Diabetic smoker blames others for CP

A woman had her final visit with her ObGyn 1 week before her scheduled cesarean section. When she arrived at the hospital at 36 weeks' gestation for the procedure, the attending ObGyn delivered the child, who was born with severe acidosis and hypoxia and was diagnosed with cerebral palsy. The mother was diabetic and a smoker.

Patient's claim Signs of a compromised infant were evident at her last visit to the ObGyn, and the child should have been delivered that day. Also, on the day of the actual delivery, the physician should have performed the delivery more expeditiously.

Doctor's defense The infant was harmed before 34 weeks' gestation. This was a high-risk pregnancy: the mother did not comply with diabetes management, and she continued to smoke although warned not to.

Verdict Massachusetts defense verdict.

Brain damage occurred despite "timely" birth

An active-duty Marine pregnant with her first child was examined twice at the labor and delivery unit and sent home. Five days before her due date—and 1 day following the previous visit—she returned with ruptured membranes and was admitted by a family practice resident. Four hours later, oxytocin was started because of decreased variability in the fetal monitoring with some late decelerations. A drop in the fetal heart rate followed the start of an epidural. A fetal scalp electrode was inserted, and within 15 minutes the mother was moved to the operating room. The attending family practice physician and the attending OB were called, and delivery by cesarean section was performed within another 15 minutes.

At birth, the infant was severely distressed. Intubation was attempted by a first-year intern, but after 25 minutes, the tube was found to be in the right mainstream bronchus with complete collapse of the left lung. For 10 minutes there was no heartbeat, but the staff reported a 5-minute Apgar score of 5. The infant was transferred to a second hospital, where a feeding gastrostomy and tracheotomy were placed. Two months later, the infant was transferred to a third hospital and, finally, 3 months after that, transferred home. The child suffered severe brain damage and developmental delay.

Patient's claim The physicians failed to recognize the nonreassuring fetal monitoring strips and deliver early.

Doctor's defense The delivery was timely.

Verdict $5.3 million California settlement.

Was ureteral injury caused by negligence?

A 49-year-old woman presented at the hospital for removal of an ovarian mass 10 cm × 12 cm in diameter. At the first incision, the two surgeons discovered severe pelvic adhesive disease, the result of a previous hysterectomy. The mass was not visible, but they finally located it—lower in the pelvic cavity than normal and near the ureter—and removed it.

Although the patient complained of pain in the back and left flank, several

Ovarian mass

For more on ovarian masses, see **"How to manage an adnexal mass"** by David G. Mutch, MD, and Christy R. Bleckman, MD, on page 50

days passed before physicians discovered that the ureter had been cut and urine was backing up into the left kidney. The patient demanded transfer to another hospital.

Five days after the original surgery, a nephrostomy tube was inserted to drain the left kidney, but the patient's abdomen was too inflamed to immediately repair the injury. She was discharged 3 days later. She was readmitted for treatment of severe infection due to the nephrostomy tube and then underwent more procedures to change the tube. Finally, 6 months after the initial surgery, she underwent left distal ureteral reimplantation and placement of an indwelling left ureteral stent.

Patient's claim The physicians were negligent for failing (1) to identify the ureter prior to cutting out the ovarian mass and (2) to check the course of the ureter after the mass had been removed.

Doctor's defense (1) The cystic mass was difficult to dissect, and a general surgeon was called to confirm that no injury had occurred. (2) Following abdominal ultrasonography and CT, cystoscopy by a urologist confirmed a ureteral injury. The need for a nephrostomy was discussed, but the patient demanded a transfer and thus left the care of the defendants. (3) The patient's outcome was ultimately good.

Verdict Texas defense verdict.

Placental abruption—and baby is stillborn

A woman in her 23rd week of pregnancy arrived at the hospital with ruptured membranes and bleeding. She was diagnosed with placental abruption, and the fetus was alive as confirmed by ultrasonography. Two hours after her arrival, a cesarean section was performed, but the baby was stillborn.

Patient's claim The infant should have been delivered within 30 minutes of the decision to perform a cesarean section.

Doctor's defense Both preparation of the mother for surgery and performance of the cesarean section were timely. Also, the child had only a 10% chance of survival because of his early gestational age.

Verdict Illinois defense verdict. Prior to the verdict, the hospital entered a confidential high/low agreement with the plaintiff.

Did surgeon fail to identify the ureter?

A breast cancer survivor in her 40s tested positive for the familial gene BRCA1, which increased her chance of developing ovarian cancer by up to 70%. To reduce that chance, she chose to have an oophorectomy, which was performed by an ObGyn. Two days after her discharge from the hospital, she complained of flank pain and inability to void. She met the ObGyn in the emergency room, where diagnostic tests confirmed an obstructed ureter. Following five stenting procedures, the patient underwent ureteral reimplantation surgery, which alleviated but did not completely cure her symptoms.

Patient's claim The ObGyn failed to identify the ureter so as to protect it from injury and also failed to inspect for ureteral injury following surgery. When he could not find the ureter, he should have consulted with another physician to help find the ureter or convert from laparoscopic to open surgery.

Doctor's defense The injury would have occurred even if the ureter had been identified.

Verdict $500,000 Maryland verdict. ■

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, of Nashville, Tenn (www.verdictslaska.com). The available information about the cases presented here is sometimes incomplete; thus, pertinent details of a given situation 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.

Decision to INCISION

For more on timely cesarean section, see **"There is no gold standard for decision-to-incision time"** by Arnold W. Cohen, MD, and David M. Jaspan, DO, in the October issue of *OBG Management* and at **obgmanagement.com**