Pitfalls in our practice: examples from four cases of obstetric litigation

Joanna C Gillham

Abstract

Obstetric litigation continues to rise and maternity claims represent the highest value claims and second highest actual number of clinical negligence claims reported to the NHS Litigation Authority (NHSLA). Between 1st April 2000 and 31st March 2010 there were 5087 maternity claims with a total value of £3.1 billion. The NHSLA in 2012 published '*Ten Years of Maternity Claims*' which highlighted the areas of practice most vulnerable to such. The five categories that represented the highest value claims were:- cerebral palsy, CTG interpretation, management of labour, Caesarean section and antenatal investigations. The main areas in which care fell below the required standard were:- interpretation of antenatal ultrasound, failure to recognise and abnormal CTG and/or act on it, failure to consider a Caesarean section, failure to perform an episiotomy, failure to diagnose the true extent of a perineal injury, failure to perform an adequate perineal repair, inadequate antenatal counselling for vaginal birth after Caesarean section, and failure to recognise a uterine rupture. Of note was that only 21% of the CTG claims involved 'high risk' cases. Below are four examples of successful litigation which highlight some common failings.

Keywords cardiotocograph (CTG); litigation; obstetric; syntocinon

Legal issues

In order to establish negligence in a case three things need to be established:

- The existence of a duty of care
- A breach of duty
- Causation of injury i.e. that the breach of duty caused the injury

Duty of care

In a medical context, this is straightforward. A doctor or other health professional treating a patient will owe that patient a duty of care. This arises out of the assumption of responsibility for the patient.

Breach of duty

This is approached two fold — first it is necessary to determine what would have been the appropriate standard of care i.e. what was reasonable, and secondly to establish that the conduct in question fell below that standard i.e. a breach. A breach of duty can relate to an 'act' or a 'failure to act'.

The standard of care is that of the reasonably competent medical practitioner in that field. In a civil negligence claim the burden of proof is on the claimant. The standard of proof required to meet this burden is 'on a balance of probabilities' i.e. more likely than not, compared to criminal negligence in which the burden is 'beyond all reasonable doubt'.

The **Bolam defence** can show that the standard of care has been met, even if some practitioners are critical of what occurred, if there are relevant practitioners who properly take the view that the treatment was appropriate. The Bolam defence does not apply where a mistake was made, even if it was a mistake that a responsible doctor might occasionally make i.e.

> *'A doctor is not guilty of negligence, if he has acted in accordance with the practice accepted as proper by a responsible body of medical men skilled in the particular art. Putting it the other way round, a doctor is not negligent if he is acting in accordance with such a practice, merely because there is a body of opinion which takes a contrary view'.*

This **Bolitho** case modified the above defence. The body of responsible opinion must not be manifestly wrong. The judge has to accept that the body of opinion is responsible, reasonable or respectable i.e.

> *'The court is not bound to hold that a defendant doctor escapes liability for negligent treatment of diagnosis, just because he leads evidence from a number of medical experts who genuinely are of the opinion that the defendants treatment or diagnosis accorded with sound medical practice — the court has to be satisfied that such opinion has a logical basis'.*

Causation

The claimant must prove that on the balance of probabilities, the substandard treatment caused or materially contributed to the injury, loss or damage, i.e. that the damage of which the claimant complains would not have occurred but for the defendant's breach of duty.

Role of an expert witness

An 'expert witness' is a person who has been instructed to give or prepare expert evidence for the purpose of proceedings. Experts should assist the court by providing objective, unbiased opinions on matters within their expertise, and should not assume the role of an advocate.

Case 1

History

Patient A was 29 years old and a low risk primigravida at booking. She had an uneventful antenatal period and remained under midwifery led care until term +5.

Visit 1—40 + 5 — Attended with contractions 1:10. On vaginal examination (VE) the cervix was closed. The latent phase was diagnosed and Patient A sent home.

Visit 2—40 + 6 — Contractions 1:5. Patient A very distressed and in pain. On VE the cervix was 1 cm dilated. Patient A wanted to remain in hospital. This was refused and she was discharged home.

Joanna C Gillham *BSc MB BS MD MRCOG is a Consultant in Obstetrics and Maternal/Fetal Medicine at St Mary's Hospital, Manchester, UK.*
Conflicts of interest: none declared.

Visit 3 (early AM) − 40 + 7 − Patient attended as unable to sleep, vomiting, and very distressed with the contractions despite taking Tramadol. Contractions were 2:10 min and the cervix was 2–3 cm dilated. A diagnosis of the latent phase of labour was made and patient A was discharged home against her wishes.

Visit 4 − (early PM) − 40 + 7 − Patient A attended very distressed with pain. As the contraction frequency had not increased and as the VE was unchanged she was discharged home again against her and her family's wishes.

Visit 5 (late PM) − 40 + 7 − Patient A attended again distressed and in pain. On VE the cervix was 3 cm dilated. She refused to go home until she had seen a doctor. The doctor recommended discharge home, however, the patient refused and she was admitted and given intra-muscular pethidine and temazepam. Patient A requested not to be discharged home as she had now been contracting for 3 days. There was a registrar review of the notes (they did not review Patient A in person) who deemed that the plan to discharge home was appropriate and that she should keep the planned appointment for a membrane sweep. She was discharged at 09:30 AM the following day. The fetal heart was auscultated, however, no cardiotocograph (CTG) tracing was performed.

Visit 6–40 + 8 − Patient A reattended distressed with pain. Contractions were 1:4–5 minutes. On VE the cervix was 3–4 cm dilated. On initial auscultation the midwives were unable to hear the fetal heart and ultrasound confirmed a fetal death *in utero*.

Post mortem cause of death was acute asphyxia.

Hospital investigation report

The internal case review from the hospital was of the opinion there had been a fragmented approach to the care afforded and due to the number of admissions she could have been offered induction of labour (IOL) rather than discharged home on visit 5.

Letter of claim

The following allegations of negligence were made:-

1. During the 3rd and 4th admissions that the latent phase of labour had now progressed outwith normal limits and that consultation should have occurred with a doctor prior to discharge home. Particular emphasis was placed on Patient A's increasing pain and distress and her wish for intervention.
2. During the 5th admission there was a failure to offer an ARM (artificial rupture of membranes) in a latent phase of labour that had gone outwith normal limits in a patient requiring intra-muscular pain relief, who was wishing intervention and who was already 3 cm dilated at a post dates gestation.

Causation was such that had an ARM been offered, fetal monitoring would have occurred and had any fetal compromise been detected and delivery would have been expedited.

This case highlighted that a holistic approach must be taken to patient care. The GMC Good Medical practice guidelines highlight in the duties of a doctor that one must:-

- Make the care of your patient your first concern
- Work in partnership with patients by
  - Listen to and respond to their concerns and preferences
  - Respect patients' rights to reach decisions with you about their treatment and care.

This case subsequently settled for £55,000 and legal fees.

Case 2

History

Patient B booked aged 37 years and was deemed to be a low risk primigravida of Indian origin. The antenatal period was uneventful and the patient remained under midwifery led care. At

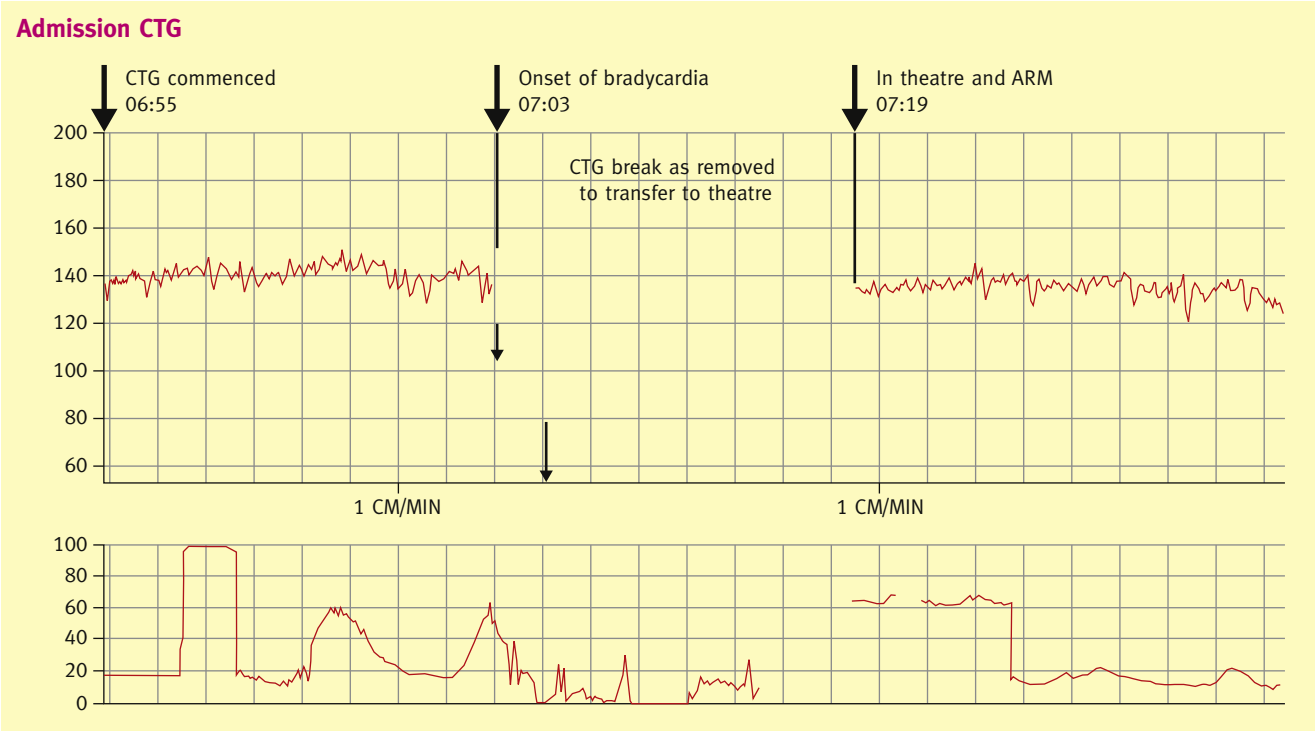

Figure 1