In 2000, Dennis Donnelly, JD, a plaintiff attorney in Chatham, NJ, won a $600,000 settlement from an OB-GYN who had failed to screen a pregnant African-American woman for sickle cell disease.

In 2002, he helped a couple that should have been screened for possible thalassemia obtain a $1 million settlement from the doctor who neglected to do so.

Illustrating the proliferation of such lawsuits, Donnelly closed four cases in 2003 involving failure to screen a pregnant woman or couple for genetic disorders that then appeared in their child:

- An OB-GYN agreed during trial to pay $1.25 million to a family after he failed to test the couple, who were of Ashkenazi Jewish descent, for Canavan disease.
- A child born with thalassemia major collected $900,000 from an OB-GYN who did not take a family history to determine the parents’ potential to be carriers of the gene, and did not interpret testing correctly or diagnose the thalassemia prenatally.
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- An obstetric practice paid $1.2 million to the family of a 6-year-old boy born with fragile X syndrome, the most common form of inherited mental retardation, for failing to offer a screening blood test to the parents despite a family history of mental retardation and autism.

Donnelly says such lawsuits are increasing because the public is becoming a lot more knowledgeable about genetic screening.

A July 21 article in The New York Times titled “As Gene Test Menu Grows, Who Gets to Choose?” stated that, “many people [are] demanding to know why screening tests for certain genetic conditions, including deafness, mental retardation, and breast cancer, are not being offered to them—even, in some cases, when they ask.” This is true of preconception or prenatal screening, newborn screening, and screening for genes that make people predisposed to some cancers or other adult diseases.

*Learning Objectives:* After reading this article, the practitioner should be better able to:

- Discuss the key points of how to stay out of legal trouble in regard to genetic screening of patients.
- Recall ways to integrate the use of genetic counseling referrals into an OB-GYN practice.
- Describe who should be screened for genetic disorders using ACOG guidelines.

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Another group of OB-GYNs paid $1.225 million to settle a lawsuit on behalf a 4-year-old child born with fragile X syndrome.

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*Top Tips:*

- Take a thorough family history of both parents, including their ancestors.
- Refer patients for genetic counseling if you have any uncertainty about their history or heritage.
- Document that you’ve provided baseline screening and offered genetic counseling or testing.
- Document carefully if a patient declines counseling, screening, and/or genetic testing and her reasons for doing so.

“Too many health care providers, critics say, have not educated themselves about the genetic tests that could benefit their patients,” the Times article said. “Others, pressed for time, simply do not communicate what can be complex information. And some choose not to inform their patients of certain tests they have deemed inappropriate, in effect, making a value judgment about abortion, disabilities,

Marion Garza and Julius S. Piver, MD, JD, have disclosed that they have no significant relationships with or financial interests in any commercial organizations pertaining to this educational activity.
OB-GYN Malpractice Prevention/October 2004

Who Should Be Screened?

Couples at high risk because of their family history should be screened for such disorders as Duchenne dystrophy, fragile X syndrome, neurofibromatosis, and hemophilia, ACOG says.

Driscoll says couples should be screened for fragile X if either family has a member with mental retardation. If a family member is autistic, she says, “it’s always important to know about it. There are genetic causes, but not one genetic test for this. But we might recommend fragile X screening or chromosome testing.”

Patients also should be questioned closely about their ethnic backgrounds, then offered genetic testing for disorders prevalent in those populations. For example:

- Caucasians may carry the gene for cystic fibrosis (CF);
- Those of African-American, Southeast Asian, or Mediterranean heritage should be screened for hemoglobinopathies (e.g., thalassemia or sickle cell disease);
- Individuals with a French-Canadian or Cajun heritage are at risk for Tay-Sachs disease;
- Those of Eastern European Jewish heritage should be offered screening for Tay-Sachs, Canavan disease, CF, and (new as of August) for familial dystauromacia, a neurologic disorder.

“Dystauromacia is a pretty morbid condition with no cure and a high detection rate,” Driscoll says. The gene for the disorder was discovered in 2001.

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She also advises asking open-ended questions about any rare medical conditions in the family. “So many of the genes for these rare conditions have been found,” she says. “So it really does pay to take an extensive family history.”

If the family has a history of a rare genetic disease, such as Huntington chorea, “we could determine the likelihood that the individual could develop that disease.”

Driscoll recommends using the prenatal forms available from ACOG, which list genetic disorders that practitioners should discuss with patients. “You can simply run down the list,” she says.

**New Guidance From ACOG**

In August, ACOG released a new committee opinion (No. 298), *Prenatal and Preconceptional Carrier Screening for Genetic Diseases in Individuals of Eastern European Jewish Descent*. That opinion recommends determining whether either member of the couple is of Eastern European Jewish heritage or has a relative with one of the following genetic conditions (in addition to those listed above):

- Fanconi anemia group C;
- Niemann-Pick disease type A;
- Mucolipidosis IV;
- Bloom syndrome; and
- Gaucher disease.

Committee Opinion No. 298 provides details on which individuals should be offered screening or testing for certain genetic disorders, OB-GYNs, nurse-midwives, and other obstetric care providers also should familiarize themselves with the following opinions from the ACOG Committee on Genetics:

- No. 161, *Fragile X Syndrome*, October 1995 (reaffirmed in 2000);
- No. 162, *Screening for Tay-Sachs Disease*, November 1995 (reaffirmed in 2003);
- No. 212, *Screening for Canavan Disease*, November 1998 (reaffirmed in 2003); and

If appropriate, OB-GYNs also should also review ACOG Committee Opinions:

- No. 257, *Genetic Evaluation of Stillbirths and Neonatal Deaths*, November 1996; and/or

Driscoll strongly advises genetic testing whenever there’s a stillbirth or neonatal death. “It’s important to establish a diagnosis whenever possible,” she says. “This provides the family with relief and provides important information for other family members and for future pregnancies.”

Such testing, she says, “could also head off a lawsuit” claiming that negligence caused the death.

**What About Cystic Fibrosis?**

What is the standard of care for CF screening?

In 1991, ACOG released a committee opinion on CF screening stating that “under the current circumstances, population-based screening should not be recommended for individuals and couples with a negative family history.” ACOG reaffirmed that opinion in 1996 but withdrew it after the National Institutes of Health (NIH) issued a consensus statement on CF screening in 1997.

The NIH recommended CF testing for all adults with a family history of CF, for all couples planning a pregnancy, and for all couples seeking genetic testing.

In October 2001, ACOG released a new document, *Preconception and Prenatal Carrier Screening for Cystic Fibrosis*, which was developed in concert with the NIH and the American College of Medical Genetics (ACMG).

The new guidelines recommend that: “CF carrier screening be offered to non-Jewish Caucasians and Ashkenazi Jews, and made available to other ethnic and racial groups.... Testing should be made available to African-Americans, recognizing that only about 50% of at-risk [African-American] couples will be detected.”

The statement also recommends: “Asian-Americans and Native-Americans without significant Caucasian admixture should be informed of the rarity of the disease and the very low yield of the test in their respective populations.”

The ACOG bookstore offers two patient-education pamphlets on CF: *Cystic Fibrosis Carrier Testing: The Decision Is Yours* and *Cystic Fibrosis Testing: What Happens If Both My Partner and I Are Carriers?*

Both non-Jewish Caucasians of European ancestry and Ashkenazi Jews have a CF carrier frequency ranging from 1-in-25 to 1-in-30.

The “good news” is that both parents must be carriers for their child to be born with CF.

The ACOG/NIH/ACMG guidelines recommend preconception testing whenever possible, “although we recognize that for practical purposes, testing will often occur in the prenatal setting.”

With Caucasian couples and those of Ashkenazi Jewish descent, they recommend...
testing both partners at the same time, “particularly when concurrently testing for other common genetic disorders in the latter population.” With couples from lower-risk groups, it may make more sense to screen the mother first, then screen the father only if the mother does carry the CF gene.

Donnelly has won settlements in two cases involving Caucasian couples who were not offered CF screening and gave birth to children with CF. One pregnancy occurred in 1997, shortly after the NIH released its consensus statement, the other in 1999. In both cases, he says, he sued only a “tertiary care provider.”

“Another patient was referred to a perinatologist for a triple screen. He counseled the couple but didn’t mention the CF screen even though they were Caucasian and they could have had a definitive test,” he says.

When speaking on genetics to the American College of Nurse-Midwives and the National Association of Nurse Practitioners in Reproductive Health in 1999, the late Dru Carlson, MD, who was then director of reproductive genetics at the University of California, Los Angeles, said: “If you’re not offering CF testing, you are operating outside the standard of care.”

When Heritage Gets Tricky

Determining who should be tested based on their ancestry becomes increasingly difficult, however, as people more frequently marry individuals from other ethnic backgrounds, and their children marry those who also have mixed ancestry.

“Ideally, you should ask every patient where their ancestors came from,” Driscoll says. “It doesn’t matter what percentage you are” of a high-risk group. For example, she says, “You can be a non-Jew and still be a carrier of Canavan’s or dysautonomia, but the likelihood of being a carrier is much less.”

Take care not to jump to conclusions about someone’s heritage based on their appearance, name, or accent. For example, an African-American patient may have a Mediterranean parent or grandparent, an Asian-American could have a parent or grandparent who is an Eastern European Jew, or someone who appears Caucasian could have an African-American ancestor, putting him or her at risk of being a carrier of the gene for sickle cell disease.

If either member of a couple has been adopted or knows little of his or her parents, assume that the person is at risk of carrying a genetic disorder and recommend screening. Also remember the issue of “non-paternity.” In other words, don’t simply assume that a patient’s husband is the father of her fetus.

“If either partner has a [genetic] mutation, take the mother aside and ask if there is any possibility that someone else is the father,” Carlson advised.

Know Your Limitations

Driscoll says OB-GYNs should be able to do baseline screening to determine whether a couple’s family history or heritage puts their child at risk for a genetic disorder. “If there’s a positive family history or ancestry, it may be useful to refer the patient for genetic counseling,” she says. “We don’t have enough genetic counselors for every patient.”

But Donnelly says too many OB-GYNs are loath to refer patients for genetic counseling. “Get over the resistance to refer patients to a genetic counselor,” he advises.

“The surest road to professional error for any profession is doing more than it’s qualified to do and failing to know when to refer patients to more-specialized practitioners,” Donnelly says.

“My own experience—as a subspecialist in wrongful birth cases in a specialized medical negligence firm—has repeatedly shown me that many obstetricians often manage their pregnant patient’s prenatal screening with at best disinterested, half-hearted efforts and at worst misinformation and mistakes,” he says.

Preconception Counseling

Ideally, Driscoll says, screening to detect carriers of genetic disorders should happen before conception. “This would reassure people if they are not carriers, inform the carriers, and influence whether carriers adopt, have prenatal diagnostic testing, or choose other reproductive options,” she says.

“This also is a great opportunity to talk with them about folic acid supplementation that reduces the likelihood of having a child with a neural tube defect,” Driscoll adds.

But she notes that neither patients nor practitioners often think about genetic risks before conception. “Also, many pregnancies are unplanned,” she notes.

“If you don’t test prior to conception, you limit [a couple’s] choices, because many people wouldn’t terminate a pregnancy,” Driscoll says.
“As long as OBs keep putting off what should be preconception counseling relative to ethnic, single-gene defects and miss an opportunity on the front end [to detect genetic problems], they cannot even hide behind the few state anti-abortion bars on lawsuits premised on termination,” Donnelly says.

“That’s because the claim would not be that we would have terminated after conception,” he explains. “The claim would be that preconception, we would have either chosen not to have any children or more children or we would have selectively conceived” using a donor egg or sperm with in vitro fertilization.

Driscoll says one solution might be to better educate the public on the importance of preconception screening for these genetic disorders.

**Don’t Get Sued for Wrongful Birth**

If a patient from an at-risk group becomes pregnant before screening to determine whether she and/or the father are carriers of a genetic disorder, the OB-GYN or nurse-midwife should suggest they see a genetic counselor, get screened, or both.

“If a practitioner does not feel comfortable counseling a pregnant patient to have a screen or test that could result in a decision to terminate a pregnancy,” Driscoll says, “they should refer the patient to another OB or to an organization where [she] can get counseled and screened.

“They need to be open to the fact that it’s up to the patient,” Driscoll says.

A failure to do so leaves the practitioner open to a lawsuit claiming “wrongful birth,” which is becoming increasingly popular with medical malpractice attorneys.

A doctor who fails to assess a couple’s risk of having a child with a genetic disorder or who neglects to offer screening to a high-risk couple may be sued for wrongful birth if their child is born with that disorder.

Make sure to carefully document discussions with patients on this topic. “Informed consent and informed refusal often play a crucial role in wrongful birth cases,” Donnelly says.

“We recommend informed consent for genetic testing, although some labs will run tests without patient consent,” Driscoll says. Recording that a patient has refused a genetic screen or test can be even more important.

“Document whenever patients decline testing and why they declined,” Driscoll stresses. “Many pregnant patients aren’t interested [in genetic screening] because nothing would change what they do with the pregnancy.”

Other wrongful birth claims have succeeded against OB-GYNs who have:

• Failed to recommend follow-up testing to a couple with a positive screen;
• Misinterpreted test results; or
• Neglected to follow up on inconclusive results.

Donnelly contends that OB-GYNs miss detecting far too many hemoglobinopathies.

He describes one case in which a father of Greek ancestry and a mother of Italian ancestry did a careful review of their heritage, filling out forms for her doctor reporting that two siblings of the father died from thalassemia major. A blood test determined that the father carried the gene, and the mother’s routine blood work showed the classic low blood indices associated with a

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**YOU BE THE JUDGE**

**Did OB-GYN Alter Records on Amniocentesis?**

**Case:** A 35-year-old woman gave birth to a child with Down syndrome. She sued the OB-GYN who had provided her prenatal care, claiming “wrongful birth” and that the OB-GYN should pay for the “extraordinary expenses” associated with delivering and raising a child with Down syndrome.

The patient said the OB-GYN had told her that a test could check for Down syndrome but did not explain the nature of the test. She insisted that she asked the doctor to perform the amniocentesis but that it was not done.

The woman also testified that she was very concerned about the possibility of birth defects because of her nearly 3-year attempt to get pregnant and her use of fertility drugs. She further insisted that she would have terminated the pregnancy if she had had known what the amniocentesis would have revealed.

The OB-GYN said he fully discussed the amniocentesis test with the woman and offered it to her but that she refused it, indicating that under no circumstances would she terminate the pregnancy.

He produced the patient’s chart, which included a note stating: “Against termination, will carry.” The OB-GYN testified that that was his documentation of her refusal of the amniocentesis test.

But the patient and her attorney produced a photocopy of the Hollister prenatal form that did not have that entry. They alleged that the defendant OB-GYN had falsified the record.

The defense denied that the OB-GYN had tampered with the record and argued that the plaintiff herself had produced this second version of the record, which she denied during the trial.

**Decision:** You be the judge. Please turn to page 79 to learn the outcome of this case.

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thalamiaemia carrier. But nothing more was done to determine whether she was a thalasemia carrier. The woman gave birth to a child with thalasemia major/intermedia. And, not surprisingly, she sued the OB-GYN who had failed to follow up.

“From the many repetitive errors in genetic screening I have seen, I believe that it is only the fact that catastrophic genetic defects are rare that prevents many, many more legitimate medical negligence cases premised on failures in prenatal screening,” Donnelly says.

Driscoll says the keys to staying out of legal trouble regarding genetic screening are:

- Taking a thorough family history of both parents, including their ancestors;
- Erring on the side of caution and referring them for genetic counseling if you have any uncertainty about their history or heritage;
- Documenting that you’ve provided the baseline screening and offered the couple genetic counseling or screening; and
- Documenting carefully if a patient declines counseling, screening, and/or testing, and her reasons for doing so.

**CASE LESSONS**

$1.7 Million Settlement

**Pregnancy Not Diagnosed Until Week 26; Child Born With Asymmetrical Dwarfism**

*Nugget: Rule out the obvious first, even if you have reason to believe it couldn’t be the right diagnosis.*

*Case: A woman received GYN care for many years at a clinic specializing in treating “DES daughters.” When she was in her 30s, the nurse practitioner (NP) who provided her care at the clinic put her on hormone replacement therapy. The NP also told her she need not use birth control because she could not get pregnant since her low estrogen levels showed that she had “ovular failure.” The NP also told her she would have had problems with a pregnancy because of her bicornate uterus.

Twelve years later, at age 44, the woman developed swelling in her abdomen, fatigue, nausea, and painful breasts. However, she continued having her period.

The woman’s regular doctor (who was not named in the lawsuit) referred her to a gastrointestinal specialist, who found no explanation for her symptoms.

When her periods stopped and she began experiencing frequent urination, the woman returned to the DES clinic. The NP did a pelvic examination—but did not palpate the patient’s uterus nor perform a pregnancy test. She told the woman that she was simply experiencing perimenopausal symptoms and that everything was fine.

Several weeks later, the patient returned from Europe with a markedly protruding abdomen. She then saw an internist who suspected an abdominal tumor and sent her for a CT scan. Tomography revealed a fetus at approximately 26 weeks of gestation.

The woman had continued on hormone replacement and had taken numerous other medications during those 26 weeks. Ultrasound showed that the fetus likely had malformations. A maternal-fetal specialist recommended that the patient travel out of state for a late-term abortion. After hearing the procedure described, however, she decided she could not go through with it.

After a painful and anxiety-filled pregnancy, her daughter was born and was diagnosed with Silver-Russell syndrome, or asymmetrical dwarfism.

The mother and child sued the hospital and its clinic where the patient received gynecologic care, the director of the clinic, and the nurse practitioner who was employed by the hospital and worked at the clinic.

**Decision:** The hospital’s insurer paid $1.7 million to settle the case.

**Lesson:** “Silver-Russell is a rare syndrome connected with [in utero] exposure to many different drugs,” says Susan M. Karten, JD, the New York City attorney who represented the mother and child.

But the plaintiff did not have to show a connection between any medications she took during the pregnancy and her daughter’s dwarfism, since the lawsuit simply claimed “wrongful conception.”

Under New York law, a plaintiff claiming wrongful conception may sue only to recover the actual cost of the child’s medical expenses and raising her to age 21. The girl will need multiple surgeries and courses of growth hormones to mitigate her condition.

“There was a misdiagnosis, plus a failure to diagnose,” Karten says.

First, she insists, the NP never confirmed her diagnosis of ovular failure. “This started the patient on a course of hormone replacement,” she says. “Then, they never retested her estrogen.”

The failure of the NP to diagnose the pregnancy deprived the patient of the opportunity to terminate it in its early stages.
“This was touchy, because the family didn’t want the child to know they considered aborting her,” Karten says.

She also says the NP provided the patient’s ongoing GYN care without physician involvement. “NPs should have oversight,” she said.

But Karten’s primary advice is: “Don’t jump to conclusions. Don’t neglect the obvious diagnosis; the most obvious thing is usually what it is.

“This NP had other explanations for everything—instead of suspecting the most obvious thing,” Karten says. ▼

$220,000 Verdict

D&C Performed on Pregnant Patient

Nugget: Make absolutely sure a patient is not pregnant before entering her uterus.

Case: A woman in her 30s with one child came to her OB-GYN for a scheduled visit. She had missed a period but had not done a home pregnancy test because she decided to have the test done by a professional.

Instead of doing a pelvic examination and performing a pregnancy test, however, the doctor performed an ultrasound and diagnosed the patient as having a blighted ovum. He also concluded from the ultrasound that she was not pregnant.

Based on the ultrasound, the OB-GYN performed a D&C. Two weeks later, the patient delivered a 3-inch fetus.

The doctor then performed a second D&C and removed more fetal material.

The patient sued the OB-GYN for negligence, saying she had suffered emotional distress because of his misdiagnosis.

YOU BE THE JUDGE

(See case description on page 77.)

Nugget: Document every significant conversation with a patient. Include what you said and her responses, using quotation marks around critical phrases.

Decision: The jury returned a verdict for the defense.

Lesson: “This case was based on the allegation that this doctor falsified his records after the fact,” says Thomas R. Mulroy III, the Chicago attorney who successfully defended the OB-GYN.

“They both agree that the doctor offered her the test, but she said she agreed to it but the doctor never set it up,” he says. “The doctor said she flatly refused the test.”

Several months after the patient gave birth, she asked the OB-GYN to send her medical records to a new OB-GYN, and he did so.

About a year later, the patient filed suit against her original OB-GYN, and he gave her attorney a copy of her medical records, which included the notation, “Against termination, will carry.”

But the plaintiff produced a photocopy of the Hollister prenatal form, allegedly from the records the OB-GYN had sent to her new gynecologist. The entry, “Against termination, will carry” was notably absent from that copy.

“This was pretty damning, in my opinion,” says Mulroy, who adds that he was brought into the case to defend the doctor only a few weeks before trial. “I said, ‘You absolutely must settle this case; there was record tampering here.’”

But several conversations with the defendant OB-GYN convinced Mulroy that the doctor was telling the truth.

“He said the patient came in during a post-birth office visit and stole one of the Hollister forms out of the chart,” Mulroy says. “When I looked at the chart, it looked as if something had crudely been pulled out and one of the carbon copies of the Hollister form was missing.”

“So we went to trial,” he says. “I didn’t have the original records that were sent to the new doctor, and that gynecologist was not available at the time of trial. There was no way to tell whether the piece of paper contained in that chart was the original yellow carbon copy of the Hollister form or a photocopy. If it was the original, the chart was falsified; if it was not, it wasn’t.”

The defense argued that the patient had stolen one copy of the Hollister file from her chart, then obliterated the entry as well as two unrelated entries below it (because the doctor’s against-termination note intruded onto the line below), made a photocopy, and given it to her attorney.

“The patient got on the witness stand and said she never stole the form and never even had a photocopy of that piece of paper,” Mulroy says. “But we introduced evidence that ... a former attorney [for the patient] had filed an affidavit with the court indicating that the plaintiff herself had obtained the copy of the record.

“I think there was enough doubt about the origin of this note that the jury ruled in our favor,” Mulroy says.

The defense attorney says the patient also hurt her credibility by testifying that the reason she never brought up the amniocentesis test after the original discussion was that she thought it might have been done during some routine blood work. “She was a very sophisticated patient, so that didn’t ring true,” he says.

“There is not a doubt in my mind that the patient had no intention of terminating this pregnancy, because she had tried for years to get pregnant,” Mulroy adds.

His advice to OB-GYNs: “Document everything, including what you say to a patient and what she says to you. Add quotation marks when necessary to show exactly what a patient said. I know this takes time and it’s a drag, but its tough for a jury to ignore what’s contained on the chart.”

Mulroy also warns: “Never go through a chart and add things after the fact unless you clearly document that it is a late entry.”
The doctor admitted negligence but disputed the claim that his misdiagnosis had caused significant emotional distress.

Decision: The jury agreed with the patient, awarding her $220,000 for her emotional distress.

Lesson: Donald S. Varian Jr., the Akron, Ohio, attorney who represented the patient, says the doctor testified that he did not need to perform a pregnancy test “because he could diagnose it clearly by ultrasound, which to him was conclusive.

“He said that was the standard of care, but none of the experts in the case—nor anyone else—said that was the standard,” Varian says. “This was a diagnosis that—at best—should leave you with uncertainty.”

The attorney says, “The negligence continued because obviously, a great deal of fetal tissue was taken during the [first] D&C, but the doctor indicated he didn’t see it. Then she passed a full fetus missing a right arm a few weeks later.”

Experts testified that the fetus likely was at about 10 weeks’ gestation, Varian says. He says this case holds several lessons:

“First, listen to your patient. Second, do a physical exam. Third, do the appropriate testing before a D&C, for example, an ultrasound and a blood test. There’s a full spectrum of pregnancy tests that can be done.

“But most important, make absolutely sure a patient is not pregnant before you do something irreversible,” Varian says.

OB-GYN Malpractice Prevention CME Quiz

To earn CME credit, you must read the CME article and complete the quiz and evaluation assessment survey on the enclosed form, answering at least 80% of the quiz questions correctly. Select the best answer and place a check mark or an X mark in the corresponding space on the enclosed answer form. Do not fill in the answer box completely. Please indicate any name and address changes directly on the answer form. If your name and address do not appear on the answer form, please print that information in the blank space at the top left of the page. Make a photocopy of the completed answer form for your own files and send the original answer form to Lippincott Williams & Wilkins, Continuing Education Department, PO Box 1543, Hagerstown, MD 21741-9914 by September 30, 2005. The CME credits are included in the subscription price.

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1. For a child to be born with cystic fibrosis:
   A. Either parent must be a carrier.
   B. Both parents must be carriers.
   C. A relative must have cystic fibrosis.

2. Preconception counseling to detect carriers of genetic disorders is not as valuable as prenatal counseling for that purpose.
   A. True.
   B. False.

3. Whenever there is a stillbirth or neonatal death, genetic testing is advisable to:
   A. Establish a diagnosis, if possible.
   B. Provide relief to the family.
   C. Provide important information for future pregnancies.
   D. All of the above.

4. Successful claims for wrongful birth include:
   A. Failure to recommend follow-up testing to a couple with a positive screen.
   B. Misinterpretation of test results.
   C. Failure to follow up on inconclusive test results.
   D. All of the above.

5. Only couples of Eastern European Jewish heritage are at risk for having a child with Tay-Sachs disease.
   A. True.
   B. False.