

Chapter 43

Liability in Obstetrics and Gynecology

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Delayed Diagnosis of Breast Cancer
Gynecologic Surgery

Obstetrics

Medical malpractice and medical negligence are an ever-looming aspect of health care today. Nearly 77% of obstetrician/gynecologists have been sued at least once in their career and almost half have been sued three or more times.¹ Moreover, virtually one-third of residents will be sued during their residency. Fear of malpractice, in general, may cause physicians to order more tests than medically necessary, refer patients to specialists, and suggest invasive procedures to confirm diagnoses more often than needed. Nearly 40% may prescribe more medications than medically necessary due to concerns of legal liability.² The public has responded by escalating the “punishment” associated with malpractice claims where multimillion-dollar jury awards are commonplace.

DELAYED DIAGNOSIS OF BREAST CANCER

Breast cancer remains a significant public health issue affecting more than 211,000 women each year.³ Breast complaints, in general, are an important reason for visits to the obstetrician/gynecologist. Despite the immense experience in this arena, delayed diagnosis of breast cancer remains a major source of malpractice allegations for gynecologists and is the most common error in diagnosis resulting in claims for medical malpractice. It is also a leading reason for malpractice claims against radiologists, general surgeons, family practitioners, and internal medicine physicians, making it the most prevalent condition resulting in malpractice claims with an average cost per case over \$200,000. Moreover, it is the second most expensive condition to indemnify (brain-damaged infant is the most expensive), accounting for nearly \$300 million in paid claims.⁴

The etiology of breast cancer is multifactorial and although numerous risk factors have been identified, they only explain 21% of the risk of breast cancer in women aged 30 to 54 years and only 29% of that in women aged 55 to 84 years. Furthermore, nearly three-quarters of women with breast cancer have no identifiable risk factors other than gender and age; thus all women should be considered at risk for breast cancer.

Previously identified risk factors for breast cancer include increasing age, nulliparity, delayed childbearing

(childbirth prior to age 18 portends one-third the risk of breast cancer than a women delivering at age 35), a personal or family history of breast cancer, oophorectomy, benign proliferative breast disease, obesity in postmenopausal women, a long menstrual history (menarche before age 12 and late menopause), or higher education and socioeconomic status. Other factors, such as fat intake, breastfeeding, previous abortions, smoking, and alcohol intake, have all been suggested to contribute to breast cancer risks, but the association remains inconclusive, inconsistent, and controversial.

Common themes associated with delayed diagnosis include a skepticism regarding the possibility of breast cancer in young women, complete reliance on negative mammograms or false, negative mammograms, “system” failures, complete reliance on negative biopsy, inattention to medical history, and failure to diagnose recurrent disease.⁵ Additional diagnostic errors occur in failing to examine a breast containing an obvious tumor while treating the patient for an unrelated disease, failure to find the tumor of concern during palpation of the breast, failing to recommend a referral, biopsy/excision, failing to follow up, actions of nonphysician providers, failing to determine the cause of a nipple discharge, mistaking a carcinomatous tumor for a breast infection/benign lesion, and disregarding a definite retraction sign or history of acute or sharp pain.⁶

The characteristics of women in whom delayed diagnosis commonly occurs include young age with a self-discovered breast mass in the face of a negative mammogram. Breast cancer has been documented in 1–3% of women younger than 30 years of age; however, it is often dismissed as a fibrocystic condition. In *Truan v. Smith*, the patient noted increased size and firmness of her breast 10 years following surgery for breast implants. This was brought to the attention of her primary care physician, who did not examine the breasts initially (as she had been recently examined only 4 months prior) but attributed the changes to the implants. Two months later the patient continued to have symptoms, at which time an examination led to a differential diagnosis of foreign body reaction, mastitis, carcinoma, benign tumor, or fibrocystic disease. This differential was not communicated to the patient. She was told to return in 30 days. As her symptoms were unchanged during the observation period, the patient phoned to see if she needed to keep the follow-up

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appointment. Although office personnel indicated they would notify the physician, the patient never received a return call. The following month the patient noted worsening symptoms and called for an appointment, but was delayed another month due to the physician being away at a medical conference. Upon exam (now 4 months after initial symptoms) the physician noted a mass and referred to a specialist. The patient underwent a radical mastectomy 8 days later and died from her cancer within weeks of the conclusion of her trial. The jury found the physician negligent for not taking action earlier to determine the cause of the patient's complaints, failing to detect a breast mass at the initial exam, and failing to adequately follow the patient throughout the observation period. Interestingly the court held: "We are of the opinion . . . that the jury reasonably could find *the physician* guilty of actionable negligence in failing to follow this patient through and after the period of observation prescribed by him . . . nor did he make any effort to see that *the patient* returned for evaluation at the end of the observation period" (emphasis added). The judgment of \$185,000 was appealed and affirmed in favor of the patient.⁷

Despite the controversy surrounding decreased mortality associated with this modality,⁸ mammography remains the gold standard for early detection of breast cancer. Miscellaneous factors leading to litigation surrounding breast cancer also include reliance on false-negative fine needle aspiration biopsy. A \$1.5 million verdict was rendered for a 37-year-old homemaker who underwent FNA biopsy that was incorrectly read as benign. The patient sued her surgeon, pathologist, and internist for the failure to diagnose breast cancer, based on an erroneous FNA biopsy. Because of the falsely negative report, the mass was not excised until 16 months later due to growth. Excisional biopsy at that time revealed invasive breast cancer. Despite treatment including mastectomy and chemotherapy, the patient died 33 months after the initial misdiagnosis.⁹

Inadequate or lack of informed consent is a pervasive issue in allegations against obstetricians and gynecologists. Physicians have been sued despite "successful" surgery for breaching the physician's duty in failing to obtain informed consent. In *Dries v. Greger*,¹⁰ a quadrant resection was recommended and performed removing three sections of tissue, each 6–7 cm (as a discrete, palpable lump could not be located on exam). None of the tissue was found to be malignant. The patient was successful in her claim against the physician, indicating she was told that a small sample would be removed but had not been told that a resection would be performed. In another lack of informed consent case, a woman sued her plastic surgeon after undergoing unsuccessful reconstructive surgery, alleging negligence and lack of informed consent as the physician encouraged her to undergo a surgery that was unlikely to succeed due to the radiation she had undergone.¹¹

Additionally, care must be taken in identification of specimens. In a Florida case, the surgeon successfully removed a cyst from each of the patient's breasts; however, he did not label them separately. As one was malignant and the other was not, the patient was subjected to a bilateral

mastectomy because it was impossible to identify which cysts came from which breast.¹² This would of course apply to fine needle aspirations as performed by gynecologists.

Medical malpractice cases based on delayed diagnosis are usually barred after the statute of limitations has run except under the continuous treatment doctrine. Here the statute of limitations is tolled until the end of a course of treatment when the course of treatment, which includes the wrongful acts or omissions, has run continuously and is related to the same original condition or complaint. The purpose of the doctrine is to "maintain the physician-patient relationship in the belief that the most efficacious medical care will be obtained when the attending physician remains on a case from onset to cure. The doctrine *response* on the premise that it is in the patient's best interest that an ongoing course of treatment be continued, rather than interrupted by a lawsuit, because the doctor not only is in a position to identify and correct his or her malpractice, but is best placed to do so."¹³ In general, neither the mere continuation of a relationship between the physician and the patient nor the continuing nature of a diagnosis is sufficient to satisfy the requirements of the doctrine, since none of the policy reasons underlying the doctrine exists in the absence of continuing efforts by the doctor to treat the particular condition. It is essential to establish a course of treatment with respect to the condition that gives rise to the lawsuit for this doctrine to apply. Accordingly, "Where the physician and patient reasonably intend the patient's uninterrupted reliance upon the physician's observation, directions, concern and responsibility for overseeing the patient's progress," the requirements of the continuous treatment doctrine are satisfied.¹⁴

Another doctrine often implicated in delayed diagnosis cases is the "loss of chance" doctrine. In general, unless there is proof that a connection exists between the conduct of the physician and the resulting injury, it is immaterial that the patient sustained an injury. The connection to physician conduct must generally be proven with "reasonable certainty"; however, the "loss of chance" doctrine has been used where it cannot be proven that the physician caused a patient's death or injury. The theory explicates that the physician caused the patient to be deprived of a chance or alters their chance to live. In a landmark case, the government's contention was that there was no medical negligence, but even if negligence was established, there was no proof that the physician's actions "caused" the injury and thus it would be mere speculation to say that any operation would have been successful. Although the District Court agreed, the Court of Appeals reversed the decision and remanded the matter for determination of damages.¹⁵ In a similar case, a pregnant plaintiff alleged negligence to perform a biopsy at the time of the first examination, failure to evaluate the breast mass during the pregnancy, failure to advise the patient of the mass at the time of her postpartum examination, and a delay of 2 months between clinical examination and treatment. The case was settled for \$1,300,000 cash immediately payable to the plaintiff, and an annuity paying each of the patient's three children \$500 per month until age 18,

\$50,000 each annually for 4 years thereafter, and \$100,000 each at age 25.¹⁶ Regarding the identical issue, a judge in another breast cancer case found that the physician “did not exercise that degree of care and diligence required of him in providing medical care to *the patient* and that his failure to do so either materially increased the chances or accelerated *the patient’s death*”; thus the physician was found guilty of malpractice.¹⁷

Hereditary cancer litigation may evolve into the new frontier of medical litigation.¹⁸ Allegations include failure to diagnose, failure to consider patient’s genealogy, failure to inform other family members (one must be cognizant of HIPAA considerations), and failure to offer testing. This has already occurred in obstetrics with Tay-Sachs testing.¹⁹ Physicians should familiarize themselves with the Gail model,²⁰ which is the only clinically validated model that derives an individual’s risk for development of breast cancer. The Gail model risk assessment tool incorporates the patient’s race, current age, age at menarche and first live birth, number of first-degree relatives with breast cancer, number of previous breast biopsies, and pathology results in generating an estimate of breast cancer risk. Conversely, the Claus model uses fewer categories, including only the number of relatives with breast cancer, their relationship to the patient, and the relatives’ age of cancer diagnosis.²¹ Although helpful in diagnosis, models are often inapplicable to the proband. In particular, the Gail model cannot be used for women younger than 35 years of age and is less accurate in women who do not obtain annual mammograms. Counseling must stress that these figures are estimates and not absolute risks, and thus balance the magnitude of risk for the individual patient. Clinicians must also become familiar with the eligibility criteria for breast cancer susceptibility gene testing, the principles of genetic counseling, options available to those at high risk, and follow-up of patients at high risk.²²

As expressed by one expert, “The price of skill in the diagnosis of breast carcinoma is a kind of eternal vigilance based upon an awareness that any indication of disease in the breast may be due to carcinoma.”²³

GYNECOLOGIC SURGERY

Surgical Sterilization

Gynecologic surgery accounted for 38.3% of claims against obstetrician/gynecologists according to the 2003 ACOG Professional Liability Survey.²⁴ Delay or failure to diagnose was the most frequent allegation, a patient injury was the second most frequent allegation.

Bilateral tubal sterilization and vasectomy are both safe and effective methods of permanent contraception. Worldwide, over 220 million couples use sterilization as their contraceptive method of choice.²⁵ Sterilization accounts for 39% of contraceptive methods used by women of reproductive age and their partners in the United States. In comparison, 27% use oral contraceptives, 21% use male condoms, 3% use injectable contraceptives, 2% use diaphragms, and 1% use intrauterine devices

(IUDs).²⁶ Of women of reproductive age utilizing this method, 28% had tubal sterilization and 11% have partners who underwent a vasectomy. Approximately 700,000 tubal sterilizations²⁷ and 500,000 vasectomies²⁸ are performed in the United States annually. The percentage of women using this method increases with increasing age, being greatest among those aged 40 to 44.

Tubal sterilization/occlusion is the only permanent female contraceptive method available to women in the United States. It may be performed by several methods depending on the timing of the procedure in relation to a pregnancy. Laparoscopy is the most common method used for sterilization procedures unrelated to a recent pregnancy, whereas minilaparotomy is most commonly used for postpartum procedures. The Federal Drug Administration (FDA) approved a transcervical hysteroscopically assisted device in 2002. Short-term studies suggest an efficacy rate at least equal to other tubal sterilization methods. However, long-term data are needed.²⁹ Less commonly practiced is the transvaginal approach of fimbriectomy, Pomeroy technique, or tubal occlusion via a posterior colpotomy. There are also several occlusive methods of sterilization including bipolar electrocoagulation, mechanical methods, ligation techniques, and chemical methods (which have shown promise but are not currently approved for use in the United States).³⁰ Mechanical methods include the silicone rubber band (Falope ring), spring-loaded clip (Hulka-Clemens clip), and the titanium clip lined with silicone rubber (Filshie clip). The most commonly used ligation methods include the Pomeroy, modified Pomeroy, Parkland, and the less used Uchida and Irving techniques.³¹

Failure rates of tubal sterilization are roughly comparable with those of the IUD. The risk of sterilization failure persists for years after the procedure and varies by method, with postpartum partial salpingectomy having the lowest and spring clip having the highest.³² Vasectomy failure rates range from 0 to 2%, with most studies reporting pregnancy rates of less than 1%.³³ Thickened or dilated tubes, major pelvic adhesions, and enlarged uterus may increase the complication rate. Other risks of the procedures consist of infection, bleeding, injury to bowel, bladder, or major vessels, cellulites, pelvic abscess (posterior colpotomy), granuloma formation, epididymitis, and “postvasectomy pain syndrome”(vasectomy). The most recent randomized, case-control study from New Zealand concluded that vasectomy does not increase the risk of prostate cancer,³⁴ although earlier data showed a weak but statistically significant increased risk in certain subgroups.³⁵ Measures of impotence were similar in men who had undergone vasectomy compared to those who had not, consistent with the fact that the nerves involved in male erectile function and ejaculation are not affected by vasectomy.³⁶

Effective counseling is a critical aspect of these procedures. Although regret for having had a sterilization procedure is uncommon, thorough and constructive counseling may minimize this risk even more. Presterilization counseling should incorporate typically principles of informed consent including the permanent nature of the procedure; full consideration of all alternatives including

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temporary contraceptive options and male sterilization; reasons for choosing sterilization; screening for risk indicators for regret (especially young age and low parity); details, risks, and benefits of the procedure including anesthesia; discussion of the possibility of failure including ectopic pregnancy; and the need to use condoms for protection against STIs.³⁷ This explanation should be provided in a manner that is understandable to the patient, taking into consideration both educational and cultural diversity, and realizing that inquiries about the method and any decision to withdraw from use is the patient's right.

Determining capacity and competence to consent are important facets of the decision-making process. In general, sterilization is regarded as a voluntary procedure—free from coercion.³⁸ However, it can also be therapeutic (if performed secondary to medical indications that would threaten the physical or mental health of the patient), incidental (if resulting from therapy performed for another purpose such as chemotherapy for cancer, hysterectomy for endometriosis, and bilateral orchiectomy for prostate cancer), or involuntary (if performed without patient consent). It may be advisable to have a separate consent form for sterilization that incorporates these principles as well as possible discussion of procedure-specific failure rates. Thorough documentation of the informed consent process is of key importance. Those anticipating their procedure in the postpartum period should have informed consent prior to the stressful period of labor and delivery. Moreover, a full assessment of maternal and neonatal well-being should be done when sterilization is performed after the delivery of the infant. Any perceived ambivalence should be addressed immediately and serious consideration should be given to delaying the procedure until a later date. Inclusion of the partner may be helpful. In addition, one should always keep in mind federal and local statutes and regulations regarding the interval from the time of consent to the procedure, the location in which the procedure must be performed, and requirements such as additional physician collaboration, particular forms for billing, or the option of spousal signature.

The most common allegations involving sterilization implicate negligence principles in performance of the procedure and inadequate or lack of informed consent. In addition, failed sterilization is the most common basis for the birth-related allegations of “wrongful pregnancy” and “wrongful conception” with associated physical and emotional injuries resulting from labor and delivery and possibly the necessity of a second sterilization procedure. Moreover, damages are often sought for loss of services, companionship, and consortium. Additional circumstances that result in wrongful pregnancy include ineffective prescription of contraceptives or counseling on contraception, failure to diagnose pregnancy in time for an elective abortion, and an unsuccessful abortion. Risk management procedures would include ensuring adequate length of tubal destruction or occlusion and obtaining histological confirmation of tubal tissue. The first successful wrongful pregnancy case was *Custodio v. Bauer*,³⁹ where a woman became pregnant soon after a failed tubal ligation.

The award was deemed a logical extension of malpractice action *soldiering* to deny the claim would be to allow the injury from a physician's negligent act to go uncompensated.

For risk management procedures in the case of vasectomy (as depicted below), standard practice generally requires the use of additional contraception until the establishment of postvasectomy aspermia. The patient's noncompliance is often the basis for failure to obtain the specimens, but a physician may have the duty to warn the patient of the consequences of his noncompliance.

The importance of informed consent and an appropriate informed consent form is illustrated in a vasectomy case where the plaintiff alleged breach of the standard of care by failing to properly inform the patient that the effect of the procedure may not be permanent. The consent form, signed by the plaintiff, clearly stated, “I realize this is a permanent procedure; and that occasionally, through no fault of the Surgeon, the tube may reunite, thus allowing pregnancy to occur. I hereby relieve the Surgeon, and all other personnel involved, for the success or possibly failure of the operation of sterilization . . .”⁴⁰ The trial court granted motion for summary disposition, concluding that because the plaintiff signed the consent form, he could not claim that he was not informed that the surgery might not be permanent. However, one must be cognizant of state laws where, as here, although the court ruled that the consent form was valid, the court also stated that it did not clearly release the doctor from liability for negligence as an exculpatory agreement in a consent form signed before receiving medical treatment may be held invalid.⁴¹ In dicta, this case suggests that all covenants not to sue or release from liability in the context of medical treatment are invalid and unenforceable even if it involves nonessential, non-life-threatening medical treatment. Many courts have held that the wife does not have an independent claim against the physician after a failed vasectomy.

Recovery of medical expenses and for pain and suffering for having an unwanted child is often allowed. However, actions seeking recovery of expenses of raising a healthy, normal child, born after an unsuccessful birth control operation, is properly characterized as a claim for “wrongful conception.” The concept of “wrongful conception” has been the subject of much scholarly debate. In general, many states have not recognized this as a legally cognizable claim as it does not result in legal harm and is thus not actionable. Liability for negligent conduct exists only when it proximately causes a legally recognized harm to a protected interest of another.⁴² Courts have generally rejected such claims as a matter of public policy, since “the birth of a healthy child does not constitute a cognizable legal harm for which an action in tort will lie: the moral, social and emotional advantages arising from the birth of a healthy child are to be preferred to the protection of a purely economic interest.”⁴³ Here courts have considered the “very nearly uniform high value” and sanctity that the law and mankind have recognized upon human life.⁴⁴ Courts have raised questions whether failure to have an abortion or to have the child adopted is a failure to mitigate that precluded recovery⁴⁵ as well as declining recovery as damages are speculative and avoidable.⁴⁶ While jurisdictions

differ, there is a respectable body of opinion that recovery for wrongful conception *should* be allowed⁴⁷ and this has not been subjected to the “crucible of plenary consideration.”⁴⁸ As stated by the Supreme Judicial Court of Massachusetts:

*The judicial declaration that the joy and pride in raising a child always outweigh any economic loss the parents may suffer, thus precluding recovery for the cost of raising the child, simply lacks verisimilitude. The very fact that a person has sought medical intervention to prevent him or her from having a child demonstrates that, for that person, the benefits of parenthood did not outweigh the burdens, economic and otherwise, of having a child. The extensive use of contraception and sterilization and the performance of numerous abortions each year show that, in some instances, large numbers of people do not accept parenthood as a new positive circumstance.*⁴⁹

Jurisdictions differ regarding recovery for birth of a child with congenital defects secondary to a negligently performed tubal sterilization.⁵⁰ Several cases have arisen in which patients were allowed to sue alleging lack of informed consent specifically regarding alternative sterilization procedures when tubal sterilizations were performed using techniques associated with high failure rates.⁵¹ Moreover, a Georgia case expounding on the narrative of a “full and reasonable medical explanation” contained in the Georgia Voluntary Sterility Act, illuminated the need for further discussion while finding in favor of a woman who documented a desire to have her tubes “cut, tied and burnt.” Without notifying the patient, the physician used clips and she subsequently became pregnant.⁵²

Laparoscopy

Laparoscopic surgery is another source of malpractice litigation where allegations include failure to obtain consultation (where technical skills are not optimum), failure to follow up in a timely manner, failure to order testing (when concerned regarding complication of procedure), communication failures, failure of sterilization (discussed earlier), and poor clinical examination of other health problems that may contraindicate laparoscopic surgery. Patient injury is the second most common gynecologic allegation. Clinicians must be familiar with relative and absolute contraindications of surgery including bowel obstruction, ileus, generalized peritonitis, intraperitoneal hemorrhage, diaphragmatic hernia, severe cardiorespiratory disease, extremes of body weight, inflammatory bowel disease, or large abdominal mass. The complications of surgery consist of inappropriate placement of the needle upon introduction, trocar hernias, and vascular, bowel, bladder, and urethral injury. In particular, laparoscopic surgeries require a heightened level of expertise reflected in appropriate intraoperative judgment and postoperative diligence. Informed consent and documentation of such is key to developing realistic expectations regarding surgical outcomes and risks. Operative and postoperative documentation should include listing adequate visualization of

bleeding sites, visualization of organs, elevation of structures prior to cautery or suturing, lack of difficulty in ventilation, and a follow-up plan of action (especially if complications are noted or the patient is having difficulty).

OBSTETRICS

Obstetric claims account for the majority of claims against obstetrician/gynecologists, forcing many to change their practice either by stopping obstetric practice altogether, reducing high-risk deliveries, or reducing total deliveries. Plaintiff recovery rates in childbirth negligence lawsuits are nearly 1.5 times the rate compared to overall medical malpractice suits.⁵³ Additionally, childbirth cases are routinely listed among the top jury awards.

Shoulder Dystocia

Shoulder dystocia is an obstetric emergency associated with failure of the shoulders to deliver spontaneously. It is most commonly caused by the impaction of the anterior fetal shoulder behind the maternal pubis symphysis or impaction of the posterior fetal shoulder on the sacral promontory and may be heralded by the “turtle sign,” where the fetal head retracts against the maternal perineum upon delivery.⁵⁴ The reported incidence ranges from 0.6% to 1.4% among vaginal deliveries of fetuses in the vertex presentation. Failure of the shoulders to deliver spontaneously places both the pregnant woman and fetus at risk for postpartum hemorrhage, fourth-degree lacerations, brachial plexus injuries, and fractures of the clavicle and humerus. Severe cases of shoulder dystocia may result in significant maternal morbidity (especially with more advanced maneuvers), hypoxic-ischemic encephalopathy, and even death.

Risk factors for shoulder dystocia are helpful but do not predict all cases and are not present in each case. Prior history of shoulder dystocia, postdates pregnancy, gestational diabetes, need for instrumental delivery, insulin-dependent diabetes, obesity, excessive weight gain, cephalopelvic disproportion, prolonged second stage, and macrosomia may be present in patients with shoulder dystocia. McRoberts is a reasonable initial maneuver as the cephalad rotation of the symphysis’s angle of inclination and flattening of the lumbar lordosis caused by the flexion and abduction of the hips may dislodge the impacted shoulder. Suprapubic pressure may be used at the same time to assist in freeing the impacted shoulder. In contrast, fundal pressure may further worsen the impaction and may also result in uterine rupture. Moreover, the Woods Screw maneuver and Rubin’s maneuver may also be helpful. Additional direct fetal/maternal manipulations may include delivery of the posterior arm, Zavanelli maneuver, and symphysiotomy. There is currently no evidence that one maneuver is superior to another.⁵⁵

Documentation is important in shoulder dystocia cases as highlighted in the following case where improper technique was alleged. The key to a plaintiff verdict in a shoulder dystocia case includes proving the 4 P’s: poor preparation,

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panic, and pulling. The predelivery and delivery should reflect risk factors, the prepregnancy weight, weight gain, estimated fetal weight, whether induction or augmentation has occurred, the duration of the first and second stage of labor, clinical pelvimetry (if performed), time to resolution, quality of traction, attempts at forceps or vacuum extraction, descriptions of the maneuvers used, durations of dystocia, cord gases, Apgars, and personnel present. Post delivery one should include the fetal birth weight, record of those present for newborn care, and evaluation for brachial plexus injury, Horner's facial palsy, and fractures. If assistance is requested this should be documented as well as the discussion with the mother postpartum, which should include discussion of recurrent risk. Consider further documentation that fundal pressure and excessive traction was *not* used.⁵⁶ Documentation tools have been developed to assist in appropriate documentation.⁵⁷

The court held in favor of the defendant in *Young v. Louisiana Med Mutual Insurance Co.*, where a medical malpractice action alleged use of improper techniques in delivery of an infant, which in effect made the dystocia more severe and the delivery more complicated.⁵⁸ Conversely, a midwife's actions were felt to fall within the standard of reasonable care required of a certified nurse midwife despite allegations that the infant's Erb's palsy was probably caused by traction on the fetal head during shoulder impaction.⁵⁹ States have in effect apology laws that support an apology without admitting fault and without indicating negligence occurred.⁶⁰

Failure to Perform Timely Cesarean Section

Many recent cases have revolved around the issue of failing to perform a timely cesarean section. In a recent case, a plaintiff verdict was rendered for a child suffering from cerebral palsy after his mother went to the hospital complaining of lack of fetal movement. Cesarean section was performed several hours later, after signs of fetal distress. Plaintiffs alleged the obstetrician should have performed an immediate cesarean section in light of decreased fetal movement and signs of fetal distress.⁶¹ Furthermore, updating informed consent issues are often contemplated as in a Wisconsin case, where the mother initially elected a vaginal delivery; however, twice during prolonged labor she requested a cesarean delivery that was performed emergently when fetal distress occurred. The court held that the patient's right to determine the method of treatment applies regardless of when the choice is made and that the right to select a treatment option encompasses the right to change one's mind about the approach selected, thus holding that the physician had breached the duty of care and caused harm to the patient and her daughter, who was born a spastic quadriplegic.⁶²

Wrongful Birth/Conception (Pregnancy)/Life

There is a close relationship between the torts of wrongful birth (involving the negligent failure to inform a pregnant

woman of the risk of birth defects), wrongful life (involving the negligent failure to properly advise the parents of birth defects or problems that would have resulted in their choosing to terminate the pregnancy), and wrongful conception (involving the negligent failure to prevent a child's birth).⁶³ Wrongful life claims are often rejected, since although a "viable fetus has been harmed in utero by the act or omission of another . . . the healthcare provider did not cause the impairment here."⁶⁴ In *Willis v. Wu*, summary judgment was granted for the physician as the high court embraced the reasoning of the majority of courts that do not recognize a claim for wrongful life. The courts noted that 27 states have either refused to recognize or have limited wrongful life actions, reasoning that being born is not a legally cognizable injury and that the physician did not actually cause their impairment. The fundamental tenet in those states that have adopted a wrongful life action generally is that the negligent party has deprived the child of the "fundamental right of a child to be born as a whole, functional human being . . ." ⁶⁵ In denying a wrongful life claim in *Greco v. U.S.*, the court held the mother could bring a medical malpractice action against the physicians for failure to diagnose the severe fetal defects, thus depriving her of the right to terminate the pregnancy. However, courts did allow recovery for the extraordinary costs anticipated in caring for her son, for future extraordinary medical, therapeutic, and custodial costs and for emotional damages, but not for loss of companionship.⁶⁶

Although previously enacted, states are often abolishing wrongful birth causes of action as continued judicial recognition would force a jury to "quantify the unquantifiable" and measure the benefits of a disabled child's whole life when the child's potential is unknown.⁶⁷ Conversely, in *McAllister v. Ha*, courts allowed a claim for wrongful conception alleging that the physician was negligent in failing to communicate results of blood test to the presents and in failing to provide genetic counseling, which deprived them of the opportunity to make an informed decision as to whether to have another child. However, recovery of damages for the extraordinary costs of raising a child with sickle cell disease was not allowed.⁶⁸ Wrongful birth suits have also been successfully brought by siblings for loss of parental services.⁶⁹

Failure to provide genetic counseling or testing will be and has been implicated not only in BRCA testing situations (as mentioned above under delayed diagnosis of breast cancer) but also in prenatal or conceptual issues.⁷⁰ Courts are now often placing limitations on the duty to inform parents of genetic risk and failure to offer genetic services, since with the advent of hundreds or even thousands of genetic risks becoming detectable it may be unreasonable to assume that physicians will be able to warn each patient of all the potential risks and tests available to determine those risks. In general, patients must be in a high-risk category and the test must be sufficiently predictive.⁷¹

Jurisdictions differ regarding recognition of wrongful death as a cognizable cause of action in the birth of a still-born child. In *District of Columbia v. McNeill*, the court

found sufficient evidence to support a finding that the plaintiff mother had suffered both physical and mental injuries as a result of the stillbirth of her child.⁷² The plaintiff alleged that her pregnancy had been allowed to continue postterm due to negligent estimation of the expected due date, resulting in the death of her fetus. Conversely, in *Shaw v. Jendzejec*, the court entered summary judgment on the wrongful death claim, as Maine does not recognize a cause of action for wrongful death brought by the parents of a stillborn child.⁷³ Interestingly, at least one court in dicta posited that a child might bring a wrongful life action against their parents, claiming "if a case arose where, despite due care by the medical profession in transmitting the necessary warnings, parents made a conscious choice to proceed with a pregnancy, with full knowledge that a seriously impaired infant would be born . . . Under such circumstances, we see no sound policy which should protect those parents from being answerable for the pain, suffering and misery which they have brought upon their offspring."⁷⁴ However, a review of case law does not reveal an instance where this kind of wrongful life suit has been alleged against a parent. California has addressed this specific issue, barring a cause of action against a parent "of a child based on the claim that the child should not have been conceived or, if conceived, should not have been allowed to have been born alive."⁷⁵

Endnotes

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