



Did CNM give too much oxytocin? Child has CP

WANTING A FEMALE PRACTITIONER, a pregnant woman chose a certified nurse midwife (CNM) at her family practice (FP) clinic. During labor, the mother's cervix failed to dilate for 2 hours, and the CNM initiated oxytocin. She continued oxytocin for 1.5 hours after the mother was fully dilated, in

the presence of repetitive fetal heart-rate decelerations. After the mother pushed for 3 hours, the CNM removed the monitor, placed the mother into a water-birthing tub, and the child was born 40 minutes later.

At delivery, the baby had a heart rate of 80 bpm, was not breathing, was blue in color, and appeared lifeless. Apgar scores were low and blood gas showed a pH of 7.165. The on-call FP physician was contacted and arrived 20 minutes later. The newborn was resuscitated and sent to another facility. A CT scan taken at 56 hours of life and an MRI at 9 months were both read as normal. The child has cerebral palsy with significant cognitive deficits and upper and lower extremity impairment.

▶PARENTS' CLAIM The CNM continued oxytocin beyond what is normally recommended. The drug should have been stopped when nonreassuring fetal heart rates were seen. The FP physician should have been called earlier, and a cesarean delivery or operative vaginal delivery should have been performed. The initial blood gas drawn from the infant was actually venous gas, and did not reflect the child's true metabolic state. A pediatric neuro-radiologist found significant hypoxic ischemic injury on the MRI.

▶DEFENDANTS' DEFENSE The continuation of oxytocin was appropriate. The fetal heart-rate monitor tapes were reassuring, and auscultation in the birthing tub was normal. There was no significant acidosis, although the CNM testified that she could not confirm which vessel she sampled, as she rarely drew blood gases. The initial CT scan was normal, indicating that the injury could not have occurred immediately prior to birth. An acute hypoxic insult occurred prior to the mother's arrival at the hospital.

▶VERDICT A \$13.6 million Wisconsin verdict was returned for the child.

▶DEFENDANTS' DEFENSE The hospital claimed that there was no need to transfer the patient; her condition was properly managed. Regardless of when the infection was diagnosed, it was not treatable. All other defendants settled before trial.

▶VERDICT A Kentucky defense verdict was returned for the hospital.

Failure to diagnose BrCa on mammogram

WITH LEFT BREAST TENDERNESS and a family history of breast cancer, a woman went for a mammogram in January 2000. Radiologist A's report was negative for breast cancer. The patient returned for follow-up screening in May 2001 and June 2003, read by Radiologist A as normal, and July 2004, read by Radiologist B as benign. In February 2005, the patient found a mass in her left breast. Diagnostic mammography and ultrasonography (US) identified a 4.7-cm mass in the left breast. Core biopsy found grade 1 invasive ductal carcinoma with angiolymphatic invasion. She underwent aggressive chemotherapy and bilateral mastectomy.

▶PATIENT'S CLAIM Both radiologists were negligent in failing to diagnose breast cancer.

▶PHYSICIANS' DEFENSE Evaluation of the mammograms was appropriate.

▶VERDICT The first radiologist was absolved of liability. A \$30,000 Florida verdict was returned against the second radiologist.

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.

Fatty liver and uterine sepsis: mother dies

A 27-YEAR-OLD MOTHER with a fatty liver condition gave birth by emergency cesarean delivery. She developed renal failure and needed dialysis, but there was no dialysis equipment in the hospital. When a machine arrived, no one knew how to operate it. After the mother spent 2 weeks in the hospital, a CT scan showed evidence of

uterine necrosis. A hysterectomy was performed 12 hours after the septic uterus was identified. The patient suffered cardiovascular collapse during surgery and died.

▶ESTATE'S CLAIM A septic uterus is a known risk of fatty liver condition during pregnancy. Once stabilized after delivery, the mother should have been transferred to another facility where the possible repercussions of her fatty liver condition could be better managed.



Was premature baby viable?

AN EXPECTANT MOTHER MISCARRIED AT HOME at 6 months' gestation, and an ambulance was called. After the EMTs helped the mother to the ambulance, they retrieved the fetus. When the baby was seen moving its head, the EMTs requested assistance from the advanced life support (ALS) team. ALS personnel visually assessed the fetus, determined it was nonviable, and placed the baby in a small container. The mother and baby arrived at the hospital 17 minutes after the ambulance was called.

At the hospital, a nurse noticed that the fetus was warm and had a heartbeat. The baby was taken to a special-care nursery for resuscitation and then transferred to another hospital's NICU. The baby died after 46 days from severe brain damage due to lack of oxygen.

► **PARENT'S CLAIM** The EMTs and ALS team should have provided better evaluation and treatment for the infant; they were not trained to determine an infant's viability. Placing the infant inside a plastic bag inside a box with a lid further deprived the baby of oxygen.

► **DEFENDANTS' DEFENSE** The case was settled before trial.

► **VERDICT** A \$1 million Massachusetts settlement was reached.

excessive force by pulling on the baby's head to complete the delivery. Standard of care required the ObGyn to take a more gentle approach to achieve delivery.

► **PHYSICIAN'S DEFENSE** Delivery was performed appropriately, and did not deviate from standard of care.

► **VERDICT** A \$20.881 million Maryland verdict was returned, including \$20 million for pain and suffering. The total award was reduced to \$1,531,082 when the pain and suffering award was cut to \$650,000 under the state's statutory cap.

Preterm birth from an asymptomatic UTI?

A BABY WAS BORN AT 31 WEEKS' gestation. The child has cerebral palsy, spastic quadriplegia, and requires assistance in all aspects of life.

► **PARENTS' CLAIM** Chorioamnionitis from a urinary tract infection (UTI) caused preterm birth. Urinalysis performed 7 weeks earlier indicated an infection, but the second-year resident caring for the mother failed to treat the UTI. The resident should have obtained a confirming urine culture, prescribed antibiotics, and monitored the mother more closely. The resident was poorly supervised.

► **DEFENDANTS' DEFENSE** Chorioamnionitis developed just before birth and could not be detected or prevented. A UTI cannot remain asymptomatic for 7 weeks and still cause premature birth. The mother was at increased risk of premature delivery because she had given birth to an anencephalic infant a year earlier. She began prenatal care in the middle of her pregnancy and ignored a referral to a high-risk maternal fetal specialist.

► **VERDICT** A New York defense verdict was returned. ☹

Were records altered because of a delayed diagnosis?

A WOMAN FOUND A LUMP in her left breast. A gynecologist ordered mammography. In January 2006, the radiologist requested ultrasonography (US), and reported that it conclusively indicated that the mass was a cyst. The gynecologist told the patient the tests were normal; further action was unnecessary. The patient saw the gynecologist four more times before being referred to a breast surgeon. In June 2006, she underwent surgical resection and chemotherapy for a malignant breast tumor.

► **PATIENT'S CLAIM** The gynecologist was negligent for not referring the patient to a surgeon earlier. The gynecologist altered records: excerpts from the mammogram and US reports had been scanned in with a notation that

the gynecologist had told the patient to follow up with a surgeon. When the gynecologist faxed the same reports to the surgeon, the annotations were absent. The gynecologist also changed the December 2005 chart, which referred to an US she never ordered.

► **PHYSICIAN'S DEFENSE** The gynecologist stated that she regularly "merged" two reports into one document in her practice.

► **VERDICT** A \$700,000 Pennsylvania verdict was returned.

Excessive force or standard of care?

SHOULDER DYSTOCIA occurred during labor. The child sustained left brachial plexus palsy. At age 6, his left arm is paralyzed and smaller than the right arm. He has trouble performing normal daily tasks.

► **PATIENT'S CLAIM** The ObGyn used

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