Approaching claims arising from childbirth

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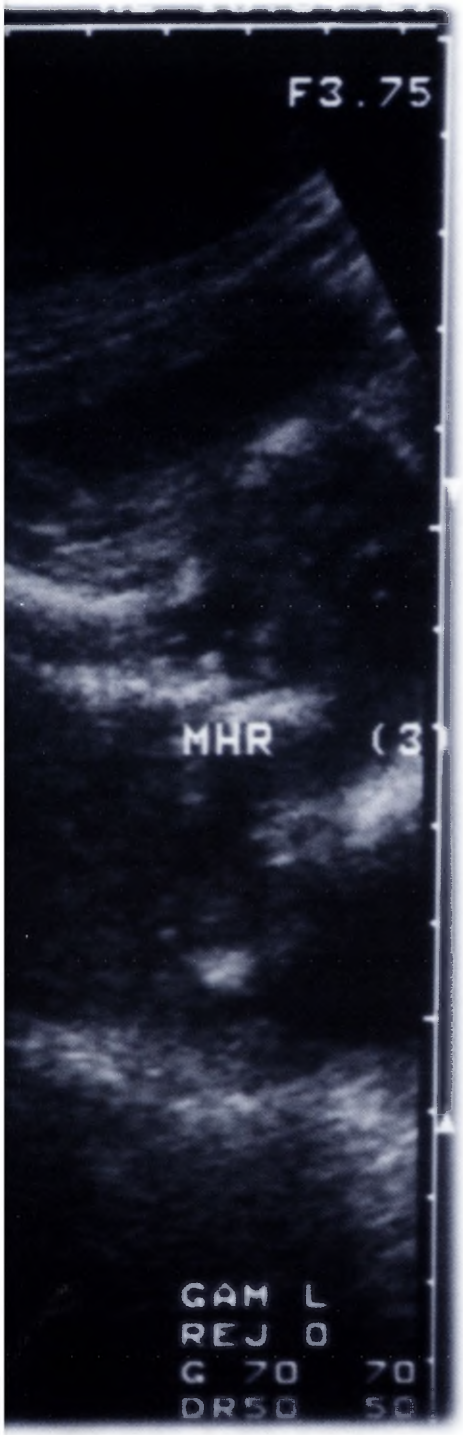
Obstetric-related claims are among the most challenging medical malpractice claims. Claims may arise from injuries to the child that include cerebral palsy, stillbirth, facial nerve palsy, erbs palsy, scarring, fractures, wrongful birth through handicap, or failure to detect some abnormality. Claims may also result from maternal injuries, which include scarring, loss of bowel function, loss of future childbearing ability, and death.



There are four consistent themes that characterise the objectives of plaintiffs who initiate claims where treatment has resulted in an adverse obstetric outcome.

1. Retribution against the health professional is the most common theme.
2. Compensation (competes with retribution for first place as the most popular theme).
3. Public safety/welfare could be described as a standard theme as most childbearing women do not want their experience to be repeated.
4. De-Registration is often an objective for those focused on revenge.

Preliminary advice

The plaintiff or their litigation guardian should be informed from the outset that:

(i) At best you can only attempt to assist them to achieve compensation for their loss;
(ii) Investigating medical malpractice claims arising from childbirth takes time and can be extremely difficult;
(iii) A number of liability reports are likely to be required and the financial costs associated with the claim will be significant;
(iv) There will inevitably be an emotional cost for the plaintiff and their family.

Interviewing your client

Instructions should be taken from your client(s) in relation to the following

Family

(i) Medical history including physical, mental or genetic problems;
(ii) Obstetric history, eg: prior termination(s) of pregnancy, spontaneous vaginal deliveries, instrumental deliveries, complications, etc.

Mother

(i) Medical history, age, parity, medical problems eg: gestational diabetes;
(ii) Obstetric history including - weight of babies, cephalo pelvic disproportion, breech or other presentations, instrumental deliveries, pregnancy induced hypertension, augmentation, infection, bleeding, response to analgesia;
(iii) History of all antenatal, intrapartal, and postnatal consultations/examinations;
(iv) History of exposure to alcohol, medication, drugs, and smoking during each trimester;
(v) Surgical history, e.g. caesarian section;
(vi) Labour progress including witnesses and attendants at delivery and timing and duration for each procedure, e.g. oxygen administration (if any).

In some cases that have resulted in an adverse obstetric outcome there will be little or no documentation particularly when an obstetric emergency precedes such outcome. It is therefore imperative to obtain detailed instructions from witnesses and attendants. The names of the attendants at the delivery should be recorded in the hospital birth register book, which is located in the labour ward.

Infant

(i) description of baby at birth;
(ii) APGAR Scores;
(iii) if at all possible, details concerning resuscitation and drugs administered noting those present at time of birth, e.g. paediatrician, family members.

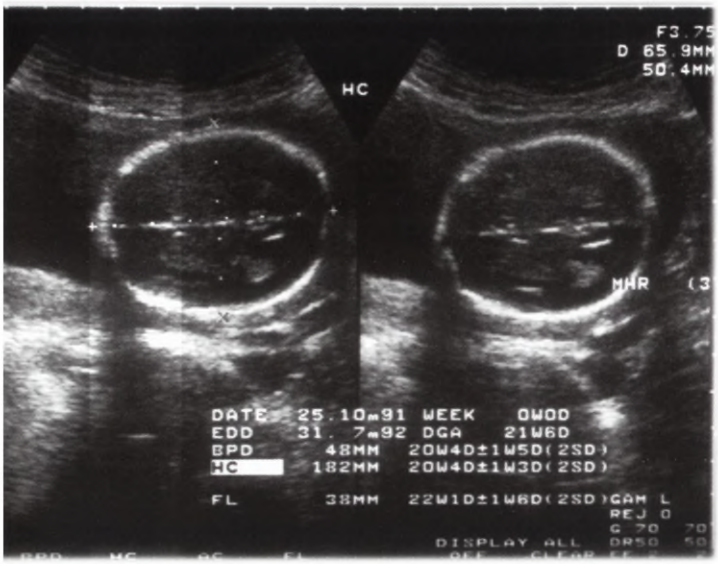
In failure to warn cases, determine whether the woman/mother would have elected to undergo the relevant gynaecological/obstetric related surgery and/or treatment/procedure had they been provided with the appropriate information including but not limited to associated risks and alternatives, and details concerning her appreciation of risk(s) associated with the surgery and/or treatment/procedure.

Clinical Records/ Details/ Result

For injuries that are alleged to have been sustained intrapartally,[1] irrespective of whether it was the mother or child who was injured, obtain both the clinical records of the mother[2] and the child[3]. The mother's clinical records should be obtained for each confinement.

The key to obtaining all relevant material is to make your request to the relevant hospital/department/organisation very specific, notwithstanding that the statutory and/or administrative processes used to obtain access to the information makes provision for complete access to records.

Doctors commonly do not provide a time along side their record of entry in clinical records. It is worth noting that if timing is provided, often it has been estimated. ▶



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MRI Scans can be used to determine the timing of hypoxic ischaemic encephalopathy. CT and MRI films must be obtained and reviewed by a paediatric neuroradiologist.

Some authors[4] are of the view that cord blood nucleated red blood cell assessment may be helpful in timing fetal neurological injury. As soon as legal investigations begin, requests should be made for copies of cord blood results. Pathology specimens including cord blood specimens can be held by laboratories for a number of years and are therefore available for analysis. The relevant health facility/laboratory should be notified that the specimen might be required for testing and that it is to be preserved.

Where placental abnormalities are being raised as the cause of an adverse outcome, placental tissue and slides should be obtained and reviewed by an experienced placental pathologist.

Hospital Policy & Clinical Practice Guidelines

The policy documents relevant to the procedure/treatment at issue should always be sought as part of the investigation process.

Obstetric-related policies can include: Pre-Labour Rupture of Membranes Protocol, Epidural Anaesthesia Protocol, Breech Presentation Protocol, Caesarian Section Protocol, Forceps Delivery Protocol, Meconium Liquor Protocol, Intrapartum Electronic Fetal Monitoring Protocol, Second and Third Stage Labour Protocol, Syntocinon for Induction/Augmentation in Labour Protocol, and Shoulder Dystocia Protocol.

In the case of *Ren v Mukerjee and Anor*[5] Miles CJ made specific reference to protocols in his judgement. Evidence was produced that there were protocols on the functions and authority of various members of the hospital staff and the procedures to be followed in cases of emergency, but the protocols were not produced in evidence and nobody seemed to know their content.

Clinical Practice Guidelines are also available for use in many hospitals. Clinical Practice Guidelines are usually available on request from professional colleges/associations.

Hospital Incident / Accident Reports

Hospital incident/accident reports are occasionally completed in circumstances where the treatment provided in the maternity ward and in particular delivery suite, requires explanation. These should be requested as part of the investigation process. Incident/accident reports are often but not always released.

Staff Allocation Packages & Patient Nurse Dependancy System

Staff supervision and/or expertise is often at issue in obstetric-related claims. For claims against hospitals where staffing and patient supervision is an issue it is worthwhile obtaining copies of the following:

(i) 24-hour printouts from Staff Allocation Packages/Patient Nurse Dependancy System for the relevant ward(s) in the relevant period;
(ii) Rosters for nursing staff, medical staff and consultants.

Every attempt must be made to obtain the following:

(i) Private medical practitioner's or health provider's medical records concerning the mother and child;
(ii) Clinical records concerning previous deliveries;
(iii) Material concerning complaints to Health Registration Boards concerning the mother and child.

Identifying and briefing an expert

The expert must not only be credible in terms of qualification and experience, and be co-operative and prepared to give evidence against fellow professionals, but must be a registered medical practitioner or health professional. At risk of stating the obvious, a consultant of the defendant health authority should not be briefed to provide a liability report.

The expert advising on liability should be someone who was practising in a relevant specialist capacity at the time of the alleged negligence and should be well experienced in the particular techniques and treatment at issue. By way of example, when the plaintiff is the child and where the damage is alleged to have occurred in the intrapartal period, at the very least a neonatologist and or paediatric neurologist will often be required to comment on the causation of damage and an obstetrician will be required to provide expert testimony as to the standard of the defendant's practice. Ideally, the expert should also have actively maintained their specialist practice up to the date of trial.

Before forwarding instructions to each expert it is necessary to check to see whether he or she has any objections to providing opinion in a medical malpractice claim and in particular that there are no objections to advising in a claim against the particular defendant(s).

In my view when choosing a midwife to provide a report on standard practice, the midwife:

(i) Must be registered/endorsed to practice in the relevant state; and

(ii) Should be practising in a full time capacity and able to argue current issues relevant to practice including standards of practice and if necessary research; and

(iii) Must have a minimum of five years post qualification experience; and

(iv) Must have significant practical experience in the particular techniques/therapies and treatment at issue. For example, in a claim arising from a delivery procedure complicated by shoulder dystocia, the midwife must have conducted a number of deliveries complicated by obstruction.

In briefing the expert, it is necessary:

(i) To have obtained all the relevant clinical information you are entitled to obtain;

(ii) To ensure that each expert is briefed with a complete copy of the mother's and child's clinical record, and x-ray/CT/MRI films when appropriate before seeking even a preliminary opinion;

(iii) Having read all the clinical information and considered your client's instructions carefully, to point out to the specialist(s) the clinical documentation on the clinical record(s) that would seem to support the client's or their representative's statement of events, in addition to that information which is relevant to liability;

(iv) To ensure that you instruct each expert in relation to the issues in your client's case and ensure that the expert understands that for the Plaintiff to discharge his onus of proof he need only tilt the balance of probability;

(v) To ask each expert to refer you to research articles which support their opinion.

On receipt of the liability report it is necessary to:

(i) Check that the expert has addressed the issue of liability. It is often necessary to go back to the expert seeking clarification of the report;

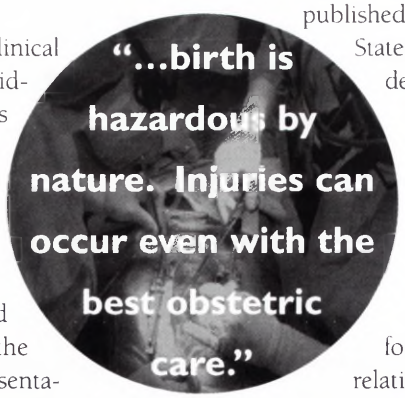
(ii) Provide a copy of the report to the client/representative/litigation guardian for comment. The client should be asked whether there are any inaccuracies in the report;

(iii) Forward any relevant comments made by the client/representative/litigation guardian and ask the specialist whether it shall be necessary for them to review their report in light of the comments made.

Cerebral Palsy Claims

Cerebral palsy related claims are probably amongst the most troubling of all obstetric malpractice claims and therefore rate a special mention. The connection between the quality of obstetric care and cerebral palsy will always be questioned. Allegations are commonly that the performance of the delivery procedure by the obstetrician was delayed resulting in the foetus suffering anoxia.

On 16 October 1999 the International Cerebral Palsy Taskforce published their Consensus Statement,[6] which was designed as a tool to be used to clarify the evidence required to establish a causal connection in cerebral palsy claims.



The template for defining a causal relation between acute intrapartum events and cerebral palsy is reproduced below:

Criteria to define an acute intrapartum hypoxic event was the cause of cerebral palsy

Essential criteria

1. Evidence of a metabolic acidosis in intrapartum fetal umbilical arterial cord, or very early neonatal blood samples (PH <7.00 and base deficit ≥12 mmol/l).
2. Early onset of severe or moderate ▶

neonatal encephalopathy in infants of ≥ 34 weeks gestation.

3. Cerebral palsy of the spastic quadriplegic or dyskinetic type criteria that together suggest an intrapartum timing but by themselves are non-specific.

Criteria that together suggest an intrapartum timing but themselves are non-specific

1. A sentinel (signal) hypoxic event occurring immediately before or during labour.
2. A sudden, rapid, and sustained deterioration of the foetal heart rate pattern usually after the hypoxic sentinel event where the pattern was previously normal.
3. Apgar scores of 0 - 6 for longer than 5 minutes.
4. Early evidence of multisystem involvement.
5. Early imaging evidence of acute cerebral abnormality.

It should be noted that in the Taskforce's view:

1. All three of the essential criteria are necessary before an intrapartum hypoxic cause of cerebral palsy can begin to be considered;
2. When the essential criteria are met it is then necessary to determine whether the hypoxia is acute or chronic;
3. If evidence for some of the criteria 4 to 8 is missing or contradictory, the timing of the neuropathology becomes uncertain;
4. Individually, criteria 4 to 8 are only weakly associated with acute intrapartum damaging hypoxia because, with the exception of criteria 4, they can result from another cause e.g. infection.

The Consensus Statement has been widely criticised. Recent references to the Statement's shortcomings although certainly not new criticisms include that the Statement creates a defendant's charter and that no lawyers were involved in the working party to guide the drafting committee on the standards applied by the civil courts.[7] One of the most constructive criticisms is that the template does not discuss prenatal events, intrapartum events such as birth trauma (which may cause cerebral palsy as a result of intracerebral bleeding rather than hypoxia) or early post-natal events, such as hypoglycaemia and infection.[8]

It is important to note that the absence of some of the criteria will not necessarily operate as a bar to the plaintiff establishing causation. Courts can draw inferences to fill in the gaps from research and gaps left by the absence of evidence, for example where clinical records are incomplete, as they often are. As we are well aware, the courts hear evidence from both sides and decide on the balance of probabilities.

In conclusion, birth is hazardous by nature. Injuries can occur even with the best obstetric care. Investigation of birth related injuries/adverse obstetric outcomes is becoming more common. However, claims should:

(i) Only proceed where sufficient evidence exists to establish causation, that is the relevant causation defences can be refuted;

(ii) Only be managed by those with a thorough understanding of the process of normal and abnormal labour, current literature, a working knowledge of the law as it applies to medical practice and the resources to manage the claim. PL

Footnotes:

1 The period from the onset of the first stage of labour until completion of the third stage of labour.

2 Antenatal/Obstetric clinical records *may include* Serum HCG; kick/fetal movement charts, letter of referral to Obstetrician, letter of Obstetrician to hospital concerning admission, Admission Summary; Obstetric Summary or Obstetric Record Form; Midwives Data Collection Sheet; Pelvimetry, Ultrasound; RMO/ MO and Nursing Progress Notes; Admission Cardiotocograph; Pre-Operative Check List; General Observation Sheet/s; Operating Room Registered Nurses Report; Cardiotocograph Tracings; Partogram; Intrapartal test results including but not limited to Foetal Blood Sampling; Placental Pathology; Inpatient Medication Sheet; Consent for Operations and Treatment Form; Blood Gas Results; IV Fluid Charts; Fluid Balance Summary; Intensive Care Unit - Daily Care Record; Specific Observation Sheet (eg: urinalysis); Neurological Assessment Chart; Pathology Reports/ Results, including - Full Blood Count; Haemolytic Screen; Urea and Electrolyte Report; Transfusion Haematology; Whole Blood Profiles; Chemical Pathology - urine chemistry; urinary amino acids; Puss Microbiology; Urine Microbiology; Blood Cultures; Faeces Microbiology; Microbiology - MRSA Screen; Blood Gas Results and Discharge Summary.

3 Neonatal & Paediatric clinical records *may include* RMO/MO and Nursing Progress Notes; Specialist Outpatient Notes eg: Social Work, Dietetics; Eye Clinic Notes; Premature Baby Clinic Notes; Audiology - Neonatal Hearing Summary; Fitting Chart/Sheet; Inpatient Medication Sheet; Consent for Operations and Treatment Form; IV Fluid Charts; Fluid Balance Summary; Operation Record; Hospital Test (Pathology) Summary Sheet or Laboratory Report Summary Sheet; Continuous Prenatal Infusion Summary; Discharge and Single Dose Sheet; Enteral Feeding Order Sheet; Inhalation Therapy Sheet; Feeding Charts; Neurological Assessment Chart; Intensive Care Unit - Daily Care Record; Specific Observation Sheet (eg: urinalysis); Pathology Reports, including - Cord Blood (PH) Results; Neonatal Blood Results; PKU, Metabolic Test Results; Full Blood Count; Haemolytic Screen; Urea and Electrolyte Results; Transfusion Haematology; Whole Blood Profiles; Chemical Pathology - urine chemistry, urinary amino acids; Puss Microbiology; Urine Microbiology; Blood Cultures; Faeces Microbiology; Blood Gas Results; Neonatal chest x-rays; Neonatal CT and MRI Scans, Neonatal EEG Scans, Neonatal Cranial Ultrasounds and Reports; Reports concerning examination/s by Paediatrician; Chromosomal Studies/ Test reports; TORCH results; Discharge Summary.

4 Phelan, Martin, et al. ANucleated Red Blood Cells: A Marker for Fetal Asphyxia@ American Journal of Obstetrics and Gynaecology (173) 1380 - 4 (Nov. 1995)

5 [1997] ACTSC 19 (16 April 1997)

6 A. MacLennan, *A template for defining a causal relation between acute intrapartum events and cerebral palsy: international consensus statement* BMJ 199; 319: 1054 - 1059 (16 October 1999).

7 Roger V. Clements and A. Simanowitz, *Editorial: A Cerebral palsy - the international consensus statement*, Clinical Risk 6 (4) July 2000 pp 135 - 136 at 136.

8 ibid