No Perfect Cases

By John T. Ryman, JD

On June 1, a 24-year-old obese female patient at 11 weeks gestation presented to the OB-GYN clinic to see Dr. Smith.[1] She had been treated at the clinic for her three prior pregnancies. At the patient's visit on September 3, Dr. Smith scheduled the patient for a three-hour glucose tolerance test (GTT), which was performed on September 12. According to those test results, the patient did not meet the criteria for gestational diabetes. The patient was seen at the clinic on October 6 and again on October 23, and at the latter visit, the patient was found to have lost nine pounds and had 3+ glycosuria. The patient reported that she had been suffering from a stomach bug and had been drinking a high-sugar content sports drink while in the waiting room. The weight loss was consistent with the reported illness, and glycosuria was attributed to consuming the sports drink. The patient also had a history of late-term weight loss in a prior pregnancy.

On October 28, the patient presented to the small local hospital with complaints of nausea, vomiting, and shortness of breath, and she was transferred to a regional hospital with a diagnosis of severe diabetic ketoacidosis. The patient was induced, resulting in a stillborn male at approximately 33 weeks. The autopsy report stated multiple causes of the stillbirth, with the mother's diabetes being the most likely cause.

The patient filed a lawsuit alleging that Dr. Smith failed to properly diagnose and treat her blood glucose levels, resulting in the death of her child. She sued for medical expenses, loss of earnings and earning capacity, loss of income, burial expenses, and non-economic damages for loss of love and companionship.

The plaintiff's OB-GYN expert opined that the child should have been delivered by

Caesarean section on October 23. His opinion was based on the patient's numerous health issues including obesity, excessive weight gain, and a family history of diabetes, yet he could not cite any medical authority for his opinions.

The plaintiff claimed non-economic damages, which were capped by state law, and economic damages of approximately $950,000. The economic damages claims were supported by the testimony of an economist expert for the plaintiff.

Dr. Smith's defense theme included that he appropriately and timely performed testing for gestational diabetes with negative results. The subsequent weight loss and finding of 3+ glycosuria was not indicative of development of gestational diabetes, and the evaluation at the October 23 office visit was reasonable based on the patient's report of illness and drinking a sugary sports drink in the waiting room. Absence of documentation from the October 23 visit, and the report of recent illness or of drinking a sports drink while waiting for her appointment complicated the defense. Dr. Smith recalled the information and testified to this in his deposition, but better documentation would have strengthened the defense. However, the defense theme was supported by multiple standard of care experts.

A placental pathologist disputed the conclusion in the autopsy report and reported that the autopsy slides indicated that the child did not die as a result of gestational diabetes. There were signs of maternal vascular issues, but the placenta was not typical for a diabetic mother. The expert opined that the most likely cause of fetal demise was placental abruption.

A maternal-fetal medicine (MFM) specialist who reviewed the case for the defense opined that Dr. Smith complied with the standard of care. There was no requirement to repeat the GTT. He believed that the patient suffered from either a UTI or gastroenteritis, which sent the patient into ketoacidosis. Earlier delivery on October 23 would probably have resulted in a stillborn or severely impaired baby.

Another maternal-fetal specialist reviewed the case and concluded the patient was not a chronic diabetic and did not develop gestational diabetes. Further, Dr. Smith appropriately screened the patient for gestational diabetes. Considering the findings of the placental pathologist, this MFM reviewer opined that an unrecognizable placental abruption led to death of the unborn child. According to this reviewer, all care by Dr. Smith was appropriate and within the standard of care.

Defense counsel recommended defending the case through trial; Dr. Smith wanted to defend his care and did not give consent to settle. Trial started nearly five years after Dr. Smith treated the patient and lasted a total of five days. The plaintiff was a likable person and made a good and sympathetic witness. Her case was primarily based on sympathy; however, the medical and factual evidence at trial strongly favored Dr. Smith. Dr. Smith and his three experts were all strong witnesses, appearing in-person at trial. They effectively refuted the plaintiff's claims with facts and medical science, explaining the standard of care and how Dr. Smith met that standard. Further, they were able to offer a plausible alternative theory for the cause of the death. At the end of the five-day trial, after

about two hours of deliberation, the jury returned a verdict in favor of Dr. Smith.

There are no perfect cases for either the plaintiff or the defendant. Perfect cases never get to the courtroom. Thus, trial is always somewhat risky, and it is unlikely that there are any doctors who enjoy being the defendant in a trial. The outcome of a fight is rarely certain. However, this case is an example of when a good doctor fought to defend his care and prevailed, despite the tragic outcome.

[1] All names have been changed.

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