Malpractice History

Provider Name: VINITA GOYAL

Please DUPLICATE this form and complete for EACH case.

1. **Patient Name:** Teresa Bushman
2. **Diagnosis:** Abnormal uterine bleeding, endometrial polyp, underwent dilation and curettage, hysteroscopy for planned polypectomy
3. **Your involvement in the case, i.e... Attending, Consulting, Etc.:** First year fellow serving as Attending
4. **Allegation(s):** negligence from uterine perforation leading to bowel injury
5. **Clinical Case Summary:** Please see attached document for complete details.
6. **Patient Outcome:** please see attached document
7. **Other pertinent details:** Please see attached document
8. **Date of incident:** 06/12/2006 **Date filed:** 02/26/2010
   Date closed: 11/23/2010
9. **Resolution of case, i.e. Dismissed, Settled Out of Court, Litigated, Pending, Other:** settled out of court
10. **Settlement amount paid on your behalf (if any):** $400,000
11. **Professional liability insurer involved:** University of North Carolina Liability Insurance Trust Fund
    a. **Name of Insurer:** same as above
    b. **Address of Insurer:** 101 Manning Dr. 4th fl Wing E
12. **Defense attorney:** Anna King

Vinita Goyal
Signature

9/17/21
Date

This attorney claim involves a then 47 year old female, para 0-0-2-0 with a history of hypothyroidism, fibromyalgia and a previous hysteroscopy, dilation and curettage for suspected endometrial polyp in 2002. She was seen by Dr. Goyal on 5/6/2008 in the University of North Carolina (UNC) GYN clinic for evaluation of abnormal bleeding. She had a transvaginal ultrasound which demonstrated a suspected endometrial polyp. She was offered the option of further characterization of the polyp with saline infused sonohysterogram or surgery including hysteroscopy, dilation and curettage and polypectomy. She elected to proceed with surgery and "the risks of infection, bleeding, hemorrhage requiring blood transfusion, damage to surrounding organs including bowel and bladder, uterine perforation, hysterectomy, abdominal incision, need for further procedure were discussed with the patient" prior to consent.

On 6/12/2008 she underwent a hysteroscopy performed by Dr. Goyal to remove the endometrial polyp. Dr. Goyal was of the opinion that the patient had a difficult anatomy due to a stenotic os and extreme uterine anteflexion, yet she felt she was ultimately able to enter the intrauterine cavity. A fluid deficit was noted, but Dr. Goyal believed the quantity of fluid deficit could be inaccurate given spillage of hysteroscopic fluid outside the collecting container. She believed she identified the intrauterine polyp and proceeded with resection. When the fluid deficit was larger than could be accounted for by spillage of hysteroscopic fluid, she stopped hysteroscopy and performed a diagnostic laparoscopy. Given the suspected appearance of damage to the rectosigmoid colon, she called for assistance from Gynecologic Oncology. Her calls for help were responded to promptly. Gynecologic Oncology immediately performed an exploratory laparotomy, evaluated the patient's bowel, and noted rectosigmoid bowel deserosalization and thermal injury. The patient then underwent an exploratory laparotomy with sigmoid resection and primary end-to-end anastomosis. Post-operatively the patient did well. She was discharged home on post operative day number seven.

On 6/22/2008 the patient was readmitted to UNC Hospital with complaints of drainage from her abdominal incision. She underwent wound exploration and received intravenous antibiotics. Her wound improved and she was taught home wound management with twice a day dressing changes. The decision was made to not continue out-patient antibiotics due to her multiple drug allergies. She was discharged home on hospital day three.

The patient continued to have problems with abnormal bleeding. On 3/19/2009, she underwent an attempted hysteroscopy with another physician at UNC which was aborted due to the severe anteversion of her uterus. On 7/16/2009 the patient underwent a total laparoscopic hysterectomy with extensive lysis of adhesions without complications.

Risk management was notified of the surgical complications the day of the initial surgery. The complications were reviewed at Morbidity and Mortality conference. In retrospect, Dr. Goyal's impression was that she perforated the posterior portion of a very stenotic cervix, created a false tract for the hysteroscope, and on visualization with the hysteroscope believed that what she thought was the intrauterine cavity was actually the uterine-ovarian fossa. What she believed was a polyp was an aspect of the ovarian ligament. Dr. Goyal felt comfortable with hysteroscopy having done approximately 50 procedures during her residency. Dr. Goyal completed her fellowship training at UNC on 6/30/2009. Prior to and since this incident, she has repeatedly performed this procedure without complications.

UNC Risk Management received an attorney claim packet on 2/26/2010. The attorney alleged negligence during the performance of the 6/12/2008 surgical procedures resulting in serious and permanent injuries to the patient, namely gastrointestinal injury causing alternating constipation and diarrhea. Notably, the patient had these complaints prior to her initial surgery and had a normal gastrointestinal evaluation, including endoscopy and colonoscopy, following the surgery.

Internal reviews opined there would be difficulty in defending some aspects of care. Although uterine perforation is a risk of the procedure, the documentation supports that Dr. Goyal had trouble entering the uterus, did not recognize she had perforated the uterine cavity given the difficult anatomy, and used electrocautery which resulted in a thermal burn to the bowel. Once the uterine perforation was evident, Dr. Goyal responded appropriately. The fluid deficit is a shared obligation of physician and OR staff, but it was felt that the documented two-liter fluid deficit would be difficult to defend. The claim was settled on November 23, 2010. A single payment of $400,000 was made to the patient and her attorney with 100% allocation to Dr. Goyal.