Who was responsible for excessive oxytocin doses? $18.2M verdict

EARLY IN THE MORNING, a woman at 40 weeks' gestation presented to the hospital for induction of labor managed by her ObGyn. Labor was lengthy, and the mother was given increasing doses of 22, 24, and 26 mIU/min of oxytocin to stimulate labor. The baby was delivered in the evening. The child suffered a hypoxic birth injury and has cerebral palsy.

PARENTS' CLAIM Excessive oxytocin was administered, causing uterine hyperstimulation and excessive contractions. Nurses failed to inform the ObGyn of an abnormal fetal heart rate during the afternoon.

DEFENDANTS' DEFENSE The parties disputed the oxytocin orders. The ObGyn claimed she has a standing order against oxytocin doses over 20 mIU/min. The nurses claimed that the dosage was based on the ObGyn's verbal orders, which the ObGyn denied. The ObGyn denied negligence and maintained that if she'd known of the oxytocin administration greater than 20 mIU/min and the abnormal fetal heart rate, she immediately would have called for cesarean delivery. The hospital denied negligence and maintained that the oxytocin was administered 10 hours before delivery and played no role in fetal distress.

VERDICT At trial, the ObGyn did not call expert witnesses and, in closing arguments, the physician's attorney asked for exoneration of the ObGyn and a finding of fault solely against the hospital. An $18.2 million Washington verdict was returned against the hospital.

What caused the child's Erb's palsy?

A MOTHER PRESENTED to the hospital for induction of labor. Oxytocin was administered and the first stage of labor progressed normally. When the mother began pushing, the ObGyn noted a turtle sign at crowning and called for assistance. The ObGyn attempted to deliver the fetus with downward guidance of the fetal head but encountered shoulder dystocia and a nuchal cord. He unwrapped the cord and instructed the nursing staff to place the mother in the McRobert's position to help dislodge the right shoulder. When that did not work, the ObGyn performed a first-degree episiotomy and completed delivery. The child was found to have Erb's palsy of the right arm. She underwent decompression and neurolysis of the brachial plexus using sural nerve grafts but still has reduced use of her right arm.

PARENTS' CLAIM Shoulder dystocia was improperly managed, causing the brachial plexus injury.

DEFENDANTS' DEFENSE The ObGyn and hospital system denied negligence. The child's injury occurred in utero due to natural forces of the mother's uterine contractions.

VERDICT An Ohio defense verdict was returned.

Woman claims lack of proper consent

A 47-YEAR-OLD WOMAN UNDERWENT endometrial ablation performed by her ObGyn. During the procedure, the uterus was perforated and the ObGyn performed a hysterectomy. Six days later, the patient was found to have peritonitis and underwent bowel repair surgery. The patient developed untreatable bowel adhesions that cause chronic pain.

PATIENT'S CLAIM There were less expensive and invasive alternatives to the ablation that the ObGyn did not offer. The patient claimed lack of informed consent for the ablation and hysterectomy and negligence in perforating the bowel. The ObGyn was also negligent in failing to recognize the perforation and to diagnose peritonitis in a timely manner.

Texas state law requires consent for hysterectomies without documented evidence of immediate danger to life. Her husband did not have the authority to consent on her behalf.

PHYSICIAN'S DEFENSE The husband gave informed consent. Failure to recognize the perforation was not negligent; it is a known risk of the surgery. The patient's care was transferred to another physician after the second postoperative day.

VERDICT A $200,000 Texas settlement was reached.

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

Bowel obstruction in pregnant woman

A 29-YEAR-OLD WOMAN at 27 weeks' gestation had abdominal pain. She went to a community hospital where a hospitalist was assigned to her care. After a day, the patient was found to have a small bowel obstruction and necrosis of the bowel. The baby was delivered preterm. The mother underwent 12 operations; half of her intestines were resected. The mother is being treated for posttraumatic stress syndrome. The child is autistic.

PARENTS' CLAIM The hospitalist did not diagnose the mother's intestinal blockage in a timely manner and did not obtain an obstetric consult or notify the patient's ObGyn. The hospital staff did not follow protocol to notify the mother's ObGyn. The child's autism is a result of preterm delivery.

DEFENDANTS' DEFENSE The hospital denied any duty to notify the ObGyn if the patient was admitted to the hospital for nonobstetric reasons. The case was settled during trial.

VERDICT A $4.2 million Washington settlement was reached including $3 million from the hospital.

Fourth-degree perineal tear and continuing pain after delivery

A WOMAN IN HER 30S went to the hospital for induction of labor. After many hours, the ObGyn used vacuum extraction due to maternal fatigue. The baby emerged in compound presentation, with her hand at the side of her head. She weighed 9 lb 12 oz at birth. A fourth-degree perineal tear occurred at birth. Postpartum, a rectovaginal fistula developed that required several repair operations. The mother is unable to have intercourse due to continuing vaginal pain and discomfort.

PATIENT'S CLAIM Knowing that the father's head was overly large, the ObGyn should have better estimated the fetus' size, and should have performed cesarean delivery.

PHYSICIAN'S DEFENSE The ObGyn admitted that he knew the baby was large but maintained that a large fetus does not mandate a cesarean delivery. There were no indications that the baby's head or body was too large to fit through the mother's pelvis, so a vaginal delivery was appropriate. A perineal tear is a known complication of childbirth and could not be prevented. The patient's current pain is unrelated to the perineal tear.

VERDICT A Pennsylvania defense verdict was returned.

CONTINUED ON PAGE 46

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Breast cancer missed in woman with dense breasts

IN 2003, A 44-YEAR-OLD WOMAN was told she had dense fibrocystic breasts. From 2003 through 2009 she regularly saw a breast surgeon due to concern that breast cancer might be difficult to detect.

In August 2009, her ObGyn identified a questionable mass in her left breast after ultrasonography and mammography. The patient saw the surgeon in late September 2009; no further imaging was ordered and she was told to return in a year.

The patient, concerned about the mass, returned to the surgeon in May 2010. Testing revealed cancer, and she underwent radical mastectomy and other treatment.

PATIENT'S CLAIM Because the mass had not been treated in a timely manner, her 5-year survival rate in May 2010 was less than 50%. The surgeon was negligent in failing to order additional testing in September 2009. Magnetic resonance imaging (MRI) would have detected the cancer at a time when her survival rate could have been 80%.

PHYSICIAN'S DEFENSE The cancer was diagnosed in a timely manner. An earlier diagnosis would not have changed the outcome.

VERDICT A Tennessee defense verdict was returned.

Child stillborn, mother injured after vacuum extraction

WHEN THE MOTHER'S LABOR SLOWED at a birthing center, she received several medications including castor oil, blue cohosh, and black cohosh to induce labor. The mother was later transferred by ambulance to a hospital. Ninety minutes after admission, the ObGyn used vacuum extraction to deliver a stillborn child. The mother sustained damage to her rectum, uterus, and vagina, had repair surgery, and has been unable to get pregnant again.

PARENTS' CLAIM While in labor at the birthing center, the castor oil, blue cohosh, and black cohosh caused the patient's uterus to contract excessively and contributed to fetal death. The patient should have been transferred to the hospital earlier. Cesarean delivery should have been performed immediately upon her arrival at the hospital but the ObGyn did not arrive at the hospital for an hour after the patient's admission.

DEFENDANTS' DEFENSE The head midwife at the birthing center conceded negligence. The hospital claimed that the fetus was already dead before the mother arrived. The ObGyn denied negligence, arguing that he had no supervisory role or ownership in the birthing center and was not present during the mother's labor. He also claimed that the fetus was dead in utero 12 or more hours before delivery and that an infectious process had developed in the mother during the 17 hours that she was at the birthing center.

VERDICT A $4,095,000 Florida verdict was returned against the ObGyn. A directed verdict was granted for the hospital.

Patient still in pain after labia reduction

A 44-YEAR-OLD WOMAN underwent surgical reduction of her labia minora performed by a gynecologist. The procedure was intended to relieve discomfort during sexual activity. The patient continues to have pain.

PATIENT'S CLAIM An excessive amount of the right labia minora was removed because proper presurgical demarcation of the operative area was not performed. Her pain during intercourse has worsened and she cannot properly urinate.

PHYSICIAN'S DEFENSE Presurgical demarcation was correctly completed using clamps. Surgery was properly performed. The asymmetry is due to poor healing of the surgical wound. The patient's clitoris was not scarred. The patient never reported complications related to urination to her gynecologist. Her ongoing pain is due to an estrogen deficiency.

VERDICT A New York defense verdict was returned.

Uterine rupture after version for breech presentation: $7M

A WOMAN WENT TO THE HOSPITAL for delivery of her baby. The fetus was in breech position, but the mother requested vaginal delivery. When the ObGyn attempted an external cephalic version to turn the baby, the uterus ruptured and the placenta was damaged. The baby sustained hypoxic-ischemic encephalopathy resulting in cerebral palsy (CP). He requires constant nursing care.

PARENTS' CLAIM The ObGyn failed to recognize fetal distress during the breech version. The ObGyn improperly performed the version, causing the uterine rupture. There was lack of informed consent for the version.

DEFENDANTS' DEFENSE The case was settled during trial.

VERDICT A $7 million New Jersey settlement was reached.

Sepsis following hysterectomy

AN OBGYN PERFORMED total abdominal hysterectomy to treat uterine fibroids in a 26-year-old woman. Despite reporting abdominal pain, the patient was discharged on postsurgical day 4.

Three days later, she went to a different hospital with moderate diffuse abdominal pain, constipation, nausea, emesis, tachycardia, and low-grade fever. An abdominal radiograph was taken, the patient was given morphine and ketorolac, and she was sent home.

She returned to the first hospital 3 days later reporting fever, nausea, emesis, diarrhea, and severe abdominal pain. After an abdominal computed tomography (CT) scan revealed numerous fluid- and gas-filled collections, indicative of abscess, intravenous antibiotics were ordered and administered.

Six days later, an infectious disease physician was consulted. He made a diagnosis of sepsis secondary to abdominal infection.

The next day, an abdominal CT scan revealed enlargement of multiple abdominal and pelvic fluid collections.

At exploratory laparotomy, purulent fluid was found in the anterior fascial compartment, with gross pus in the abdomen. The entire bowel was dilated, inflamed, and matted. Necrotic rind and infection were noted on multiple surfaces of the colon and small intestine and the transverse colon was gangrenous and sealed to the right lower quadrant. The patient's intestines were resected and an ileostomy was placed, which was reversed several months later.

PATIENT'S CLAIM The ObGyn did not offer an alternative to hysterectomy. The ObGyn was negligent in injuring the small intestine during surgery and failing to recognize and treat it intraoperatively. The patient should not have been discharged based on her reported symptoms. Failure to recognize and treat the injury led to sepsis with severe complications and months of recuperation.

PHYSICIAN'S DEFENSE There was no negligence; small bowel injury is a known risk of hysterectomy. Other caregivers at both hospitals were at fault for not properly diagnosing and treating the infection.

VERDICT A $901,420 Nevada verdict was returned; the ObGyn was found 85% at fault and other parties 15% at fault. The court granted the physician's motion to reduce the verdict to $436,954, which included $371,411 from the ObGyn.

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