$24.5 million verdict after oxytocin, then uterine rupture

A 37-YEAR-OLD WOMAN in labor was administered oxytocin. Her uterus ruptured, and oxytocin was continued for another 3 minutes. In an emergency C-section, the baby was found to be half-extruded from the uterus into the abdominal cavity. He was born asphyxiated; his Apgar scores were low; and umbilical artery blood gas indicated hypoxia and metabolic acidosis. He was diagnosed with cerebral palsy and requires a feeding tube.

PATIENT'S CLAIM The nurses were negligent for not contacting a physician and for continuing oxytocin.
DOCTOR'S DEFENSE There was no negligence.
VERDICT $24,554,880 Illinois bench verdict.

ObGyn follows fetal distress remotely—child born with CP

WHEN A PREGNANT WOMAN presented at the hospital, both she and her fetus were found to be healthy with no complications. About 4½ hours later, the fetal monitor indicated decelerations of the fetal heart rate, and the ObGyn was notified. After another 1½ hours, it had increased without returning to baseline, and the decelerations became more frequent, severe, and prolonged, with coupling of contractions. These changes were relayed to the ObGyn, who then reviewed the monitoring strips with the nurse and ordered oxytocin to be started. Increasing heart rate and decelerations continued over the next hour. The depressed heart rate then was slow to return to baseline, and the fetal tracings began to flatten. Again the strips were reviewed by the nurses and physician. After 3 more hours, the ObGyn was informed of the continuing signs of fetal distress—the patient was 8 cm dilated and labor had shown no progress in the previous 2 hours. The ObGyn ordered increased oxytocin. After 45 minutes, the mother was dilated 9 cm and was told to start pushing. When she pushed, fetal decelerations decreased to as low as 60 bpm during contractions. Again the ObGyn was informed of persistent ominous signs of fetal distress. Without assessing the patient, he asked to be told when the baby began to crown—and then went to take a nap. Nearly 2 hours later, informed of a lack of progress and continued decelerations, he reviewed the strips and ordered increased oxytocin. Within 2 hours, the baby was born. She was covered with meconium and had Apgar scores of 2, 3, and 4 at 1, 5, and 10 minutes. She was limp, gray, and not breathing, and cord gases indicated acute severe metabolic and respiratory acidosis. The infant was taken to the NICU with multiple problems, including no primary reflexes, seizure disorder, and cerebral edema. She was diagnosed with cerebral palsy with right hemiplegia, chronic head pain, memory deficits, motor dysfunction, and many other deficits.

PATIENT'S CLAIM Not reported.
DOCTOR'S DEFENSE Not reported.
VERDICT $3.45 million California settlement: $1 million from the ObGyn; and $2.45 million from the hospital.

Midwife has turn, then MD finishes difficult delivery

DELIVERY OF AN INFANT at term was performed by a physician who used forceps to assist. The child suffered brain damage and died.

PATIENT'S CLAIM The physician failed to deliver the child in a timely manner, which led to brain damage and death.
DOCTOR'S DEFENSE Labor was managed primarily by a midwife. The physician responded immediately when called and used appropriate emergency measures to deliver the child as quickly as possible.
VERDICT $1.5 million settlement with the hospital before trial; Illinois defense verdict for the physician.

Embolism after C-section causes death

A 38-YEAR-OLD WOMAN pregnant with her second child had a C-section and tubal ligation performed by her ObGyn. She developed a pulmonary embolism a few days later and died.

PATIENT'S CLAIM The patient's age and weight were risk factors for pulmonary embolism, and she was immobilized for over 72 hours following surgery, which also increased the risk. The defendants took no steps to prevent a pulmonary embolism.
DOCTOR'S DEFENSE There was no negligence.
VERDICT Ohio defense verdict.

CONTINUED ON PAGE 65

Surgery for pelvic pain and cyst leads to ... more surgery

A SONOGRAM REVEALED an ovarian cyst in a woman, in her mid-40s, who was experiencing pelvic pain. Her physician recommended and performed surgery to find the source of the pain, as well as to possibly remove the cyst and ovaries. Following surgery, the woman was diagnosed with a colon perforation. A colostomy and two further surgeries were necessary. In addition, the patient suffered a bowel obstruction, colovaginal fistula, and scarring.

PATIENT'S CLAIM The original surgery was unnecessary, and the colon perforation was negligent.

DOCTOR'S DEFENSE Surgery was necessary to determine and treat the cause of the pain. Perforation of the colon did not occur during surgery, but resulted from the patient's diverticulitis.

VERDICT A $3,497,000 Maryland verdict was returned; however, this was reduced to $702,000 pursuant to the state cap for noneconomic damages.

Femoral nerve palsy occurs after hysterectomy

A 39-YEAR-OLD WOMAN was diagnosed with a leiomyomata in her lower uterus. The tissue in the area became necrotic, and prolapse resulted. Surgery was performed. A week later, the patient returned to the hospital because of pain and bleeding. The ObGyn covering for the physician who had performed the surgery recommended—then performed—a hysterectomy. Following the surgery, the woman experienced numbness in the right anterior and lateral thigh. According to a neurological consultation, the femoral nerve was damaged. The patient suffers from persistent femoral nerve palsy, affecting her ability to walk. She has undergone physical therapy and rehabilitation, as well as nerve conduction studies.

PATIENT'S CLAIM The ObGyn negligently placed the retractor or failed to reposition the retractor blades after they moved during the surgery.

DOCTOR'S DEFENSE There was no negligence. Femoral nerve injury is a known risk of pelvic surgery. The patient suffered only minor sensory and motor palsy immediately following surgery, and her ongoing complaints had no physical basis.

VERDICT California defense verdict.

Patient fails to report continued irregular bleeding

AT HER ANNUAL EXAM, a 49-year-old woman told her gynecologist, Dr. A, about cramping and bleeding on day 10 and sometimes day 17 of her menstrual cycle over the previous 6 months. Dr. A noted a normal pelvic exam. She told the patient that the bleeding was a normal perimenopausal symptom and suggested taking Advil for the pain. No further testing was recommended. The patient failed to report continued irregular vaginal bleeding. A year later, Dr. B conducted the next annual exam and found an enlarged uterus in the 7- to 8-week range. Endometrial biopsy showed the left ovary to be tender, slightly enlarged, with a possible mass present. A sonogram 2 days later showed an enlarged right ovary with multiple cystic areas and a large complex mass of the left ovary—findings suspicious for ovarian cancer. Pathology following a D&C 1 month later indicated adenocarcinoma consistent with primary endometrial cancer. The patient was diagnosed with endometrioid type adenocarcinoma involving both ovaries and the uterus, as well as metastatic disease to the omentum and diaphragm. She underwent total abdominal hysterectomy, bilateral salpingo-oophorectomy, bilateral pelvic and periaortic lymph node dissection, omentectomy, and CUSA of the diaphragm. She is not expected to survive long-term.

PATIENT'S CLAIM Dr. A was negligent for failing to timely diagnose and treat the cancer.

DOCTOR'S DEFENSE As the patient reported irregular vaginal bleeding at one visit only, there was no indication for further testing of a woman her age and no reason to suspect any disease. Most likely, the irregular vaginal bleeding was unrelated to the ovarian cancer, and an endometrial biopsy after the first visit would not have changed the prognosis.

VERDICT $750,000 Massachusetts settlement.

The cases in this column are selected by the editors of OBG Management from Medical Malpractice Verdicts, Settlements & Experts, with permission of the editor, Lewis Laska (www.verdictslaska.com). The available information about the cases presented here is sometimes incomplete; pertinent details of a given situation therefore may be unavailable. 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.