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Litigation: an International Perspective*

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INTRODUCTION

The history of litigation after postpartum hemorrhage spans more than 100 years, but only 34 decided cases have been reported in common law jurisdictions.

The LEXIS database includes reported legal cases from the common law jurisdictions, but it does not include civil law jurisdictions such as those that use Napoleonic law. This history was compiled using the following search terms: [(post-partum OR postpartum) AND (haemorrhage OR hemorrhage)]. First, databases of English, Commonwealth and Irish, US Federal and US States case law were searched. Then full-text or abbreviated-text reports of all potential cases were searched visually for key words to determine the relevance of each for inclusion. Most were discarded as irrelevant, for example: 'retinal hemorrhage in the postpartum period'; after this only 34 relevant cases remained. It is possible that some cases from lower courts may have been missed, as no straightforward method exists to retrieve all such cases across all the jurisdictions studied.

FIRST MATERNAL DEATH LITIGATED (1905)

Half (17) of 34 (i.e. 50%) of the litigated cases involved a maternal death. The first of these occurred in the US. On 27 February 1905, Florence Westrup delivered her first child at home outside Newport, Kentucky. She had *'a great aversion to physicians'*, and planned a natural home birth. The birth of the child (at term) went well, but she began to hemorrhage. Despite her protests, her husband called the family physician. He arrived, examined her, and found a retained placenta. He went home to fetch his bag of instruments and returned, but by this time Florence Westrup was dead. The local police charged the husband with involuntary manslaughter, and this was said to have been committed:

> 'by wilfully neglecting to furnish his wife . . . with such care and attention as were necessary during her confinement in childbirth, thereby causing her death'.

He was tried in Campbell Circuit Court, found guilty and sentenced to 8 months imprisonment. He appealed this decision to the Kentucky Court of Appeals, which expressed its own view of the matter[1]:

> 'Those of us who reverence the medical profession and implicitly trust the learning and skill of the family physician . . . [take the view that] . . . postpartum hemorrhage is nearly always fatal [and that] . . . the trial judge should have peremptorily instructed the jury to find appellant not guilty'.

Nowadays courts are rarely so deferential to the medical profession or to physicians and, as is shown in numerous other chapters of this book, fatality is less likely if physicians are present and well prepared to treat hemorrhage.

UNLAWFUL PRACTICE OF MEDICINE (1907)

In 1907, Hannah Porn, a diplomate of the Chicago Midwife Institute and a practising midwife of many years experience, was charged with practising medicine unlawfully. Among the reasons cited was the fact that she had used *'formulae'* for treating uterine inertia and postpartum hemorrhage, and also used obstetrical forceps for delivery. These were *'acts confessedly performed by the defendant'* but she did so only rarely, and *'never, if a physician could be called in time'*. Nevertheless, she was convicted, and on appeal the Supreme Court of Massachusetts upheld her conviction on the grounds that:[2]

> 'The maintenance of a high standard of professional qualifications for physicians is of vital concern to the public health.'

Here, the Kentucky deference to physicians was not afforded to a midwife.

DANGEROUS SIDEWALK (1908)

The second maternal death case was heard in 1908. Mollie Short, the wife of an East St Louis physician, was 36 weeks pregnant. Out shopping on the evening of 17 November 1906, she walked along a wooden sidewalk situated 6 feet above the ground (i.e. a boardwalk). This had been damaged in the cyclone of 1896, but had not been properly repaired. Her left leg slipped down a hole, she dislocated her hip, and

*Reprinted from first edition.

subsequently went into preterm labor. Although the baby survived, she suffered a postpartum hemorrhage from which she died. Her husband sued the city authority for having a dangerous sidewalk, and was awarded damages of $5700. He successfully argued that postpartum hemorrhage was a direct consequence of the preterm labor, which would not have happened had not the sidewalk been dangerous. On appeal, the trial court's verdict was affirmed[3].

TELEPHONE PROBLEM (1909)

At 3 am on an October morning in 1909 in Georgia, Mrs Glawson started bleeding in a pregnancy of unknown gestational age. Her husband telephoned the local physician who was situated 7 miles away. He advised that certain remedies be applied, but these did not ameliorate the situation. The husband repeatedly tried to make telephonic contact again with the physician, but the telephone operator did not answer for over 2 hours. Eventually, connection was reestablished with the physician who set off to visit the home immediately. By the time he arrived, Mrs Glawson had miscarried, had a *'postpartum hemorrhage'*, and died. The husband sued the telephone company for gross negligence in not answering his telephone call for 2 hours. His lawyer argued that *'but for this negligence the physician could and would have reached the plaintiff's house in time to save the life of his wife'*. He won his case, and he was awarded $5000 in compensation. The telephone company appealed the decision to the Court of Appeals of Georgia, but their appeal failed[4]. The court held that generally failure of equipment in the telephone exchange would not be negligent, but in this case there was a failure of diligence on the part of the telephone operator in that he did not notice the incoming call.

ROAD TRAFFIC ACCIDENT (1930)

More than 20 years were to pass after the case of Mrs Glawson in 1909 before another postpartum hemorrhage case reached the courts and was reported. This was to be the first road traffic accident in pregnancy that was litigated.

In 1930, only 2 days after Mrs Peterson conceived her second pregnancy, she was involved in a road traffic accident near St Paul, Minnesota. The automobile in which she was travelling overturned. It was said to have been going too fast, but the driver claimed that a tire blew out. By the end of pregnancy, it was recognized that she had a central placenta previa, in which the maternal mortality was known to be *'very high'*. Her doctor consulted with another expert. Rather than carrying out the then relatively rare operation of cesarean section, it was advised that she should be delivered vaginally. Her doctor used what was termed the *'Vorhees bag method'*, and he broke through her placenta by the vaginal route. The child died, the mother had a postpartum hemorrhage and she died too. The driver of the car in which she had been sitting 9 months previously was sued for negligence. In court, expert medical evidence said the road accident had caused the placenta to be situated in a previa position, and this directly led to the mother's postpartum hemorrhage and death. This evidence did not convince the jury, however, who found in favor of the driver. An appeal to the Supreme Court of Minnesota failed[5].

IATROGENIC OBSTETRIC INJURY (1955)

Occasionally, maternal death has occurred as a result of unusual management of labor. In 1955, Bette Goff had her labor induced by means of pituitrin. During the labor, her doctor diagnosed a constrictive band of cervical muscle, and he incised it just left of the 12 o'clock position. She delivered vaginally, but the cervical incision was not repaired. She had a postpartum hemorrhage over the course of the next few hours, but the two attendant nurses did not recall the doctor until it was too late, and the patient died of blood loss. The family took legal action against the doctor and the hospital as it was vicariously liable for the nurses' omissions. For legal reasons, the case went to retrial[6]. Negligence on the part of the doctor was admitted. As for the nurses, this was evidenced from the records. There was no later report on this case, so presumably it settled.

HEALTH INSURANCE (1956)

Postpartum hemorrhage has occasionally been at issue in insurance matters. The earliest reported case was that of Juanita Whitten in 1956. Her health insurance policy covered hospitalization for any complication of pregnancy. She had had seven pregnancies: two miscarried with severe bleeding, and she had a severe postpartum hemorrhage following the delivery of her last child, after which she was sterilized. Her gynecologist said the sterilization operation was undertaken to prevent further postpartum hemorrhage, a complication of pregnancy that was covered by her insurance policy. However, her insurance company and the Court of Appeals of Alabama disallowed her reimbursement claim, on the grounds that her policy covered only actual complications, and not potential complications that might or might not occur in the future[7].

TRANSFUSION OF THE WRONG BLOOD (1951, 1955, 1972)

Three cases involved allegations that the wrong blood was transfused.

In 1951, Mrs Madison bled heavily postpartum whilst in San Francisco Hospital, a county hospital and a state governmental institution. Unfortunately, she was given a blood transfusion that had been incorrectly cross-matched, and she died as a result. Her husband sued the City and County of San Francisco, but he lost his case as the court held that the state was immune

from suit, in a manner akin to sovereign immunity. The appeal court judges said they were unhappy in delivering this decision, but they were bound to follow the precedent of other cases in which state immunity had been the issue, explaining themselves as follows[8]:

> 'This doctrine of non-liability of the state and its agencies for injuries caused by the negligence of an employee engaged in the discharge of a governmental function originated in the fiction that the king can do no wrong.'

[In English law, the Queen is still regarded as above the law, but her ministers of state (i.e. the government) are not above the law, and often a court will find against them.]

In 1955, Josephine Gillen delivered at the Brooke Army Hospital in Texas. She then had a postpartum hemorrhage and she was given a blood transfusion. Her condition deteriorated, and 2 days later she died of renal failure. The family sued the United States of America, alleging negligent military medical care which included the claim that there had been an incompatible transfusion of rhesus O-positive blood into a rhesus O-negative patient, and that this led to her renal problem. In defence, it was claimed that the patient was in fact rhesus O-positive, and she had been given rhesus O-negative blood, which would have been a group-compatible transfusion. The court found that there had been no incorrect blood transfusion, no renal problem arising from this, and no negligence in the medical care. This finding was affirmed on appeal[9].

More than 15 years passed until the case of Theda Parker in 1972. Her third labor was induced at 38 weeks gestation at her request. The birth went well, but she had a postpartum hemorrhage, and her obstetrician had to perform a hysterectomy. During the course of the operation, she needed a blood transfusion, but unfortunately she was given blood that had been cross-matched for another patient. She survived the ordeal, but in the long term she developed hematuria due to cystitis, and her marriage eventually broke down. In 1976, she and her husband sued her obstetrician for inducing her labor too soon (for convenience rather than for medical reasons) which they said led to the postpartum hemorrhage; and for the transfusion error which they claimed had triggered the events that led to their marital breakdown. On appeal, most of their claims were dismissed, except that she was awarded $20 000 compensation to be paid by the hospital for the negligence of its employee in mixing up the bloods[10].

INFECTION FOLLOWING BLOOD TRANSFUSION (1981, 1982, 1985)

Four cases have been litigated where blood-borne infection occurred following transfusion for postpartum hemorrhage. Three cases involved HIV, and one hepatitis C.

HIV

AIDS was recognized in 1982, and the HIV virus was identified in 1983. Shortly thereafter, HIV infection was first reported as a consequence of postpartum hemorrhage. In 1984, the HIV-ELISA test was first marketed as a kit, and the FDA approved it for sale on 2 March 1985. Only 11 days later, on 13 March, the Belle Bonfils Memorial Blood Center in Denver, Colorado took delivery of its first testing kit, but its staff were not yet trained in its use. On that very same day, Mrs KW was admitted to hospital with a secondary postpartum hemorrhage following an apparently uneventful delivery of her baby son 2 weeks earlier. Her bleeding could not be stopped and so a hysterectomy was carried out. Six units of blood were transfused, none of which were tested for HIV. However, by 1986, donor blood was being routinely tested for HIV, and at this time one of her 1985 donors tested positive. All previous recipients of his blood were tracked and tested, and Mrs KW was found to be HIV-positive. She (and her husband and son) sued Belle Bonfils Memorial Blood Center on the grounds that the Center had not appropriately identified and excluded this donor as 'not a suitable person' to donate non-infected blood. (Specific testing for HIV, *per se*, was not an issue in this case.) Most of the legal arguments in the case revolved around confidentiality issues regarding access to the donor's medical records, and so they are not relevant here. The Supreme Court of Colorado ordered limited disclosure of his medical records[11].

In 1981 Matsuko Gaffney, the wife of a US naval man, was booked to deliver at the Long Beach Naval Hospital in California. Her pregnancy went overdue by 4 weeks *(sic)*, but her cervix was judged unfavorable for induction of labor. She was delivered vaginally, but had a postpartum hemorrhage for which she was transfused two units of blood. Various experts later agreed that, if she had had appropriate fetal monitoring, fetal distress would have been recognized, and she would have been delivered by cesarean section, without intrauterine death, infection, postpartum hemorrhage, and blood transfusion, all of which she did have. In 1983, she delivered her next child, a healthy girl, and then in 1985 she delivered a boy. He proved to be a sickly child and was diagnosed with AIDS, from which he died in 1986. Mrs Gaffney and her husband were tested for HIV and both proved positive. She died of AIDS in 1987. After her death, a 1990 Court heard that one of her units of blood came from *'a donor who had engaged in homosexual activity involving the exchange of bodily fluids'*, although he was never actually tested for HIV. The Court found that, as the United States of America was responsible for the military hospital, it was liable for the unfortunate train of events that befell Mrs Gaffney and her family, even though HIV infection had not been discovered at the time. It held that the United States was negligent in the treatment of Mrs Gaffney, that she needed to be transfused as a direct result of that negligence, and that it was

foreseeable in 1981 that a communicable disease could be transmitted through blood transfusion[12].

In contrast to this was the case of Sheri Traxler, who delivered her baby in 1982. Two weeks later, she had a major postpartum hemorrhage, for which she was transfused two units of blood. Hysterectomy was considered, but it proved unnecessary. Eight years later, in 1988, it emerged that one of her blood donors had tested positive for HIV, and now she too tested positive. She sued her 1982 obstetrician on two principal grounds: (1) that he had not removed her placenta completely, and (2) that she had not specifically consented to any blood transfusion. His defence was (1) that retention of placental fragments occurs commonly, and (2) that her written general consent to treatment provided sufficient authority for him give blood as she had lost 30–40% of her blood volume. The lower court held that there had been no negligence at the times of delivery or of the postpartum hemorrhage, and that the risk of HIV infection could not be foreseen. This decision was upheld by the Californian Court of Appeal[13].

Hepatitis C

Blood transfusion following postpartum hemorrhage may cause other blood-borne infections, such as hepatitis C. In 1988, Anita Endean delivered vaginally in British Columbia. She had a postpartum hemorrhage, and she was given a transfusion of packed red cells supplied by the Canadian Red Cross (CRC). After she went home, she had a debilitating flu-like illness. Six years later in 1994, she offered to donate blood, but she now tested positive for hepatitis C. Although its short-term effects are transient, hepatitis C carries a long-term risk of cirrhosis (10% per annum) and in those patients a further risk of hepatocellular carcinoma (5% per annum). The CRC carried out a 'traceback' procedure, and found that one of her 1988 blood donors now tested positive for hepatitis C. (Hepatitis C virus (HCV) was first identified in 1988. An antibody test for HCV was soon developed, but British Columbia did not introduce widespread testing until 1990. Nevertheless, surrogate testing for non-A non-B hepatitis had been widely available in 1988.) She took no legal action against her obstetrician, but sued the CRC who supplied the blood transfused in 1988, on the specific grounds that it had neither tested for HCV nor carried out surrogate testing, and thereby failed to prevent hepatitis C contamination of its blood supplies. She also alleged that the CRC had deliberately destroyed some of her medical records, thus disadvantaging her legal action, i.e. a separate tort known as 'spoliation'. Furthermore, together with many other patients infected with hepatitis C from blood transfusions, she joined a class action, or a mass tort action, against the Canadian Red Cross under British Columbia's Class Proceedings Act 1995. Hers proved to be a unique case of postpartum hemorrhage, as she was to become the 'representative plaintiff', or lead case, in this mass tort action. As her case raised novel legal points that were challenged by the CRC, it fell to the Supreme Court of British Columbia to grant her membership of this class action. Because the final outcome of her legal action was not reported, it is possible that the matter was settled out of court[14].

DELAY IN TRANSFUSING BLOOD (1984, 1988, 2000)

In several cases it was alleged that there was unnecessary delay in giving blood after postpartum hemorrhage.

In 1992, a Saskatchewan court considered the dangers of postpartum hemorrhage in a rural setting. In 1984, Corrine Naeth had delivered her baby uneventfully in Hospital A, but her uterus inverted when 'controlled cord traction' was used to deliver the placenta. Before replacing the uterus, the delivering doctor tried to peel the placenta off the inverted uterus, but the placenta was adherent (placenta accreta). Massive hemorrhage ensued, but there was no blood transfusion facility in the hospital. She was then transferred by ambulance to Hospital B, a traveling distance of 90 min, rather than to Hospital C, a traveling distance of only 30 min, but which only had facilities for uncross-matched blood transfusion. During transfer to Hospital B, she lost consciousness in the ambulance, and she was probably brain-dead by the time she arrived there. Hospital B had limited facilities for blood transfusion, but no obstetrician in attendance. Here blood was transfused, and the uterine inversion was corrected using normal saline as in O'Sullivan's method. She was then transferred to University Hospital in Saskatoon (Hospital D) which had full blood transfusion facilities and an obstetrician in attendance. But she was already dead by the time her ambulance arrived at Hospital D. The court recognized the additional hazards of delivery in a remote rural setting but, even so, it held that in a number of respects *'the standard of competency, skill and diligence exercised by the delivering doctor fell below the standard expected of a general practitioner practising in a rural setting'*, and it awarded her estate damages of $343 000[15].

In 2000, a Dr Gabaldoni appeared before the Maryland State Board of Physician Quality Assurance in connection with his management of a patient he had induced at term for pre-eclampsia. The birth went well, but the mother had a postpartum hemorrhage that was thought to be due to retained fragments of placenta. She deteriorated over the next 48 h and her hemoglobin level went as low as 4.7 g/dl. Dr Gabaldoni was said to be leisurely in attendance, and slow to transfuse blood. However, blood transfusion was started at 48 h postpartum, but by this time she was in severe respiratory distress, and her condition continued to deteriorate. She was admitted to the intensive care unit at 72 h postpartum, but she died there 48 h later. Two days later, Dr Gabaldoni was said to have made a series of undated additions to her notes, which suggested that she had received better care than she did. He was said to have made these additional entries in the same color ink as the original

progress notes, in such a manner that his alterations to the notes would not readily be apparent. The Maryland Board of Physician Quality Assurance filed charges under the Maryland Medical Practice Act 1995. When this case was considered by the Board, there was dispute about when he had seen the patient, when he had offered a blood transfusion, and whether the medical notes as written were correct. After reviewing the evidence, the Board found he had *'failed to meet the appropriate standard for delivery of medical care'*, and so it issued a reprimand. He appealed, but in a 'deferential review' the Court of Special Appeals of Maryland dismissed his appeal[16].

In 2000, a Malaysian Court of Appeal considered whether a medical center had a duty to keep blood available for transfusion. In 1988, Pearly Choo was booked to deliver her first baby in her local medical center, which carried no stored blood. She was healthy, had an uncomplicated pregnancy, and she was considered to be at low risk. She delivered her baby uneventfully, but she then sustained a major postpartum hemorrhage. In keeping with routine practice, blood was requested from the nearby Kuala Lumpur General Hospital, and her husband was sent to collect it. By the time the husband returned with the blood, his wife had already bled to death. He took legal action against the medical center, on the grounds that it should have carried blood, and it should have transfused blood in a timely fashion. The local Sessions Court found for the defendant hospital. The case was appealed to the High Court, which reversed the decision of the Sessions Court, and it found for the husband. However, the hospital then went to the Court of Appeal, which affirmed the Sessions Court's rejection of expert medical evidence that blood must be stored before any delivery, as this *'would result in an absurd situation when one bears in mind that deliveries are also conducted by midwives in houses of the mothers where blood would not be stored before such deliveries'*. The Court of Appeal thus reversed the High Court's decision, as it held that there was no duty to hold blood for a low-risk patient in case she bled. Further, it held that in this case the postpartum hemorrhage had been managed conventionally[17].

OBSTETRICIAN ON VACATION (1961)

Obstetricians traditionally hand over the management of a complicated case to a colleague when out of town or on vacation. The case may then go wrong due to the colleague's negligence, but the vacationing obstetrician might find himself sued for negligence. In 1961, this happened following death from postpartum hemorrhage. When pregnant with her fifth child, Patricia Sturm told her obstetrician at 33 weeks that she no longer felt fetal movements. He could not detect any fetal heart beat and, as obstetric ultrasound had not yet been invented, he advised a conservative approach. He told her that she would probably deliver normally in due course, but he did discuss the possibility of fetal death. As she was upset, he did not fully discuss all the possible complications, but he did test her serum fibrinogen levels intermittently. He told her he would be on vacation at the time of her delivery, but would arrange for a colleague to look after her. However, she chose not to attend any further antenatal appointments. At 41 weeks' gestation, when her own obstetrician was away on vacation, she began to bleed vaginally. She was admitted to hospital, and the colleague delivered her of a stillborn infant. A massive postpartum hemorrhage followed for which she had an eight-unit blood transfusion and a hysterectomy. (The court report says it was carried out vaginally, but this may be incorrect.) Unfortunately, she died despite the emergency treatment. The autopsy report attributed her death to postpartum hemorrhage due to a clotting defect that was in turn due to intrauterine death. The family sued both the delivering doctor and the vacationing doctor, on the grounds that he shared in liability for any perinatal negligence on the part of his deputy. The Supreme Court of Oklahoma rejected this argument, and the obstetrician on vacation was exculpated[18].

UNLICENSED PRACTICE OF OBSTETRICS (1963)

Only two cases of postpartum hemorrhage have been litigated where a professional attendant at delivery was not licensed to practise obstetrics. Earlier, the 1907 case of Midwife Porn was discussed. The only other reported case was in 1963. Bernhardt and Lund were two doctors of chiropractic, but they held themselves out as competent in the management of childbirth. They supervised the delivery of Ladean Stojakovich at home, but unfortunately she had a postpartum hemorrhage and she died before she could be transferred to hospital. They were charged and convicted of breach of the Business and Professions Code (for practising medicine) and of manslaughter (for causing a death that was avoidable). Surprisingly, and for complex legal reasons, the Court of Appeals of California reversed both convictions, and it denied a request for retrial[19].

DISCHARGING PATIENT HOME TOO SOON (1977)

In 1977, Patricia Hale (aged 20) delivered vaginally at term at Fannin County Hospital in Texas, under the care of Dr Sheikholeslam. Although she was still bleeding at 30 h after delivery, she was discharged home. At 8 days postpartum, she was readmitted with continued bleeding. She was given a preoperative injection (presumably of ergometrine) to contract her uterus, a blood transfusion and a uterine curettage. After her operation, she was given no injection and no antibiotics. She was discharged home after 36 h, although she felt weak and she was still bleeding. At 20 days, heavy postpartum bleeding restarted. She was then admitted to a different hospital, where a different gynecologist diagnosed an intrauterine infection. Despite a second D&C, her heavy bleeding continued,

and a hysterectomy had to be carried out. She sued the first doctor and hospital for negligent care. She won her case in the lower court, which held the doctor and the hospital jointly and severally liable for damages of $100 000. However, the hospital appealed the court's decision on the grounds that the doctor was an independent contractor, and not the hospital's servant or agent and that, as the hospital was a governmental unit, it was immune from tort liability. The Court of Appeals upheld the hospital's appeal, and it reversed the lower court's decision as regards the liability of the hospital. Dr Sheikholeslam did not appeal, and thus the original liability decision against him remained unchallenged[20].

INADEQUATE STAFFING LEVELS (1981)

In 1981, Stephen Martin was born in Ontario by spontaneous vaginal delivery following a labor complicated by fetal distress. He was in poor condition, and later he was diagnosed with cerebral palsy. When the case came to trial 17 years later in 1998, Obstetrical Nurse James was found guilty of negligence in failing to give appropriate care during labor. In her defence, she said she was involved with another patient who was having a postpartum hemorrhage. This was not accepted as a valid excuse as she should have called for help. She and her hospital were each found liable for 25% of the damages of $250 000 awarded to the claimant[21].

NO AUTOPSY (1982)

In 1982, Yong Siew Yin was in labor at term with her first baby. The labor was prolonged and (on one account) she was in labor for over 24 h. She had a small intrapartum hemorrhage. As there was delay in the second stage and fetal distress, urgent delivery was needed. The fetal head was low in the pelvis, and in an occipitoposterior position, so the baby was delivered 'face-to pubes' by Neville Barnes forceps. Following this, she had a postpartum hemorrhage, and this was attributed to vaginal tears. Whilst these were being repaired she collapsed, and a coagulation disorder became manifest. She continued to bleed heavily. An amniotic fluid embolism was suspected, but it was never proved. She was admitted to the intensive care unit where she died. Surprisingly, there was no autopsy. The judge in the lower court found the obstetrician guilty of negligence, and the hospital vicariously liable. This verdict was upheld on appeal[22].

SUING THE WRONG DOCTOR (1982)

Occasionally, a patient may sue the wrong doctor. In 1976, Jean Johnson had a normal vaginal delivery at the Wishard Memorial Hospital in Indiana. This was followed 2 weeks later by a secondary postpartum hemorrhage. She was seen by the Chief Resident, Dr Deaton, who diagnosed retained products of conception, and advised uterine curettage. He checked his diagnosis and treatment plan with Dr Padilla, a staff instructor with the Indiana University Medical School, and the operation was carried out. By 1982, it had become apparent that Jean Johnson was infertile, and this was attributed to over-vigorous curettage of the endometrium in 1976 (Asherman's syndrome). She sued Dr Padilla for negligent performance of the curettage, but did not suggest that the curettage decision itself was negligent. The defence was threefold: (1) Dr Padilla did not carry out the curettage; (2) there was no doctor–patient relationship between Dr Padilla and Jean Johnson; and (3) there was no agency relationship between Dr Padilla and Dr Deaton. The Court of Appeals of Indiana accepted all three lines of defence, and dismissed the case against Dr Padilla[23].

OBSTETRICIAN WITHOUT SUFFICIENT EXPERIENCE (1986)

In 1986, Christine Steinhagen became pregnant for the third time. She had two previous cesarean sections, the second being complicated by *'extreme and profuse bleeding'*. In her third pregnancy, she had a sudden vaginal bleed at about 20 weeks' gestation, and an anterior placenta previa was diagnosed. She was kept in hospital for 18 weeks and throughout this time given terbutaline to inhibit uterine contractions. The last dose was given on the morning she was delivered by elective cesarean section. Her obstetrician-gynecologist had recently completed his residency training but was not yet board-certified. Moreover, he had not discussed her management with any board-certified obstetrician-gynecologist, and had no other suitably qualified surgeon in attendance. The cesarean operation was carried out through a low transverse abdominal incision, but surgery proved to be difficult. After the baby was delivered, the uterus failed to contract, and she hemorrhaged profusely. In these circumstances, it would have been usual to give Methergine (methylergonovine) and/or Pitocin (oxytocin) to promote uterine contraction. No Methergine was given; half a dose of Pitocin may have been given, but it was not documented in the medical notes or on the drug chart. A hysterectomy was carried out, but the bleeding continued. Her bladder was damaged and she developed hematuria. A urological surgeon was then called, and he ligated the left internal iliac (or hypogastric) artery. This slowed the bleeding considerably, but it did not stop it completely. The tissues were now friable and so the abdomen was packed and closed, and she was managed overnight in intensive care. The abdomen was reopened the following day as internal bleeding continued. At the second operation, all bleeding was brought under control, but she lost her right ovary. During this episode, she was given a total of 34 units of blood, 14 of fresh frozen plasma and 10 of platelets, but she survived. Postoperatively, she developed a vesico-vaginal fistula, hepatitis, an extremely short vagina that made intercourse impossible, and severe psychological problems. As she was managed and delivered at a naval military hospital in

Illinois, she took legal action against the United States of America. After hearing expert evidence, the trial judge was critical of: an obstetrician-gynecologist who was not board-certified managing this complicated case without more experienced help; his giving terbutaline immediately prior to the cesarean section, thereby inhibiting uterine contraction after delivery; his failure to perform the operation through a midline incision which would have minimized the risk of bladder damage; his failure to give Methergine to contract the uterus; and his failure to ligate both hypogastric arteries which might have avoided the hysterectomy and the loss of an ovary. He awarded her $300 000 in compensation[24].

NO OPERATION NOTE (1992)

In 1992, Mrs Suchorab was delivered in Saskatchewan by cesarean section. Six weeks later, she had a postpartum hemorrhage and was readmitted to hospital. Her obstetrician took her to the operating theater, where he stabilized her condition. The operation log and the anesthetist's note both record that a dilatation and curettage operation was carried out, but no surgical operation note was ever found to confirm this. The following day, she had a further major hemorrhage, and a hysterectomy was carried out. She took legal action against her obstetrician. She argued that his care had been deficient as her bleed was due to retained products of conception, and he had failed to curette her uterus as (she claimed) was evidenced by the absence of any operation note. He claimed that he had curetted her uterus, but he had forgotten to write an operation note. Moreover, he claimed that her bleed was from a *'necrotic cervix'*, and not from the uterine cavity, and so no extra harm would have resulted from failure to curette the uterus. The court rejected her claim[25].

SHEEHAN'S SYNDROME (1977, 1995)

In 1977, Mrs Parker delivered her first child. Her obstetrician delivered the placenta by continuous cord traction. However, she had a uterine inversion and a major postpartum hemorrhage followed. She was taken to the operating theater, and in the operation note it was recorded that her *'uterus had resolved itself'*. Five months later, she was found to have *'an inverted uterus presenting well down in the vagina'*. She had various ongoing symptoms, but it was not until 1991 (14 years later) that Sheehan's syndrome was diagnosed. She then took legal action against her obstetrician of 1977. A four-person jury awarded her $960 000 in damages. Her obstetrician appealed the case on both liability and quantum. The New South Wales Court of Appeal dismissed his appeal on liability, but it ordered a new trial limited to damages, as it considered the jury award excessive[26].

In 1995, Natalie Lomeo was delivered by elective cesarean section at her local Community Medical Center (CMC) in Pennsylvania. She had an extensive blood loss during the operation, and a postpartum hemorrhage followed. Although she exhibited signs of hemorrhagic shock, blood was not transfused until much later in the day. Over the next 3 years, she complained of fatigue, weakness, dizziness, hair loss, amenorrhea, dyspareunia, and vasomotor symptomatology. In 1998, the diagnosis of Sheehan's syndrome was made. She then took legal action against her obstetrician and the CMC. However, the defendants filed for summary judgment, asserting that her claim was time-barred under Pennsylvania law, as it had been filed more than 2 years after the allegedly negligent conduct. The Common Pleas Court denied the motion for dismissal, saying that the litigation clock only started to run when Sheehan's syndrome was diagnosed[27]. What happened next was not reported, so the case was probably settled.

MALIGNANT HYPERTENSION (1993)

In 1993, Evelyn Dybongco-Rimando had an uneventful spontaneous vaginal delivery of a healthy daughter, and she went home shortly afterwards. Some 8 years later, a judge of the Superior Court of Justice of Ontario was to say that her case *'presents a puzzle with a thousand pieces'*. The trial started in 1999, and it lasted for 33 days spread over 3 years. The judge described it as *'a challenge to bench and bar alike'*. Although her delivery was normal, 7 days later she suffered a massive postpartum hemorrhage, and she was readmitted to hospital. Over the next 2 days, she had three operations before her bleeding could be brought under control: uterine exploration, hysterectomy, and then a second-look laparotomy. She was given a large transfusion of blood, and also blood products as she developed a coagulation disorder. She became profoundly hypotensive, and required inotropic agents (principally dopamine) to support her blood pressure. However, her blood pressure then went too high, and within 33 h of readmission to hospital she had developed malignant hypertension. Dopamine was given but discontinued when her pressure reached 237/113 mmHg. However, the maximum level of blood pressure later recorded was 256/126 mmHg. She then had a cerebral hemorrhage, and soon after this she died. Her estate started a legal action against 55 defendants, but only three defendants remained shortly after the trial started in 2000. These were her obstetrician, her internal medicine physician, and her intensivist. In his final judgment, the judge said of the internal medicine physician's testimony *'It reflects a triumph of tactics over truth. He is not credible.'* He found all three defendant doctors guilty of negligence, and he reserved judgment on the amount of damages to be awarded to the deceased patient's estate[28].

NO EXPERT MEDICAL REPORT (1995)

In 1995, Marcia Laidley had a postpartum hemorrhage after delivering her third child. A supracervical hysterectomy was performed. Later, she took legal action

against her obstetrician. However, she failed to provide a timely expert medical report in support of her case by the court-imposed deadline, and so summary judgment was awarded against her. She appealed. The Court of Appeals of Ohio held that the trial court had committed a prejudicial error when it granted the defendant's motion for summary judgment without providing the opportunity for sufficient discovery on the issue[29].

POSTPARTUM HEMORRHAGE IN AN AIRCRAFT (1997)

In 1997, Gina Paone delivered her baby in Ontario, but her placenta had to be removed manually. Her uterine cavity was explored and considered to be empty. The placenta was judged to be complete. One month later, she flew to Italy, but she had abdominal pain and heavy vaginal bleeding during the flight. On arrival in Italy, she was admitted to hospital where she had a uterine curettage. She claims she was told there was further placental tissue recovered from the uterus, but there was no written confirmation of this. In 1998, she started legal proceedings in Italy by an Act of Citation naming her obstetrician, two nurses and St Joseph's Health Centre, all of whom were in Ontario. The Italian court refused to hear the case, saying it lacked jurisdiction as the medical treatment had occurred in Ontario. In 2000, she brought a similar legal action in Ontario. However, the defendants prevailed, as Ontario law requires an action against a doctor to be brought within 1 year from when the Plaintiff *'knew or ought to have known'* the material facts on which the malpractice is alleged, and against a hospital or nurse within 2 years of the patient being discharged from hospital or stopping treatment. Furthermore, the Ontario Court of Justice also found that in this case there was no genuine issue for trial as no expert reports were filed[30].

POSTPARTUM HEMORRHAGE INTO THE PLEURAL CAVITY (1997)

In 1997, an unusual case of postpartum hemorrhage occurred in California. Martha Guandique had severe pre-eclampsia at 38 weeks' gestation. Her signs and symptoms included shortness of breath, hypertension, renal malfunction, hepatomegaly and pleural effusion. Labor was induced and she delivered a male infant. She had a postpartum hemorrhage due to uterine atony, so she was given Pitocin. Blood clots were evacuated from her uterus. Shortly after delivery, she had considerable difficulty in breathing, and back pain. Various physicians were called in to see her. Pulmonary embolism and amniotic fluid embolism were in the differential diagnosis. Supportive therapy with oxygen was given and various drugs were used. Her hemoglobin fell at first to 9.5 g/dl, and it continued to fall thereafter. (Subsequent hemoglobin levels were not recorded in the court report.) A blood transfusion was started, but 20 min later she had a cardiopulmonary arrest and then she died. At autopsy, she was found to have suffered a major postpartum hemorrhage (of 1500 ml) into her right pleural cavity. The pathologist reported that *'The mechanism of production of this hemorrhage remains unknown in spite of a careful dissection of the blood vessels in the area. . . . That is why the mode of this death remains undetermined.'* In this case, much of the complicated legal argument before the Court of Appeal of California focused on which doctors might have been liable for her death, but these legal arguments need not concern us here[31].

DISAPPEARING BABY (1999)

This too represents an unusual case, but I have seen something very similar (see below). In 1999, an unmarried mother was having an adulterous affair with a co-worker. He noticed that her abdomen was enlarging, and asked whether she might be pregnant. She said that she could be. The matter was discussed no further, neither with him nor with any other co-workers. A few weeks later, she attended her family doctor complaining of swollen feet. She told him that she was 7 months pregnant. The doctor heard the fetal heart beat and felt fetal movements, and so he pronounced the fetus healthy. This was the only medical care she sought before 12 May 1999, when she was admitted to a Texas hospital with a 2-day history of vaginal bleeding. She was said to be in shock: she was weak and pale, had a low temperature, and a tachycardia. (Her blood pressure was not mentioned in the court report.) She said that she was pregnant, but she did not know the date of her last menstrual period, nor when her baby was due. A blood test showed that she was severely anemic. Her hemoglobin level was not mentioned in the court report, but, from comments in the report, it was probably around 4–5 g/dl. Four units of blood were transfused. An obstetrician was called, and she scanned the uterus with ultrasound. She found no evidence of a baby, but she did find a placenta of a size compatible with a term baby. The placenta was then delivered, but it had no cord attached. Both the patient and her attendant family denied that any baby had been born. Therefore the police were called. They searched her home, and there they found evidence of extensive blood staining of her bed, and of her bathroom – but no baby. A grand jury was convened to determine whether any charge, such as homicide, should be brought. Under oath she said that *'I did not pass a baby'*, and she insisted that she had only passed clots of blood. She was later charged with aggravated perjury before a grand jury, convicted by a jury, and sentenced to 10 years confinement probated for 10 years. She appealed against her conviction on the grounds that the evidence was legally insufficient to support the jury's verdict, and the State had failed to prove the materiality of her alleged false statement. The Court of Appeals of Texas considered her arguments but it dismissed her appeal[32].

[In the late 1970s, I had a similar case in the UK: a 14-year-old girl who presented in shock with heavy

vaginal bleeding. She had a perineal midline tear, a widely open cervix, and an enlarged uterus, but there was no baby and no placenta. Her hemoglobin level was only 4 g/dl, so she was transfused with blood. Her presentation was clearly consistent with recent childbirth followed by a major postpartum hemorrhage. Despite the overwhelming evidence, the girl and her parents firmly denied any pregnancy or recent delivery of a baby. The police were duly called in. They investigated the matter and searched the family home, but no baby was ever found. No charges were ever brought.]

ABANDONMENT (2000)

In 2000, the New York Bureau of Professional Medical Conduct considered the case of Dr Wahba, an obstetrician who was charged with professional misconduct in the treatment of seven of his patients. Two of these were at risk of postpartum hemorrhage, and here he was found guilty of negligence and/or incompetence. In both cases, he left the delivery room before the placenta was delivered. The first patient had a stillbirth, and so she was at a higher risk of postpartum hemorrhage. The second was still hemodynamically unstable; she then hemorrhaged but by this time the obstetrician had already left the hospital. Moreover, he refused the nurse supervisor's requests to return. After reviewing his management of all seven patients, the Administrative Review Board for Professional Medical Conduct revoked his licence to practise medicine in the state of New York. He then appealed to the Supreme Court of New York, but his appeal was dismissed[33].

POSTPARTUM HEMORRHAGE IN A FEMALE DOG (2006)

American courts are well known for leading the way into new areas of litigation. Therefore it may come as no surprise to learn that in February 2006 the Court of Appeals of Texas ruled on a case involving the management of postpartum hemorrhage in a female dog in the Bureau of Animal Regulation and Care in Houston in 1999. This facility takes around 20–30 000 animals a year. One of their veterinarians was Dr Levingston. He had made a number of complaints to his employers about the inhumane treatment of animals in their care, but on one particular occasion they accused him of the negligent care of animals, and they terminated his employment. They cited his alleged mismanagement of the care of a female Rottweiler dog who had given birth to nine puppies, and who had a postpartum hemorrhage from which she exsanguinated and died. They said he should have considered the possibilities of hysterectomy or euthanasia. He appealed his termination of employment and won his case. He was awarded damages in the lower court. His employers appealed the decision, and the case went to the Court of Appeals of Texas who dismissed their appeal. The court awarded him a total of $1.24 million for past and future lost wages and compensatory damages. This amount was to include $194 000 for his lawyers' fees. If the lawyers' fees of his employers, the City of Houston, were of the same order of magnitude, then the legal bill on this case would have been around $400 000. Overall, this case ran for more than 5 years[34].

CONCLUSIONS

This account has been international in its scope, albeit confined to common law jurisdictions. It is clear that the history of litigation following postpartum hemorrhage stretches for over 100 years, from Florence Westrup of Newport, Kentucky in 1905 to the female Rottweiler dog of Houston, Texas in 2006.

In 17 of 34 cases (50%), a maternal death no doubt prompted the litigation, rather than the postpartum hemorrhage itself.

After maternal death, the second most common reason for litigation was a problem with the transfusion of blood, such as infection, delay or possible incompatibility. Such problems occurred in ten of 34 (29%) of the cases.

Equal third reasons for litigation were having a diagnosis made of Sheehan's syndrome after postpartum hemorrhage (only two cases), and having professional birth attendants who were not licensed to practise obstetrics (only two cases, one of which was litigated in 1907).

Apart from the general observation that poor obstetric practice was a typical feature of many of these cases, they were otherwise sporadic in etiology, with no common cause.

Given the millions of women who have delivered over the last 100 years across the English, Commonwealth, Irish, and American jurisdictions studied, given that the incidence of postpartum hemorrhage is around 5–10%, and given that there has been an international increase in litigation for alleged clinical malpractice, it is surprising that there have not been many more cases of postpartum hemorrhage litigated in the courts.

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