

RSM 00021

## Moot Point

# Was the obstetric care negligent?

Catherine E. James

*Medical Secretariat, The Medical Defence Union, London, U.K.*

*Considerations of safety and risk are more complex in day-to-day care than they sometimes seem in theoretical debate. In the series "Moot Point", the Journal publishes cases – closely based on actual fact – in which fine points of judgement arise. The paper which follows relates to events which occurred in Great Britain in 1980, but the case to which they gave rise came to trial only in 1989. The author is a Fellow of the Royal College of Obstetrics and Gynaecology, and her paper appears simultaneously in the Journal of the Medical Defence Union, London. Reactions from readers – both as to the rights and wrongs of the case and the way in which it was handled judicially (and might have been handled under any other system of law or compensation) – are invited. The judgement which was actually passed, as well as the author's own comments on the case will be found on page 149 of this issue.*

## Introduction

The onset of labour is difficult to predict, particularly when there is a long history of uterine irritability and vaginal bleeding associated with a low lying placenta. In the case described below, in which the mother delivered prematurely and unexpectedly, a claim was brought on the child's behalf alleging that negligence in her mother's management had caused the child's severe degree of cerebral palsy.

## Case

Mrs A. was aged 34 and had had four previous full term deliveries in 1966, 1970, 1972 and 1974. In 1975 she had a 20-week miscarriage and in 1976 she had a vaginal termination of pregnancy at 12 weeks. Her husband suffered from chronic illness and was unemployed.

In October 1979 Mrs A. became pregnant for the seventh time. Initially she considered another termination but later rejected the idea and booked at her local district general hospital.

---

*Correspondence to:* Catherine E. James MB FRCOG, Medical Secretariat, The Medical Defence Union, 3 Devonshire Place, London W1N 2EA, U.K.

Vaginal bleeding commenced within the first 12 weeks and continued throughout. An ultrasound scan which was performed on 17 January 1980 recorded a 16 week size fetus and the expected date of delivery was predicted as early July 1980. The scan also indicated a low lying placenta which covered the internal os of the cervix.

On 21 February 1980, at 22 weeks gestation, Mrs A. was admitted to the antenatal ward because of persistent vaginal bleeding and remained in hospital until delivery. She complained intermittently of abdominal discomfort associated with uterine tightenings which sometimes she likened to labour and was reviewed regularly by the obstetric team. She was prescribed regular oral salbutamol 2 mg three times daily (a uterine relaxant). Vaginal bleeding continued throughout March 1980 with resulting mild anaemia which necessitated a blood transfusion.

On 3 April 1980 at twenty seven and a half weeks gestation a further ultrasound was performed which confirmed the placenta to be covering the internal os. From the time of this scan Mrs A.'s abdominal pain and discomfort increased and she noticed a little more vaginal bleeding. At 19.30 hours she was seen by the registrar who examined her abdomen but could detect no uterine activity. He noted the baby to be presenting by the breech and thought Mrs A.'s vaginal loss was not excessive. At 23.30 hours the obstetric Senior House Officer was informed by the midwifery staff that Mrs A. continued to complain of vaginal blood loss and abdominal discomfort which was again likened to labour. The SHO could find no evidence of labour on abdominal palpation. She discussed the case with the registrar on the telephone who suggested an analgesic and dihydrocodeine tartrate was given intramuscularly.

At 03.30 hours Mrs A. delivered precipitously into her bed in the antenatal ward; the baby and placenta apparently arrived simultaneously according to the midwife who attended when called urgently by the patient who had felt a sudden urge to bear down. The baby was a girl and weighed 1060 grams with Apgar scores of 3,5, and 8. She was resuscitated within a few minutes of birth by the same Senior House Officer (who had only recently completed a six-month paediatric appointment). The baby was in good condition at birth and apparently cried immediately but then stopped breathing. She was intubated and given assisted ventilation and spontaneous respiration was re-established by 2-3 minutes. She was extubated at five minutes and transferred to the special care baby unit. The heart rate did not fall below 100 beats per minute throughout.

The baby had a stormy neonatal course, her progress being complicated by recurrent apnoeic attacks which persisted for the first 18 days of life and which were associated with transient falls in the blood oxygen levels. She was eventually discharged on 19 June 1980 aged two and a half months.

The child subsequently developed moderately severe cerebral palsy with locomotor problems. At examination shortly before the trial when she was just approaching nine years of age she was noted to have severe motor disability which, it was felt, was unlikely to improve. Her intellect was normal and there was no reason to suppose her life span would be shortened. She would always need a walking aid and because of weakness of her arms would be dependent on a motorised wheelchair to travel any distance outside her home. She would need special structural adaptations

to any house she were to live in, would never be completely independent and would always need assistance both in the home and outside. At the time of examination she attended a private school where the staff were able to cope with her disability.

### **Allegations of negligence**

Mrs A. brought an action against the obstetrician for negligence. In the “statement of claim” it was alleged that her medical attendants:

1. Failed to monitor the patient and her baby on a cardiotocograph.
2. Failed to heed the repeated oral indications from the patient and her husband that she was in labour.
3. Made no or no adequate attempt to ascertain whether the patient was in labour.
4. Failed to observe and/or heed an increase in the patient’s vaginal bleeding.
5. Took no or no adequate steps to ascertain whether the patient’s complaints of pain coincided with uterine contractions.
6. Failed adequately to monitor, observe or examine the patient between the time of her ultrasound scan on 3 April and the baby’s birth.
7. Failed to diagnose the onset of labour.
8. Gave no or no sufficient heed to the patient’s complaints of pain but gave her injections at 23.00 and 01.00 hours.
9. Made no attempt to arrest the process of labour.
10. Failed to transfer the patient to the labour ward.
11. Failed to summon a consultant to attend the patient or inform any consultant of her condition.
12. Failed to deliver the baby by lower segment caesarean section at or before 01.40 hours on 4 April 1980.

### **Opinion of the plaintiff’s experts**

Specialists in both obstetrics and paediatrics gave evidence. It was the obstetrician’s view that daily cardiotocograph recordings of the fetal heart and uterine activity should have been made from late March (26–27 weeks) onward. Furthermore the expert considered that if more attention had been paid to these observations and to the patient’s assertions that she was in labour, then its onset on 3/4 April could have been recognized. Following on from this a consultant should have been called to assess the patient, attempts should have been made to arrest labour with intravenous salbutamol and if this failed Mrs A. should have been promptly delivered by caesarean section because of her major degree of placenta praevia. Had labour been recognised she could also have been transferred to the labour ward where more regular observations could have been carried out and an unassisted precipitate delivery avoided.

The paediatricians could find no negligence in the management of the baby after delivery and felt there was no indication that the episodes of oxygen deprivation after birth, i.e. the recurrent apnoeic attacks, accounted for her resultant cerebral palsy. They concluded that the child's disabilities were in all probability the result of events surrounding her delivery.

### **Opinion of the defendant's experts**

Obstetric, midwifery and paediatric evidence was put forward on behalf of the defendants. Use of regular cardiotocography at 26–27 weeks was dismissed as without practical value for either mother or baby since it would not diagnose labour nor would action have been taken upon irregularities of the fetal heart at this gestation, particularly bearing in mind that these events took place in 1980 when neonatal intensive care was less advanced. The experts believed that it was important when assessing the care provided to place oneself in the position of the doctors and midwives. Although Mrs A. was an experienced mother who, it might be felt, could recognise labour when it commenced, she did have an unusually complicated pregnancy in which discomfort and uterine irritability were to be expected. The doctors' and midwives' main aim was to prolong the pregnancy for as long as was reasonably possible in order to give the baby its best chance of survival.

It was further contended that the only reliable way to diagnose labour is to observe progressive cervical dilation by vaginal examination but this assessment was contraindicated in Mrs A.'s case because of her central placenta praevia. In such a patient however one might have expected a substantial increase in vaginal bleeding to accompany labour as the placenta separated from the dilating cervix but this did not occur in this case. Thus, given the facts with which they were presented and their negative findings on examination it was reasonable for those involved in Mrs A.'s care to conclude that she was not in labour. Had they felt that she was in labour, however, the use of a beta mimetic agent such as salbutamol would have been contraindicated as these are not recommended where there is vaginal bleeding. On the subject of operative delivery it was the expert's view that caesarean section at 27 weeks with a placenta praevia would almost certainly require a classical incision as the lower uterine segment would not be adequately formed and would be intensely vascular. A baby delivered by caesarean section at 27 weeks would be at the same or greater risk of the complications which developed with this child. The best interests of both were served by aiming to continue the pregnancy as long as possible.

The defendant's paediatric expert agreed there had been no negligence in the postnatal aspects of the baby's management and felt that the most probable cause of the cerebral palsy was brain infarction or periventricular parenchymal haemorrhage sustained in the first week or two of life. In his view this was more likely to be associated with the natural and well recognised neonatal complications of preterm birth rather than the delivery itself.

**Some questions to consider**

If you had been the judge, on the medical evidence put forward:

1. Would you have considered that the standard of care received by the patient fell below that she could reasonably expect, in other words her management was negligent:
  - a. as far as the doctors were concerned?
  - b. as far as the midwives were concerned?
  - c. both?
2. Would you have considered, on the balance of probabilities, that the harm which resulted, namely the child's subsequent handicap, was caused by events surrounding the precipitate and unassisted breech delivery or was it a recognised complication of the baby's very preterm delivery howsoever managed?
3. Would you have found in favour of this child and awarded her damages?
4. If so, what sort of figure would you have felt was appropriate to compensate her generally and to provide for her lifelong needs as far as special accommodation, education, transport and day-to-day assistance were concerned?