LEGALLY SPEAKING
Risk management in obstetrics and gynecology

CASE STUDY: THE GENETIC DEFENSE

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THE FACTS:

The plaintiff was a private patient of the defendant ob/gyn's midwifery practice. Although he had no "hands-on" involvement with the woman's care, his employees (midwives and physicians) managed the plaintiff's prenatal care, labor, and delivery At 32 weeks' gestation, the patient had a mildly elevated 3-hour glucose tolerance test (GTT) and was placed on a low-carbohydrate diet. On January 6, at 36 weeks' gestation, she presented to the defendant's office with complaints of decreased fetal movement. Nurse-midwife "B" performed a nonstress test (NST), which she interpreted as reactive.

On January 9, the patient telephoned the defendant's service early in the morning and again complained of decreased fetal movement. Co-defendant nurse-midwife "S" told her to report to the defendant hospital. At 1:20 am that day, that nurse-midwife performed another NST, which was interpreted as nonreactive, and a nipple stimulation test, which revealed three mild decelerations to 120 bpm, with good recovery but poor beat to beat variability. Contacted at about 3 am, co-defendant ob/gyn Dr. S directed the patient to go home and return later that morning, after eating breakfast.

At 9:30 am, the woman came back to the hospital for a repeat NST, which was nonreactive; at 10:55, an oxytocin challenge test (OCT) was performed. At about 1:40 pm, a house physician told Dr. S that the OCT results were positive. At about 5:15 pm, co-defendant ob/gyn Dr. G ruptured the patient's membranes, placed her on an internal monitor, and ordered induction with oxytocin. At 8 pm, meconium-stained fluid was noted and Dr. G performed a vaginal examination. Fetal monitoring strips recorded between then and delivery at 9:26 pm showed occasional variable decelerations and minimal variability. The infant's Apgar scores were 9 and 9 at 1 and 5 minutes, respectively, and a pediatrician was present at delivery because of the meconium-stained fluid.

The infant was admitted to the transitional nursery, but within an hour, became cyanotic (blood gases pH 7.09, bicarb 12.8) and was transferred to the neonatal intensive care unit (NICU). The child did not suffer any neonatal seizures but was quickly diagnosed with and treated for hypoglycemia. He eventually developed thrombocytopenia and his cytomegalovirus titers were positive. At age 5 days, he was transferred to another hospital by his parents. The infant was significantly brain damaged with microcephaly and considerable language deficits.

THE ALLEGATIONS:

The plaintiff alleged that:

• The defendants were negligent in failing to deliver the infant plaintiff as early as January 6 and failed to have a physician review the NST on January 6.

• Dr. S was negligent in failing to review the NST results in person before discharging the patient over the phone the morning of January 9.

• He failed to have a physician present and involved in the patient's care between 9:30 am and 5:15 pm on January 9, did not deliver the patient during that interval, and did not tell the pediatricians who were present during delivery about the mother's prenatal gestational diabetes.

• He failed to appropriately provide the infant with respiratory support when the baby arrived at the NICU.

As a result of all of this, the plaintiffs alleged, the infant was severely brain damaged.

DISCOVERY:

During deposition, the mother testified that she felt reduced fetal movement from January 6th through 9th. She further testified that on January 9, a nurse called her and told her that the defendant ob/gyn wanted her "delivered right away," and that was why she returned to the hospital.

At deposition, the nurse-midwives who managed the patient's care testified that the woman had only one elevated glucose value during the 3-hour GTT and was not a "true" gestational diabetic. Nurse-midwife "S" also testified that although she discussed the results of the NST and OCT with Dr. S, she did not specifically ask him to come see the patient. This disclosure gained significance when Dr. S later testified at deposition that, had he seen the NST strips, he would have recommended that the patient remain in the hospital for retesting later that morning. He said he would not, however, have recommended an earlier C/S.

The defendant ob/gyn confirmed that he never treated the patient but that all of the midwives and obstetrical co-defendants who had provided her prenatal care and been involved in the delivery had done so as his employees. Not only did he not recommend "immediate delivery," he said, he had never been consulted about the woman's care at all.

Initially, our neonatology expert was of the opinion that the infant was not asphyxiated in utero but that CMV or viral septicemia was responsible for his difficulties. Examination of the infant's blood by a geneticist showed that he was negative for Fragile X syndrome but a karyotype revealed abnormality in chromosome 8, which the geneticist insisted explained his deficits.

THE TRIAL:

Before trial, a number of co-defendants, including all of the midwives, settled with the plaintiff for slightly more than $1 million because of the significant exposure the infant's injuries merited and the notoriously difficult venue for the trial. The remaining defendants were the ob/gyn, the hospital, and Dr. S.

During his opening statement, the attorney for the plaintiff divulged for the first time that he had the infant genetically tested and the results were normal. However, not only was the test only for Fragile X but it also violated the rules of evidence, which required disclosure of the testing before trial. Rather than granting a mistrial, the court appointed an independent geneticist to test the child, and his findings of abnormal chromosome 8 coincided with those of the defendant's expert.

During trial, the plaintiff produced an ob/gyn expert, who testified that Dr. S should have come in and done a C/S by 6 am on January 9. He added that the care in the newborn nursery was substandard, in that the infant was allowed to become cyanotic and limp. The plaintiff's neonatology expert testified that the respiratory support and response to the poor blood gases, combined with the delayed reaction to the infant's hypoglycemia, caused or exacerbated the infant's brain damage.

The independent geneticist opined that the infant's mental retardation was due to his genetic abnormality. He also refuted the plaintiff's attorney's argument that the genetic abnormality could not be responsible for both the mental retardation and the congenital anomalies. The defendants then simply called their own geneticists to support the finding of the independent geneticist, and a neonatologist to support the care in the newborn nursery and refute the assertion that the infant ever was asphyxiated.

After 3 days of deliberation, the jury returned a defense verdict, finding that while Dr. S departed from the standard of care by not coming to the hospital and reviewing the strips, none of the defendants' actions caused or contributed to the infant's deficits.

ANALYSIS:

This case is interesting because the ob/gyn never treated the patient but remained a defendant until the trial's end. As the owner of the midwifery group and the employer of the co-defendants, he was legally "vicariously liable" for their acts and/or omissions. The co-defendant employees each maintained their own insurance coverage for the litigation. But if the verdicts rendered had been above and beyond their policy limits, the ob/gyn's coverage—and potentially his assets, which is a frightening position to be in—would have come into play as the "excess" or "over" insurance. Fortunately, that scenario never arose, because the midwives settled and defense verdicts were rendered for the remaining defendants.

In this case, the troubling gaps in care and spotty documentation were overcome by a unified defense for all of the defendants through depositions and trial and irrefutable testimony by the independent geneticist. That testimony opened the door for the defense to present persuasive evidence in support of a genetic etiology for the infant's deficits. Even in a "plaintiff-friendly" venue, high-exposure cases can be successfully defended on causation if the theories are valid, the witnesses are credible, and the medicine is supported by fact and experience.

This case was tried by Richard V. Caplan, a senior partner at Aaronson, Rappaport, Feinstein & Deutsch, LLP. He has been practicing law in the New York metropolitan area since 1968 and has dedicated his entire legal career to insurance defense litigation. For the past 25 years, he has concentrated on trial of high-exposure personal injury cases, including medical malpractice claims and product liability litigation.

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