# Chapter II

## The Human Face of Medical Malpractice

> "You must understand that some of the malpractice out there is so grievous, offensive and implausible as to beggar the imagination."
>
> — Barry S. Schifrin, M.D., Director of Maternal/Fetal Medicine at Huntington Memorial Hospital, Pasadena, California, in remarks to the American College of Obstetrics and Gynecology, as reported in the ***AMA News***, June 21, 1985.

There is a conspicuous omission in the public discussion of medical malpractice. That is the voice of the victims. To listen to their anguished voices and acknowledge that their suffering is real, irreversible and preventable is a transforming experience. The stories of injured victims and their families expose the real-life suffering wrought by malpractice. They call into question the pitiless abstractions of health care "policymakers," and reveal the ethical cocoon that many in the medical community inhabit.

This reality was confirmed by the Harvard Medical Practice Study, which found in its interviews with doctors that most of them have trouble acknowledging that doctors ever commit negligence. Physicians are extremely reluctant to make any judgments of their peers' professional behavior, according to the Harvard study: "One reason for this difficulty became obvious in the comments of one representative surgeon: 'One of these days, I am going to be wrong. So far, I have not, but I will be.' "[22] Surgeons who were asked to consider possible malpractice by their colleagues had a difficult time concluding that negligence had occurred, even though the patients had been injured by surgical mistake:

> This natural tendency to identify with colleagues presumably makes judgments of negligence more difficult. All of this tends to highlight the problems that surgeons, and in fact all physicians, have in judging negligence. They do not equate failure to meet the standard of care with negligence. Rather they seem to believe negligence requires culpability beyond the standard of care threshold. In short, they cannot admit to negligence and so have difficulty labeling care provided by others as negligent.[23]

The medical and insurance industry's lobbyists and public relations professionals who presently dominate the medical malpractice debate are experts at reducing the issue to a matter of anecdotal malingering — a deliberate strategy that permits the dead and injured to be dismissed as non-persons.

The searing experience of medical malpractice is a uniquely individual event. Those best qualified to discuss it, and the quality of justice offered by the legal system, are the victims themselves. To fully understand the dimensions and the impact of medical malpractice, we must recover the unheard voice of victims, and register their tragedies in the medical malpractice debate.

**The Disfiguring, Unauthorized Practices of the "Love Surgeon" — and the Medical Profession's Tacit Collusion**

***The doctor bragged in his self-published 1975 book that he would turn women into "horny little mice."***

Dr. James C. Burt, a Dayton, Ohio, obstetrician-gynecologist, was proud to be called the "Love Surgeon," and even self-published a book to promote his medical specialty — experimental surgery on the sexual organs of women, supposedly to enhance their sex lives. Over the course of 22 years, hundreds of women underwent this surgery at St. Elizabeth Medical Center in Ohio. Unfortunately, Dr. Burt's procedures were medically unfounded, and many of his patients were unwitting guinea pigs. While his patients were under general anesthesia for entirely different reasons, Dr. Burt sometimes performed his "love surgery" without their consent. The procedures included female circumcision and "realigning"

the vagina, which Dr. Burt claimed would make women "horny little mice." The surgeries were disfiguring, caused extreme pain and major, irreparable medical complications.

Remarkably, all of this occurred with the full knowledge of his surgical teams and the "prestigious" hospital where the surgery was performed. The local medical society and doctors in the community knew of Dr. Burt's practices yet trivialized them, dismissing them with a laugh, "Oh, I see Jim Burt got hold of you." The profession took no real action to stop Dr. Burt's highly unethical behavior. What finally brought down Dr. Burt's violent practice was a series of lawsuits brought by his victims. Those lawsuits, the attendant publicity, and pressure from the Governor of Ohio and the Ohio Medical Board, finally resulted in Dr. Burt forfeiting his license to practice medicine. Burt, who never apologized to his victims, retired to a comfortable life in Florida.[24]

**Faulty Lab Tests and a Negligent Pediatrician Leave Kelly Schnebly an Invalid for Life**

> ***The baby looked 'like refugees that haven't eaten and the skin is clinging to their bones and they have a kind of dead, lost look to them."***
>
> — Wanda Schnebly

Orvin and Wanda Schnebly of Forest City, Iowa, knew that their new baby, when born, might be affected by bilirubin. The disease, characterized by an incompatibility of blood between mother and child, is well-known and highly treatable. During the first 72 hours of a newborn's life, a baby is monitored for signs of jaundice, lessened sucking reflex, irritability and other symptoms. When such symptoms appear, blood tests are administered every few hours and, if necessary, blood transfusions are given.

When Kelly Schnebly was born, his bilirubin levels were elevated and kept rising. The next day the baby exhibited clear signs of jaundice. None of these symptoms were a surprise. When it became clear that a blood transfusion might be necessary, Kelly was transferred to St. Joseph Mercy Hospital in nearby Mason City, where the bilirubin blood tests and blood transfusions could be administered. Despite the baby's obvious jaundice, the tests performed by the lab pathologists at St. Joseph

understated the actual bilirubin levels by about four times — an inaccuracy due to the use of an outdated chemical reagent. As a result of faulty lab tests and the pediatrician's continued reliance upon them in the face of clear clinical symptoms to the contrary, Kelly Schnebly suffered very severe brain damage.

After discharge from the hospital, Kelly cried continually. It took an hour or more to feed him. He spit up curdled milk. His hard crying caused a double hernia. Clearly, something was wrong. Years later, doctors confirmed that Kelly had the classic symptoms of severe kernicterus (the disease caused by excessive bilirubin levels): mental retardation, profound failure of growth and development, quadriplegia, apparent deafness, among other serious deficiencies. For the rest of his life, Kelly Schnebly will be permanently disabled and completely unable to care for himself, unable to coordinate his movements or communicate in any way. After a jury trial against their pediatrician and the hospital, and an appeal, the Schneblys were awarded $912,124 on behalf of their son.[25]

**A Gifted Music Student's Career — Snuffed Out**

A tonsillectomy without informed consent of its risks left Jayne Hill unable to play an instrument.

Jayne Hill was a highly talented nineteen-year-old student at the prestigious Juilliard School of Music, where she was studying trumpet. Her instructors concluded that she was on her way to a distinguished professional career in classical music performance. Then she discovered that she had tonsillitis. Upon seeking medical advice and treatment at New York Hospital, Hill saw Dr. John Seward, an otolaryngologist, who recommended and later performed a tonsillectomy.

One possible, but not customary, risk of tonsillectomy is a condition called "velopharyngeal insufficiency" — the inability to fully close portions of the throat. In Ms. Hill's circumstances, this risk was particularly relevant. And disastrous. After her tonsillectomy, scar tissue formed; it was caused by the removal of too much tissue from the tonsillar cavities. This in turn pulled on the soft palates. As a result, Ms. Hill could not achieve full velopharyngeal closure and blow enough air to play the trumpet. Her future career as a trumpet player, for which she had been practicing for much of her life, was ruined.

In a subsequent lawsuit against Dr. Seward, Ms. Hill argued that the back of her throat had not been thoroughly examined before surgery and that, in any case, surgery was inappropriate in cases in which a patient has not had a chronic history of tonsillitis. Perhaps most critically, even though the doctor knew that she was a trumpet player, Ms. Hill was never informed that a tonsillectomy could have this possible outcome. At trial, Ms. Hill's former music teachers testified to Ms. Hill's great talents and the likelihood of her employment with a symphony. She received a $2.5 million award to offset the loss of what she would have earned had her career continued, and to compensate her for physical and emotional injuries.[26]

**A 38-Year-Old Father's Needless Death from Testicular Cancer**

> ***If the diagnosis had been made [following Carey Dunn's radiological tests], it was virtually certain that the cancer could have been conquered and the decedent's life saved.***
>
> —Dr. Lawrence Einhorn, M.D.

In May, 1982, Carey Dunn, a rigger in the Navy Yard in Philadelphia, began to suffer from pain and swelling in the epididymis, the tissue surrounding his right testicle. After his private physician prescribed antibiotics, the condition improved. But seven months later, when he was a member of the Health Care Plan of New Jersey, a health maintenance program or HMO, his primary care physician diagnosed a recurrence of the epididymitis and referred Dunn to a urologist, Dr. Donald Praiss, who ordered a radiological scrotal scan performed in February, 1983. The test revealed a "solid mass" that could be symptomatic of testicular cancer. An appointment was scheduled with the HMO for a week later.

At that appointment, yet another HMO physician saw Carey Dunn. Even though he was aware of Dunn's testicular problems and the radiological report indicating a questionable mass, the doctor merely told Dunn to note any change in his pain or in the size of the mass through self-examination, and to return if necessary. The physician did not order any blood tests, or a hydroelectomy, two procedures which could have determined if Dunn's testicular mass was a cancer. No follow-up visit was scheduled, and no further HMO contact of any kind was made with Dunn.

In October, 1983, Dunn began to experience a "full feeling" in his chest. It turned out that he did indeed have testicular cancer, which had spread to his liver. The cancer was so advanced that Carey Dunn's life could not be saved. A world-famous specialist in testicular cancer later testified that if a proper diagnosis had been made in the seven months after the radiological report, it was virtually certain that the cancer could have been arrested and Dunn's life saved. Dunn died inApril, 1985, at age 38, leaving behind a wife and two children.[27]

**One Doctor's Sorry Surgical Record**

Following the birth of her third child, Katie Schraub, a twenty-seven-year-old homemaker from Indianapolis, asked Dr. Mauro Chavez to tie her Fallopian tubes in order to prevent future pregnancies. As the anesthesia wore off, while she was on the operating table, Ms. Schraub knew that something was seriously wrong. "It felt like he [Dr. Chavez] had a big wooden spoon just stirring my guts around." As it happened, her obstetrician had had difficulty locating her Fallopian tubes, and completed the operation without knowing if he had, in fact, found them.

Schraub's abdomen began to swell and she grew extremely weak. Dr. Chavez incorrectly suspected an intestinal block and gave her a barium enema, so that X-rays could confirm the blockage. But this procedure allowed the barium fluid to seep into her abdominal cavity through puncture wounds that Chavez had himself inflicted during the course of surgery. When Schraub started to leak fluid in the X-ray room, she was rushed into emergency surgery to deal with what turned out to be peritonitis — a serious inflammation of the abdominal wall that is usually caused by infection. Doctors found that her small intestines, parts of which were stuck together, were bathed in barium, pus and their own debris. After the emergency surgery, Schraub became delirious and imagined her respiratory therapist was trying to kill her. She ripped out her intravenous tubes and heart monitor, and was found crawling on the floor to the door. Following still more surgery, Ms. Schraub was discharged — 47 days after entering the hospital for a relatively simple procedure. She filed a malpractice suit, charging that Dr. Chavez had pierced her intestinal wall while searching for her Fallopian tubes. A medical review panel unanimously awarded her $310,000.

Chavez was the target of three other successful malpractice suits by women — one who lost a kidney as a result of complications from Fallopian tube surgery; another who suffered a torn bladder during a hysterectomy; and a third woman who risked a miscarriage after Dr. Chavez failed to remove an IUD during her pregnancy. In six years, while practicing at the Methodist Hospital in Indianapolis, Dr. Chavez lost four large malpractice lawsuits, three of them for more than $100,000. But as of 1990, he still practiced medicine, as a doctor at the Indiana State Reformatory in Pendleton — which has no female inmates.[28]

**The Sexually Abusive Gynecologist Who Medical Authorities Ignored**

> ***"We've all heard doctors grumble about protecting themselves from lawsuit-crazy patients, but how do patients protect themselves from dangerous doctors, especially when it seems the fraternity of physicians is often reluctant to police itself?"***
>
> —Sam Donaldson, ABC News

Dr. Ivan Namihas, a highly regarded gynecologist with a practice in Southern California, committed repeated acts of sexual abuse on as many as 200 women over the course of 30 years, according to an investigation by ABC News. Yet it took nearly two decades after the first complaint against Dr. Namihas for California authorities to initiate proceedings against him. The first complaint, by Kathleen Jewell Elliot, was representative of many others: "During the examination of the pelvic region," she wrote to the Orange County Medical Association, "he [Dr. Namihas] began massaging the erogenous zones of my vagina, telling me to close my eyes and relax. He also used foul language." Other women reported physical exams without gloves and sexual touching; one woman was falsely told she had AIDS.

The local medical association took no action. And the California Board of Medical Quality Assurance, the state licensing agency for doctors, routinely purged records after five years, making it extremely difficult to establish a pattern of malpractice or abuse. When a second complaint against Namihas was lodged, it was regarded as a first complaint. It took so long to bring the complaint to the police that the one-year

statute of limitations had almost expired. According to ABC News reporter Renee Poussaint, "The case was rejected for criminal prosecution, in part due to 'negligence of the state board.'"

Even though Dr. Namihas admitted to sexual misconduct a few months later, the state board refused to take any action against him for three more years — during which time he intensified his abuse of some patients. During this period, if any person called the state medical board to see if any complaints had been lodged against Dr. Namihas, the answer would be, "License status is clear." It wasn't until March, 1991, after three formal complaints, that the medical board began proceedings to revoke Namihas' license. After newspaper stories appeared, more than 200 other victims stepped forward to say that they, too, had been abused as long ago as 1962, the first full year he had his license.[29]

**The Infertility Doctor's Monstrous Fraud**

> ***"He will never know the emotional roller coaster we were on. We mourned every one of those dead babies."***
>
> — Jean Blair, who was told, falsely, that she had suffered seven miscarriages.

Dr. Cecil B. Jacobson was supposedly helping couples desperate to have their own babies. But it turned out that the highly respected infertility specialist practicing in Fairfax County, Virginia, had committed a monstrous fraud on dozens of emotionally vulnerable patients. For ten years, he had injected women with hormones to simulate the symptoms of pregnancy, including positive urine tests. For up to 18 weeks, he conducted phony ultrasound tests and calculated fetal measurements for the nonexistent babies. When the fraud could no longer be continued, he would tell the women that their fetuses were dead, and would "resorb" into their bodies.

Dr. Jacobson's cruel hoaxes began to unravel in 1987 when one couple brought suit against him. The publicity surrounding the suit elicited 27 more women who also complained that they were falsely informed that they were pregnant when they were not. The case gained an extra measure of notoriety when it was learned that Jacobson had used his own semen to treat women for infertility. Prosecutors in the case said that Jacobson may have fathered more than 70 children in the Washing-

ton, D.C. area. While these multiple frauds were taking place, several members of the local medical community confronted Dr. Jacobson about his practices, but none reported him to medical or law enforcement officials.

After a large settlement, Dr. Jacobson forfeited his medical license and the Federal Trade Commission obtained refunds for over 200 patients. In March, 1992, Dr. Jacobson was convicted on 52 counts of fraud and perjury, and sentenced to five years in prison.[30]

## Infants and Children Injured by Medical Malpractice

Infants and children are the most vulnerable to medical malpractice, for they have little or no control over their medical destiny and frequently cannot express the reality of an injury. Here are our nation's saddest casualties of medical mistakes:

— In Florida, a newborn infant died of a massive brain hemorrhage several hours after birth due to multiple skull fractures caused by the doctor's misuse of forceps during delivery. While the doctor made no mention of any difficulty with the birth in his post-birth report, "a nurse in the delivery room said the skull fractures were so loud the cracking could be heard throughout the delivery room." The family settled for $275,000 without filing a suit.[31]

— In New Jersey, a pediatrician failed to recognize an infant as small for gestational age (SGA) and therefore at risk for certain treatable conditions such as hypoglycemia. The pediatrician did not perform screening tests for hypoglycemia. The infant, severely hypoglycemic, developed seizures and suffered brain damage resulting in cerebral palsy, blindness, quadriplegia and mental retardation. Four years before, the chief of pediatrics at the hospital in which the physician practiced had discussed the physician's need for "remedial training" with the chairman of the department of medicine, yet no action was taken. The jury awarded $13 million in this case.[32]

— In Illinois, an asthmatic eleven-year-old came to the emergency room with a moderately severe asthma attack. Neither the nursing nor the resident staff followed the protocol posted in the emergency room for asthmatics. The child was given an intramuscular drug with no monitoring,

reassessment, or supportive therapy. He received inadequate resuscitation and ventilation, which resulted in massive brain damage. The boy will require lifetime custodial care. The case was settled for $2.4 million.[33]

— A fourteen-year-old Florida girl died of a massive blood clot to her brain three days after she fractured her skull in a swimming pool accident. Her doctor allegedly waited more than eight hours to perform surgery, despite clear signs of a clot.[34] The case was settled in 1992 by his insurance company for $740,000. This was just one of many lawsuits brought against the physician.[35]

— In Florida, a three-year-old boy suffered severe brain damage as a result of an operation to have his tonsils removed. The tube placed down his throat to help him breathe was incorrectly inserted and cut off his oxygen supply, causing his heart to stop. Doctors were not paying close attention and were slow to respond. The defendants agreed to settle for $3.9 million.[36]

—An East St. Louis boy went with his mother to the hospital complaining of stomach pain. The doctor did only a brief examination and told the boy to take Kaopectate, recommending another physician in case of further pain. The second doctor did not return the mother's calls for help when the boy's temperature reached 107 degrees. The boy finally went to another hospital, where doctors discovered that his appendix had ruptured days earlier, poisoning his bloodstream. Doctors operated to stop the release of poisonous material, but their inadequate surgical tie-off loosened, which released more poisonous material into his bloodstream. As a result, the child is now a quadriplegic and is totally dependent on his mother. The case was settled for an undisclosed sum.[37]

— In 1981, a four-year-old died of meningitis after admission to a New York hospital that lacked proper facilities. A transfer to a hospital with the necessary facilities was not arranged until six hours later — too late. The New York State Health Department investigated the case and found 13 deficiencies in the hospital's procedures, including failure to "document a complete physical examination on admission" and failure to "obtain mandatory consultation for any case of meningitis."[38]

— In Maryland, an infant was taken to a Navy clinic emergency room with a fever and vomiting. The pediatrician diagnosed gastroenteritis and released the child. When the infant screamed at a high pitch during the night, the parents called the clinic, and the corpsman on duty told them the child's ears were "only temporarily stopped up." The next morning, after having difficulty awakening the lethargic child, her mother brought the child to the clinic, but waited over three hours before a medically trained person saw them. When the same pediatrician saw that the infant's condition had worsened, he arranged admission to a regional hospital, but did not do a spinal tap, start I.V. antibiotics, or begin any other treatment. When the mother took the child to another hospital an hour away, pneumococcal spinal meningitis was finally diagnosed. The child is totally deaf and unable to learn speech. The defendants settled the case for $300,000.[39]

— In Washington, D.C., a twelve-year-old went to a physician with a broken jaw. During the necessary surgery, the seventh cranial nerve was separated, paralyzing the left side of his face. The physician discharged the boy without informing him or his parents of the condition, without repairing the nerve, and without warning that nerve repair should be done as soon as possible. By the time the boy sought repair at another hospital the entire left side of his face was permanently paralyzed. He has lost facial expression, has scarring and disfigurement, cannot close his left eye or smile, and has a 15 percent hearing loss in the left ear. The jury awarded $600,000 in this case.[40]

—A twelve-year-old Washington, D.C., girl, who went to the hospital for treatment of a condition in her jaw, is now legally blind and had half her tongue removed after her surgeon negligently administered an alcohol compound during the procedure, and improperly placed a catheter causing damage to her optic nerve. The parties settled for $1.1 million.[41]

— A five-year-old from Virginia, whose heart murmur and abnormal growth at age nine months were misdiagnosed by both his family physician and a radiologist (who diagnosed pneumonia), now requires a heart-lung transplant. His heart condition, now irreversible, could have been corrected had it been treated before he reached two years of age. The parties settled for $925,000.[42]

—A hospital nurse injected a seven-day-old Massachusetts baby with an antibiotic which was diluted with potassium chloride instead of sterile water, causing the baby to suffer cardiopulmonary arrest and brain damage. He now suffers developmental delays, requiring special schooling. The jury awarded $1.1 million.[43]

—A three-day-old boy from Maine suffered cardiac arrest and brain damage when, following surgery, a nurse and therapist attached him to a central venous line without properly removing all the air from the line, forcing air into the baby's heart. The child suffered from cerebral palsy, spastic quadriplegia and mental retardation. The parties settled for $2.5 million.[44]

— A four-month-old Texas boy who had had heart surgery went into cardiac arrest but did not receive cardiac compressions for five minutes, four minutes longer than the maximum allowable time. The child suffered severe brain damage and functions at the developmental level of a four-month-old. The parties settled with the attending surgeon for $800,000 and the other defendants were ordered to pay $1.7 million.[45]

—When a two-week-old Texas infant developed a fever and began vomiting, her parents called a nurse, as their health plan required them to do, before taking the child to a hospital. Although they called the nurse three times that night reporting symptoms, the nurse did not give them permission to take the child to a hospital. When they finally took her in the next morning, she was diagnosed with meningitis. The child has scoliosis and developmental delays. The parties agreed to a settlement valued at $2.75 million.[46]

— A three-year-old Oklahoma girl with a known heart condition died from heart failure during outpatient ear surgery. Her death was caused by the anesthetic used, forane, a drug known to cause dilation of the blood vessels which, in turn, can and did lead to the cardiac arrest. The parties settled for $425,000.[47]

— Over the course of two days, a four-year-old Wisconsin boy was twice misdiagnosed with the flu by clinic doctors, who prescribed Tylenol and nothing to treat an infection, despite the fact that his heart was

racing, he was growing weaker, becoming dehydrated, had trouble standing, in addition to having a 105-degree fever and muscle aches. He was finally diagnosed in a hospital emergency room with meningitis, sustaining severe brain damage. The parties settled for $2.5 million.[48]

—An eleven-year-old Wisconsin boy was brain damaged during open heart surgery to repair a congenital defect, when his surgeon and staff reversed tubing on the heart-lung machine causing blood to flow in the wrong direction. The boy, who requires full-time care, has spastic quadriplegia, suffers seizures, incontinence, and has problems communicating. The parties agreed to a settlement valued at $10 million.[49]

— A twelve-year-old girl from Washington state, who was born with a port wine stain birthmark covering the entire right side of her face, was admitted for laser surgery to remove the birthmark after a test-patch procedure indicated the surgery would be successful. During surgery, her doctor increased the power setting and rate of the laser, severely burning the entire side of her face. She required plastic surgery. The parties settled for $380,000.[50]

— A four-year-old girl from North Carolina, who was misdiagnosed with gastroenteritis and sent home from the emergency room, was not diagnosed properly with meningococcemia until she returned to the hospital four hours later. By then, both of her arms and legs had to be amputated. The parties settled for $9 million.[51]

— A sixteen-year-old Texas girl who was admitted to an emergency room with pelvic pain went into shock following an exploratory laparoscopy. The gynecologist who performed the procedure had punctured an artery, but was unable to locate the source of bleeding, closed the incision and left the room. Emergency surgery was eventually done to repair the artery. A jury awarded $595,000 plus interest.[52]

—A six-year-old Georgia girl died from cardiac arrest as a result of an undiagnosed bacterial infection. A non-physician in her pediatrician's office had first diagnosed chicken pox over the phone and prescribed treatment. Two days later, advising the office of her worsening condi-

tion, her parents were told by a staff person that the illness was running its course and that they should continue the same treatment. The next day, her parents brought her to a clinic, where a doctor told them to return in two or three days. The following day, they called her pediatrician, who prescribed Mallox for vomiting. She died later that day. The parties settled for a confidential amount.[53]

— A five-year-old boy fell head first into a pile of sticks; a two and three-quarter inch twig penetrated his nasal passage and lodged in the frontal lobe of his brain. However, he was sent home from the emergency room after doctors concluded that the pain the boy felt in his nasal passage was just a swelling. Over the next 11 days he was brought back to the emergency room with more symptoms; however, doctors performed no tests which would have detected the stick. By the time the stick was finally discovered, the child had suffered brain damage resulting in a learning disability and hyperactivity. The parties settled for an amount valued at $870,000.[54]

## Malpractice Injuries During Childbirth

— A New York City baby was born with a severed arm due to a botched abortion attempted illegally during her mother's third trimester. For years, the doctor, Abu Hayat, had been bungling the abortions he performed upon his clientele — principally poor, immigrant women in New York City. In one case, a seventeen-year-old girl died because he perforated her uterus during an abortion. In another case for which he was criminally convicted, the doctor stopped midway through an abortion and sent the patient home, semiconscious and bleeding, because her husband could not pay $500 more than the agreed-on price.[55]

— A child was born in Ohio with ripped nerves (brachial plexus) after his shoulder became stuck behind the mother's pubic bone during a vaginal delivery, and the doctors used a vacuum extraction procedure. When the mother became pregnant, she notified her obstetrical group that this precise injury had happened before, during delivery of her first child (forceps were used then), and specifically requested a cesarean delivery. The child suffered paralysis in his left shoulder, arm and hand at

birth, and will never have a functional arm. A jury awarded approximately $1.58 million.[56]

—An infant in Illinois was born brain damaged after a low-forceps vaginal delivery, which was done 40 minutes after the first signs of fetal distress, and about 30 minutes after the fetal monitor indicated that the infant's death was imminent. The child suffered from spastic quadriplegia, cerebral palsy and cortical blindness. A jury awarded about $6.95 million.[57]

— A Maryland baby, in fetal distress and born not breathing, was not delivered until almost an hour after an obstetrical resident had ordered an emergency cesarean, because the resident could not find a physician to supervise. The obstetrician who had confirmed the diagnosis and had instructed the resident to perform the operation with supervision, went to perform elective surgery on another patient instead. The child suffered from cerebral palsy, spastic quadriplegia, mild retardation, was unable to speak, use his hands to grasp objects, or walk without assistance. The parties settled for $4.1 million.[58]

—A Maryland infant was born severely brain damaged after doctors failed to detect the presence of an identical twin who had died in the womb. The twin's death had spread contaminating chemicals and fluids to the surviving child. She is blind and will never walk, talk or feed herself, has cerebral palsy, suffers from seizures and will need full-time, 24-hour care. A jury awarded $9 million.[59]

— A Texas infant in fetal distress was not delivered until 50 minutes after her mother's obstetrician ordered a cesarean delivery, the cord having prolapsed, because the delivery room had no anesthesia equipment or an operating table. She was eventually taken to an operating room. The infant suffered seizures shortly after birth, causing brain damage that has left him in a vegetative state, requiring oxygen therapy and tube feeding. The parties structured a settlement valued at $4.7 million.[60]

— A New York infant, who was in a breech position and whose mother had a borderline pelvis, was nevertheless delivered vaginally after

residents noted that the fetus' feet were dangling outside the mother. In turning the infant's body around inside the birth canal, a third-year resident broke the infant's neck. The child is paralyzed, has a partial loss of bladder and bowel control, and has difficulty breathing. A court awarded $3 million.[61]

— In California, an infant was born brain damaged because doctors waited 43 hours while his mother was in labor before performing an essential cesarean. In the meantime, his mother developed a high fever and the child was deprived of oxygen. The boy is severely mentally retarded, has seizures, impaired motor skills and poor eyesight. He cannot stand up, talk or distinguish one parent from the other. Constrained by state laws sharply limiting the amount of compensation a jury can pay to malpractice victims, the victim's attorney settled the case for $936,000.[62]

## Too Many Tests, or Too Few?

The medical and insurance lobbies frequently complain that the threat of malpractice lawsuits leads doctors to order unneeded tests, a contention that will be considered in Chapter IV. Consider, however, these examples of what happens when doctors skimp on tests:

— A fifty-seven-year-old man from New York went to a doctor complaining of frequent nose bleeds. He was misdiagnosed as having, and was treated for, allergies, even though the nose bleeds continued. Thirteen months later, after finally consulting a specialist, a CT-scan indicated a tumor. The tumor was malignant, had by then grown to grade III cancer, and was removed during surgery. To fill the void in his mouth left by surgery, he must wear an artificial palate. The parties settled for $650,000.[63]

— A thirty-nine-year-old man from New York, who was suffering from severe headaches, went to two separate doctors over the course of two days, both of whom prescribed painkillers. Only when the headache persisted the following evening was he referred to a neurologist. By the time the neurologist examined him and ordered a CT-scan the next morning, an aneurysm in his brain was leaking. It ruptured before sur-

gery could be performed. He was now severely brain damaged, requiring custodial care. The parties settled for $2.8 million.[64]

—A twenty-one-year-old Louisiana woman, who was admitted to the hospital after suffering a seizure and other symptoms, was discharged five days later, having been misdiagnosed with an infection. After returning to her doctor's office four times over the next several weeks with increasingly severe symptoms, she was readmitted and diagnosed with lupus. Ten hours later, she finally began treatment, but died within nine hours. The Supreme Court of Louisiana upheld a trial court's award of $150,000, plus interest.[65]

— A thirty-year-old California woman detected a lump in her breast while she was pregnant. Her doctor did not perform a biopsy and initially told her the lump was an impacted milk duct. She died of breast cancer. A jury awarded $1.04 million.[66]

— A thirty-nine-year-old man from New York was told by his oral surgeon not to be concerned about a lesion on his tongue even though the doctor had previously written in his notes that it should be removed. Three months later, his family practitioner examined his tongue but did no follow up. Seven months later, the lesion erupted and a biopsy showed cancer had spread to his neck and lymph nodes. He died four months later. The family doctor settled for $650,000; the jury ordered the oral surgeon and a pathologist to pay $1.95 million.[67]

— A twenty-seven-year-old woman from Florida, who experienced persistent coughing and congestion following childbirth but whose chest X-rays were misread as normal, returned for X-rays a year later as the symptoms persisted. This time, an X-ray revealed a cancerous mass in her right lung. The cancer, which had spread to her brain, was considered terminal. The parties settled for $1 million.[68]