Ill-advised genetic counseling

A MOTHER HAD GIVEN BIRTH TO TWO CHILDREN with thalamic abnormalities that resulted in seizures, developmental delays, and death. Before getting pregnant again, the parents sought genetic counseling and were told that identifying the specific defective gene would be impossible. The geneticist advised them that a child conceived with a donor egg and father's sperm would have essentially the same risk as the general population. The parents asked in writing if it would be safer to use both donor egg and donor sperm; the geneticist responded that the difference in risk was negligible.

The mother gave birth in June 2007 to a child conceived with a donated egg and the father's sperm. After the child began to show the same symptoms as the others, an MRI of the child's brain revealed a thalamic abnormality, and testing revealed Alpers syndrome caused by *POLG* gene mutations. The third child died in September 2008.

PARENTS' CLAIM The chances of having a child with Alpers syndrome are about 1:200,000 in the general population; if one parent is a known carrier, the chance is 1:1,000. If the parents had known this risk, they would have used donor egg and donor sperm to conceive or adopted. They were not told about Alpers syndrome and its relationship to the *POLG* gene until after their third child was born. The geneticist was negligent in failing to provide this information.

PHYSICIAN'S DEFENSE The parents received appropriate and accurate genetic counseling.

VERDICT A $1 million Florida verdict was returned.

What caused a delay in breast cancer diagnosis?

A 39-YEAR-OLD WOMAN underwent mammography in October 2004. After recommending a spot-compression film of a left-breast lesion, and then ultrasonography, the radiologist concluded that the lesion was benign, and suggested a 1-year follow-up. Reports were sent to the patient and her primary care physician.

In August 2006, when mammography was suspicious for breast cancer, a biopsy diagnosed infiltrating ductal carcinoma of the left breast. After undergoing a mastectomy, radiation therapy, and chemotherapy, the patient was cancer-free at the time of the trial.

PATIENT'S CLAIM The radiologist failed to properly interpret the 2004 mammography.

PHYSICIAN'S DEFENSE The radiologist's interpretations of the 2004 tests were correct. The patient failed to follow up in 1 year, as recommended, and this delayed the cancer diagnosis. The patient's survival indicated that she had been cured of her breast cancer.

VERDICT A confidential settlement was reached with the hospital before the trial. An Illinois defense verdict was returned for the radiologist.

Heparin overdose for preemie

AT 27 WEEKS' GESTATION, a woman went to a clinic with preeclampsia. After she was stabilized, the baby was born by emergency cesarean delivery.

At birth, the baby was thrombocytopenic (platelet count, 37,000/mL) with a heart rate of 60 bpm. The child's cord blood pH was 7.27, indicating no significant hypoxia. At 1 minute of life, the child's heart rate had not improved. After trying three times to place an endotracheal tube, chest compressions were begun at 10 minutes of life. An umbilical vein catheter (UVC) was placed at 22 minutes. Heparin was used to flush the UVC. After 40 minutes, the baby's pH was 6.88, indicating severe acidosis. The infant was transferred to another hospital 3 hours after birth.

Head ultrasonography at 5 days of life revealed hemorrhagic and ischemic changes in the baby's brain.

The child suffered massive brain damage, is ventilator-dependent, and has a G-tube for feeding. She cannot sit up, walk, or speak, and will require specialized care for life.

PARENTS' CLAIM Emergency resuscitation was not performed at birth: the low heart rate and thrombocytopenia were not treated; the UVC was not immediately placed. Twice, adult doses of heparin were used instead of normal saline to flush the UVC; heparin caused bleeding in the baby's brain.

DEFENDANTS' DEFENSE The case was settled during trial.

VERDICT A $3 million Maryland settlement was reached.

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PHOTO: SHUTTERSTOCK

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PHOTO: THINKSTOCK

Uterine rupture: $130M verdict

AFTER A WOMAN'S FIRST CHILD WAS BORN by cesarean delivery, vaginal birth after cesarean (VBAC) was planned for her second pregnancy.

When a nurse recognized a ruptured uterus, the ObGyn ordered a cesarean delivery. The newborn suffered severe brain damage, with seizures. She has cerebral palsy with near-normal intelligence, but cannot talk or walk and continues to have seizures.

PARENTS' CLAIM The baby's injuries occurred due to a failure to respond to fetal distress. When the intrauterine pressure catheter (IUPC) stopped working for 27 minutes, the nurse did not notify the ObGyn or apply an external monitor. Fetal heart decelerations occurred, including a prolonged deceleration for 3 minutes; the nurse did not notify the ObGyn, reposition the mother, provide oxygen and extra fluids, or discontinue oxytocin. A cesarean delivery should have occurred 30 to 60 minutes earlier.

DEFENDANTS' DEFENSE The fetal heart rates were what typically occur during the second stage of labor. The hospital's accepted practices were followed. When the IUPC failed, the nurse measured contractions by hand and analyzed the fetal heartbeat from audible sounds; therefore, it was not necessary to notify the ObGyn. The physician was promptly called when uterine rupture was suspected. Uterine rupture and placental abruption caused the child's injury. Uterine rupture cannot be predicted or prevented and is a known complication of VBAC.

VERDICT After the parents declined an $8 million settlement, the matter was tried to a defense verdict. That decision was overturned on appeal, and, at a second trial, a $130 million New York verdict was returned against the hospital that employed the ObGyn and nurse.

Uterus, small bowel injured during D&C

A 65-YEAR-OLD WOMAN UNDERWENT dilation and curettage (D&C) to screen for uterine cancer performed by an ObGyn and a general surgeon. Her uterus and small intestine were perforated during the procedure, and a second operation was required to repair the damage.

PATIENT'S CLAIM Both physicians were negligent in performing D&C.

PHYSICIAN'S DEFENSE The ObGyn denied negligence and countered that the injuries are known complications of the procedure.

VERDICT The surgeon settled for a confidential amount before trial. A New Jersey defense verdict was returned for the ObGyn.

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.*