DEFENDANTS' DEFENSE:** There was no negligence. The patient's anatomy was abnormal, making the risk of surgery higher. The injury is a known complication of laparoscopic surgery.

**VERDICT:** An $8,718,848 Illinois verdict was returned.

## Did oxytocin cause child's spastic CP? $14.4M verdict

**WHEN A WOMAN** went to the hospital in labor, her ObGyn ordered oxytocin to enhance delivery. The FHR monitor showed repetitive decelerations for the next hour, dropping to 60 bpm by 8:00 PM, when the ObGyn expedited delivery but did not stop the oxytocin. By 8:20 PM, the baby's head was crowning, but the ObGyn waited another 10 minutes before performing an episiotomy and delivering the baby.

The child, intubated 5 minutes after birth, was found to have spastic tetraparesis cerebral palsy (CP) with impaired cognition, seizures, and global aphasia.

**PARENTS' CLAIM:** The ObGyn and nurses failed to properly monitor labor and delivery. The ObGyn should not have started oxytocin because the patient's labor was progressing normally. He should have taken the mother off oxytocin at 8:00 PM when the FHR dropped to 60 bpm. He should have performed an operative

*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: SHUTTERSTOCK

delivery at 8:20 PM when the baby's head crowned. An earlier delivery would have prevented injury.

**DEFENDANTS' DEFENSE:** The ObGyn's treatment was within the standard of care. He properly determined that vaginal delivery would be the quickest. It is his practice to stop oxytocin when the FHR slows, though he had no memory of halting oxytocin administration in this case. The baby's CP stemmed from insufficiencies in the placenta, seizures, and meconium aspiration syndrome.

**VERDICT:** A $14.4 million Pennsylvania verdict was returned. The ObGyn was found 60% liable for the baby's injuries and the hospital 40% responsible.

## Wrong fallopian tube transected: $1.8M award

**A 28-YEAR-OLD WOMAN UNDERWENT** an appendectomy. During the operation, the surgeon saw an abscess on the patient's right fallopian tube and called in an ObGyn to remove the abscess. While doing so, the ObGyn transected the left fallopian tube. Both fallopian tubes were removed.

**PATIENT'S CLAIM:** The surgeon did not tell the ObGyn which fallopian tube was abscessed and therefore the ObGyn operated on the wrong tube. In addition, the surgeon failed to obtain informed consent for bilateral salpingectomy. The patient is now unable to conceive without assisted reproductive treatment.

**PHYSICIAN'S DEFENSE:** The surgeon admitted his mistakes but disputed the informed consent claim. The patient probably would not have been able to conceive naturally due to the infection.

**VERDICT:** A $1.8 million Connecticut verdict was returned.

## Woman with preeclampsia dies: $6M verdict

**A 34-YEAR-OLD WOMAN** had been a patient of her family practitioner (FP) for many years. Her blood pressure (BP) averaged 105/63 mm Hg over that time. At a regular prenatal visit on February 26, the patient reported a headache and cough. Her BP was 130/90 mm Hg and she had gained 8.6 lb since her last visit 4 weeks earlier. She was told to return in 2 weeks.

She contacted her FP 2 days later to report acute vaginal bleeding and a severe headache. The FP sent her to the hospital, where potential placental abruption was considered. Two US studies demonstrated oligohydramnios, intrauterine growth restriction, and a grade II placenta. She continued to have repeated high BP readings, headaches, variable and late decelerations, and a dropping platelet count.

She was discharged on the morning of March 3 and sent to another hospital for a specialized US. The FP spoke to the physician who was to perform the US, advising him by phone and in writing to evaluate the oligohydramnios and intrauterine growth restriction. No other information was provided.

At 6:00 PM on March 3, the patient's husband called the FP to report that his wife was vomiting, reporting abdominal pain and intense headache. He was advised to call back in 1 hour, and when he did, he was told to take his wife to the hospital. At the hospital at 8:50 PM on March 3, her BP was 128/103 mm Hg. She reported throbbing headache, vomiting, and facial edema. She was admitted for observation.

At 9:30 PM, when the patient's BP was 155/100 mm Hg, a nurse contacted the FP to report the patient's continued throbbing headache and elevated, labile BP. The FP neither requested a consultation with an attending ObGyn nor went to the hospital until 4:31 AM on March 4.

At 3:15 AM on March 4, a nurse found the patient with her head hanging over the side of the bed in an obtunded state, having vomited. The rapid response team and an attending ObGyn were called. The ObGyn diagnosed eclampsia, ordered magnesium sulfate and hydralazine and immediately transported her to the operating room for an emergency cesarean delivery. Although the baby was healthy, the mother remained unresponsive. A computed tomography (CT) scan confirmed a massive intracranial hemorrhage. She was pronounced dead at 5:10 PM.

**ESTATE'S CLAIM:** The FP negligently deviated from the standard of care, leading to the mother's death. The FP fraudulently misrepresented her experience and training for obstetric conditions. She was negligent for failing to adequately diagnose and react to the patient's condition or refer her to an ObGyn, per hospital policy.

**DEFENDANTS' DEFENSE:** The patient's treatment met the standard of care. The FP was credentialed to practice obstetrics at the hospital. The patient's BP never reached or sustained a level that would require the FP to consult an ObGyn until 3:15 AM on March 4. When the patient first presented with a headache, the FP had consulted a board-certified ObGyn and an MFM, who suggested continued antepartum testing and induction at 39 weeks. The patient's death was unforeseeable because her BP values were inconsistent; the FP had no knowledge of a family history of stroke. The autopsy reported that a ruptured aneurysm was the cause of death.

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**VERDICT:** A $6,067,830 Ohio verdict was returned. The award was reduced to $900,000 due to a high/low agreement.

## Fetal abnormalities not diagnosed: Baby has Down syndrome

**ON SEPTEMBER 6,** at 10 weeks' gestation, a woman began prenatal care at a clinic with Dr. A, an ObGyn. The mother participated in the California Prenatal Screening Program and received test results on October 23 that showed normal risk for birth defects. On November 1, she saw Dr. B, another ObGyn, who confirmed the negative prenatal screening and ordered an US. A radiologist reported to Dr. B that the fetal anatomy was not well visualized. When the mother was at 23 2/7 weeks' gestation (December 6), Dr. B told the parents that the US results were normal.

On January 2, the parents saw Dr. A, who disclosed that the US radiology report indicated an incomplete fetal anatomy scan and ordered a repeat US. The US performed on January 17 showed a cardiac defect. Further testing confirmed that the fetus had Down syndrome. The parents scheduled but did not appear for a late-term abortion because they feared that the procedure was illegal.

**PARENTS' CLAIM:** The parents told both ObGyns that they wanted extensive prenatal testing because of a family history of birth defects and that they would terminate the pregnancy if birth defects were discovered. Because Dr. B did not discuss prenatal testing, the parents did not know their child had Down syndrome until it was too late to legally terminate the pregnancy. The mother testified that she had never heard of amniocentesis until mid-January, when a perinatologist confirmed that the baby had Down syndrome.

**DEFENDANTS' DEFENSE:** The ObGyns denied having any discussions with the parents about their request for extensive prenatal tests or desire for termination. Difficulty in visualizing the fetus is common in second trimester US, and therefore Dr. B routinely performs another US later in the pregnancy. He also denied responsibility for discussing prenatal testing with the parents, stating that such discussions should happen in the first trimester. Since the parents saw Dr. A during that time, Dr. B believed that those conversations had already taken place. The prenatal screening pamphlet that the mother signed on September 6 discussed amniocentesis. The child's grandmother testified that she had discussed amniocentesis with the parents early in the pregnancy. A clinic employee testified that in January she asked the mother why she had not chosen amniocentesis earlier in the pregnancy; the mother replied that she had decided against it because her prenatal screening test was normal.

**VERDICT:** A California defense verdict was returned.

## Complications after vaginal hysterectomy

**A WOMAN UNDERWENT** laparoscopic vaginal hysterectomy and bilateral salpingo-oophorectomy with anterior and posterior repair using mesh in August 2010. Shortly after surgery, the patient reported vaginal discharge with pain and bleeding. She was treated with antibiotics. Results of a CT scan identified the cause of her symptoms as vaginal cuff granulations.

Her pain continued and in June 2011, she underwent vaginal tissue biopsy. After testing revealed the presence of fecal matter, a small-bowel vaginal fistula was identified. She underwent laparoscopic enterectomy, urethral lysis, an omental pedicle flap, and cystoscopy. The mesh had perforated several loops of the small bowel.

In August 2011, the patient reported spinal pain. Magnetic resonance imaging (MRI) revealed a new fluid abscess in a disc extending through the tract anterior to the soft tissue of the pelvis. She underwent intensive antibiotic therapy.

**PATIENT'S CLAIM:** The gynecologic surgeon fell below the standard of care in his treatment of her conditions.

**PHYSICIAN'S DEFENSE:** The surgeon denied allegations.

**VERDICT:** A Nevada defense verdict was returned.