Pelvic injury from the McRoberts maneuver?

DURING PRENATAL CARE, a woman repeatedly complained of severe discomfort, and requested a cesarean delivery. The ObGyn's charts did not note her complaints.

A first-year resident and nurse covered for the ObGyn because he did not arrive at the hospital for hours after the mother notified him she was in labor. When shoulder dystocia was encountered, the resident used the McRoberts maneuver. The ObGyn arrived a minute before the birth. The baby weighed 10 lbs. The mother suffered symphysis pubis diastasis, required several surgeries, and now uses a cane to walk.

PATIENT'S CLAIM The ObGyn was negligent in not arriving in time to deliver the baby. The mother's pelvis was injured during the McRoberts maneuver. The baby's size was not properly estimated.

PHYSICIAN'S DEFENSE The use of the resident's care was appropriate, as this was a teaching hospital.

VERDICT A $5.5 million New York verdict was returned.

Cancer Dx "not timely"; additional tx required

IN JUNE 2000, AN OBGYN PALPATED a pelvic mass in a postmenopausal woman. After ultrasonography (US) in August 2000, the ObGyn told the woman that a uterine fibroid had been found but no further testing was needed. In December 2001, US revealed that the mass had enlarged, but no further testing was done. In May 2002, the patient reported fatigue, distention of her abdomen, and an increase in the frequency of urination.

In July 2002, the ObGyn removed a 3-lb malignant uterine tumor during hysterectomy. A second staging surgery was performed, and the patient underwent chemotherapy.

PATIENT'S CLAIM An earlier diagnosis would have reduced the amount of treatment required. The ObGyn should have reacted immediately when the mass was first palpated in June 2000 and found on US in August 2000, as postmenopausal women do not develop uterine fibroids. A gynecologic oncologist should have been present at the hysterectomy to perform concurrent staging.

PHYSICIAN'S DEFENSE The patient failed to report symptoms that suggested cancer for 10 months; a prompt response was made when symptoms were revealed. It was appropriate to accept the results of US regarding a uterine fibroid.

VERDICT A $1.25 million New York verdict was returned.

Abnormal thickness of fetal nuchal fold

WHEN A 31-YEAR-OLD WOMAN was 18 weeks' pregnant, she underwent ultrasonography, which was reportedly normal. The child was born with Down syndrome.

PATIENT'S CLAIM The ObGyn and radiologist failed to detect an abnormal thickness in the fetal nuchal fold—often a sign of Down syndrome.

PHYSICIANS' DEFENSE The sonogram was properly analyzed. A thickened fold is an unreliable indicator of Down syndrome.

VERDICT A $1.7 million New Jersey settlement was returned.

Ovary retained; cancer recurs; death

A WOMAN UNDERWENT SURGERY for ovarian cancer in July 2004. She died of ovarian cancer in 2008 at age 59.

ESTATE'S CLAIM The gynecologist did not tell the patient that only one ovary was removed, or that a pathologist had not found the second ovary in the specimen. Ovarian cancer developed in the retained ovary a few years later. She would have undergone additional surgery had she known the second ovary was still there.

PHYSICIAN'S DEFENSE Both ovaries were removed in July 2004. The left ovary was not found during an autopsy performed on the decedent.

VERDICT A $1.967 million Pennsylvania verdict was returned.

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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

5 birth injuries, $54 million in verdicts and settlements

1 Severe birth asphyxia: cerebral palsy and seizures

AFTER A NORMAL PREGNANCY, a woman went to the hospital in labor. Her ObGyn, Dr. A, went off duty at 4 PM and was replaced by Dr. B, a practice partner who delivered five other babies between 11 PM and 2:15 AM.

At 9:40 PM, the fetus was occiput posterior. At 12:31 AM, Dr. B attempted manual rotation; no exam was recorded in the chart. By 2:30 AM, the fetus had returned to the occiput posterior position, and Dr. B again tried manual rotation. Then he left to take a nap while the mother's epidural was reinforced. There was a delay in achieving a satisfactory epidural, and Dr. B was not called back to the bedside until 4 AM. He decided to perform a cesarean delivery when the fetal heart monitor showed an increased baseline with persistent variable decelerations.

Although Dr. B had called Dr. A earlier to elicit her help with the cesarean, she had gone back to bed and was not prepared to assist. During a 30-minute delay, the electronic fetal monitor was disconnected and never reconnected. A nurse checked the fetal heart rate with ultrasonography, and reported that it was normal; however, there was no copy in the chart.

The incision was made at 4:33 AM, and the baby was delivered at 5:06 AM. The infant was born without a heart rate or respiration (Apgar scores, all 0). A neonatologist was not available for resuscitation; a neonatal nurse practitioner arrived 7 minutes after delivery. The baby finally had a heart rate 24 minutes after delivery. The child suffered severe birth asphyxia, causing athetoid and spastic cerebral palsy and seizures.

PATIENT'S CLAIM The ObGyn failed to deliver the baby in a timely manner. The fetus was not continuously monitored with a fetal scalp electrode. The nurse violated several hospital policies.

DEFENDANTS' DEFENSE The baby suffered an acute, total cord occlusion minutes before birth; this was unpredictable and the injuries could not have been prevented.

VERDICT At the end of the discovery period, the defendants' attorney withdrew and new attorneys sought to name new experts. While these issues were pending, the matter was settled for a Washington total of $20 million. The mother settled with the hospital for $9.85 million. Although the doctors' group had $5 million in insurance coverage, the plaintiff demanded that the insurance company pay in excess of limits due to potential bad-faith claims. The insurance company ultimately paid $10.15 million.

2 Profound metabolic acidosis after emergent delivery

WHEN A WOMAN WAS 2 CM DILATED and 99% effaced, she was given dinoprostone and oxytocin to begin induction and augment labor. Oxytocin was continued even though her pattern of contractions showed tachysystole. An intrauterine pressure catheter that had been placed to assess contractions was removed. Monitoring revealed an elevated fetal heart rate at 170 to 180 bpm. Ten minutes before birth, the fetal heart tracing ended; a sonogram showed fetal bradycardia and prompted an emergency vacuum extraction.

The baby was floppy at birth, did not cry, and was intubated and transferred to the NICU. Apgar scores were 1, 3, and 5 at 1, 5, and 10 minutes. The umbilical cord gas had a venous pH of 6.637, indicative of profound acidosis. Ongoing hypoxia and anoxia resulted in massive and irreversible brain injury. An EEG at 5 days confirmed the presence of encephalopathy due to perinatal asphyxia. The child will require specialized treatment and attendant care for life.

PATIENT'S CLAIM Oxytocin was never stopped or reduced throughout labor and delivery. The ObGyn failed to promptly deliver the baby. No internal scalp electrode was used to directly monitor the fetus; the intrauterine pressure catheter was never replaced.

DEFENDANTS' DEFENSE The ObGyn and hospital denied negligence or causation, claiming that there was a sudden placental abruption 10 minutes before birth that caused perinatal asphyxia.

VERDICT A $6.95 million District of Columbia settlement was returned.

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3 Breech 2nd twin has cerebral palsy

PREGNANT WITH TWINS and in early labor, a woman went to the hospital, where a nurse midwife administered dinoprostone. The labor and delivery nurses only monitored one fetal heart rate during most of the labor period. The mother's contraction pattern was indicative of tachysystole, and the twin who was being monitored showed a decelerating heart rate. The ObGyn arrived minutes before the birth unprepared for delivery, and a nurse delivered a healthy first child.

The second child's heart rate dropped to 90 bpm, and the baby shifted to a breech position; the ObGyn tried manual rotation but was unsuccessful. After 20 minutes, cesarean delivery was performed. The boy was born with signs of metabolic acidosis and suffered a seizure 2 hours later. He was given a diagnosis of cerebral palsy and is fed through a tube, cannot speak, and requires skilled nursing care.

PATIENT'S CLAIM The ObGyn and nurses were negligent in only monitoring one fetus, and for failing to perform cesarean delivery in a timely manner.

DEFENDANTS' DEFENSE The ObGyn claimed he was not informed of the decelerations shown on the fetal monitor, nor of the mother's rapidly progressing labor. The hospital maintained that the nurses had given the ObGyn proper information and that the injuries to the infant had occurred after the ObGyn's arrival. The mother's weight of 322 pounds made monitoring difficult during labor and delivery.

VERDICT A $21,573,993 Pennsylvania verdict was returned against the hospital; a defense verdict was returned for the physician.

4 Shoulder dystocia, uterine tachysystole complicate vaginal delivery

WITH MILD PRE-ECLAMPSIA and vaginal spotting, a woman was admitted to a hospital's L&D unit. Dinoprostone was administered, but the fetus was unengaged. Oxytocin was added to induce labor. Labor was complicated by repeated tachysystole; prolonged dilation; prolonged descent; severe, prolonged decelerations; and tachycardia. Uterine tachysystole continued for extended periods. Vaginal delivery was complicated by shoulder dystocia, which took 2 minutes to resolve. The child was delivered without a heart rate or respirations. A heartbeat was obtained a minute after delivery, and Apgar scores were 0, 2, and 2. The child was given a diagnosis of hypoxic ischemic encephalopathy, cerebral palsy, and a seizure disorder.

PATIENT'S CLAIM The L&D nurses and physicians were negligent in failing to properly monitor labor progression, fetal heart rate, and oxytocin management. They failed to communicate with the woman's ObGyn, and did not exercise the proper chain of command. The physicians failed to recommend a cesarean delivery when labor became complicated.

DEFENDANTS' DEFENSE The patient's treatment was appropriate. Brain damage did not occur during labor and delivery.

VERDICT A $3.55 million Idaho verdict was returned.

5 Fetus transverse; oxytocin given

A WOMAN ARRIVED AT THE HOSPITAL after her membranes ruptured. A first-year resident failed to realize that the fetus was in a transverse position, and, with the attending physician's approval, ordered oxytocin. When vaginal bleeding began, it was suspected that the placenta had detached. An hour later, after vaginal bleeding increased and late decelerations were noted on the fetal heart monitor, cesarean delivery was performed. The child was given a diagnosis of cerebral palsy and other complications, and died at 16 months of age.

ESTATE'S CLAIM The use of oxytocin is contraindicated for a baby in a transverse position. The fetus' position indicated a need for a cesarean delivery. Placental detachment was not promptly addressed, leading to fetal oxygen deprivation.

DEFENDANTS' DEFENSE The fetus appeared to be fine under all objective criteria until a "softball-sized" clot emerged from the mother's vagina. The attending physician came to the mother's bedside at that time. Umbilical cord blood gases showed no evidence of acidosis. A fetal brain injury occurred prior to the mother's arrival at the hospital.

VERDICT A $2.5 million Pennsylvania verdict was returned.