Medicolegal issues in obstetrics

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Abstract

Obstetric claims cost over £1.8 billion pounds per year. Recent judgements have changed the emphasis on consent issues and these are becoming very important in obstetric cases. Clinicians need a basic understanding of legal principles around the Bolam case, The Montgomery consent case and the concept of material contribution. Understanding the way a claim will be analysed will assist clinicians when they get involved in legal cases, which is almost inevitable in obstetric practice. It will also inform them about the importance of having discussions with women about treatment plans and documenting the nature of the discussion and its outcome.

Keywords bolam; breach of duty; causation; montgomery

Introduction

In 2017/18 NHS Resolution settled 211 cerebral palsy claims at a cost of £1861 million. Whilst the number of claims had dropped from the previous year (down from 231), the costs increased from £1750 million. Obstetric claims account for 10% of claims by volume, but 48% by cost. Medicolegal issues are important for families and have significant cost implications for organisations. Sadly behind every claim there is a significantly injured child with major care needs, which is why the costs are so enormous. Maternity care can be associated with claims in other areas such as stillbirth, brachial plexus injury, maternal perineal injury and even maternal death, but these claims are not of such high value.

In order to understand the way in which a case will be considered we have to understand the basic principles that underpin how the court will determine whether there has been negligence. A claimant has to establish breach of duty, which means a consideration of the standard of care. However, once a judgement has been made about the standard of care the claimant then has to establish whether any breach of duty has caused the injury. Only then will a claim be successful.

The bolam test

The court uses the test which arises from the judgement in the Bolam case to consider the standard of care. This requires the court to identify whether the doctor acted in accordance with a practice accepted as proper by a responsible (ie reasonable and respectable) body of medical opinion at the relevant time (the date the care was provided). That body of opinion need not be a majority body. The doctor must then act in accordance with the practice and to a standard to be expected of a reasonably competent body of medical opinion. If the doctor is specifically qualified in a particular area of practice then the standard is that of a reasonably competent specialist. However there is a modification to this requirement that the approach taken has to withstand logical analysis. These have been the principles that have been followed in cases for many years.

Montgomery

However, a relatively recent judgement has changed the legal position on consent and this requires discussion. This is the case of Montgomery v Lanarkshire. It was decided in the Scottish Supreme court but has been accepted in cases across the United Kingdom.

In 1999, Nadine Montgomery was pregnant for the first time. She is diabetic and of small stature. She expressed concern to her doctor about giving birth vaginally but was reassured. The doctor gave evidence that she did not offer caesarean section because too many women would want one. The risk of shoulder dystocia and the option of caesarean section were not discussed. The experts in the case agreed the likelihood of shoulder dystocia was 9–10%. Nadine Montogmery gave birth vaginally to Sam. The birth was complicated by shoulder dystocia. Medical staff performed the appropriate manoeuvres to release Sam but, during the 12-min delay, he was deprived of oxygen and was subsequently diagnosed with cerebral palsy. Mrs Montgomery brought a claim against Lanarkshire Health Board, alleging that she should have been advised of the 9–10% risk of shoulder dystocia associated with vaginal delivery, notwithstanding that the risk of a grave outcome was small (less than 0.1% risk of cerebral palsy). It was also alleged that delivery by caesarean section ought to have been offered. It was accepted that this would have prevented the child's injury.

The defendant argued that only the risk of a grave adverse outcome triggered the duty to warn of such risks and that the risk of such an outcome was too low in this case. They also argued that an expression of concern was not the same as a direct question requiring a direct answer, so no warning was required. The defendants were successful at the first trial. However, the claimant appealed to the Supreme court who subsequently ruled that Mrs Montgomery should have been informed of the risk of shoulder dystocia and given the option of a caesarean section. The court determined she would have requested caesarean section if offered. Mrs Montgomery was awarded £5.25 million in damages.

This case means that the Bolam test will no longer apply to the issue of consent. It will still be relevant to other aspects of care but was deemed unsuitable for cases regarding the discussion of risks with patients. The court took the view that the extent to which a doctor may be inclined to discuss risks with patients is not determined by medical learning or experience. This moves away from the concept of the 'reasonable doctor' being the test for whether information was appropriately provided, and towards the 'reasonable patient'. This is referred to as to the materiality of risk.

"The test of materiality is whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is, or should reasonably be aware, that the particular patient would be likely to attach significance to it."

Following the Montgomery judgement consent issues are raised in many cases. One of the difficulties with obstetric claims

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is that they are often quite old. The Montgomery case was from 1999. This means that as far as the courts are concerned the standard expected, with regards to consent, is that described in the Montgomery judgement. Whilst GMC Duties of a Doctor guidance has moved to a similar approach in more recent times that was not the position even at the time of the Montgomery case in 1999. This creates significant issues in older cases in particular when the standard of information provision and note keeping was not as it is now. However even in current practice there are important issues to consider as a result of the Montgomery judgement. Certainly, whilst it has always been appropriate to discuss treatment options, it is much more important now to document the nature of those discussions, the risks explained, and the reaction of the woman to those risks. It is advisable to identify that a treatment plan has been jointly agreed. This can be challenging from a time perspective in the outpatient setting. However it is even more difficult in the more acute setting of labour.

One of the challenges in obstetrics concerns discussions around the timing of birth and the mode of birth. It is not clear as to whether the courts are of the view that a doctor has to offer all women a caesarean section, and from what gestation birth should be offered. This would be particularly challenging against a background of National guidance indicating that caesarean section is not indicated in certain situations. Maternity services are under external pressure to avoid inappropriate interventions which may elevate further already high caesarean section and induction rates. The rise in intervention causes considerable capacity issues for services, and this itself can lead to adverse outcomes. At present, there is no clarity about these issues and so clinicians have to provide explanation and document the nature of those discussions.

Other judgements dealing with obstetric consent have added further to the complexity. In the case of Tasmin v Barts Health NHS Trust Mr Justice Jay had to consider whether a caesarean section should have been offered as an alternative to a fetal blood sample, and he accepted that it should not have been. He argued that in order to objectively discuss the risks of continuing labour further investigation with a fetal blood sample was required. He also indicated that a risk of 1 in 1000 of an adverse outcome, even in this case where the risk was brain damage, was immaterial, although he did not say at what level a risk would be deemed material.

In the case of ML v Guys NHS Trust the issue before Mr Justice Martin Spencer was whether appropriate information was provided when a woman raised the issue of a caesarean section in labour. The Judge accepted that the request was in the context of the pain of labour and ultimately came to the conclusion that to provide pain relief was appropriate at that point. Only if there had been further request for caesarean section would it have been required to perform a caesarean section. However, he also provided some general consideration of care in labour. He stated:

> "I should say something about the duty of a hospital where a woman requests a caesarean section. It seems to me there is the world of difference between a woman who requests a caesarean section in the ante-natal period and a woman who requests a caesarean section in the throes of labour pain. In the former situation which, as it seems to me, the NICE guidelines are intended to address, such a request needs to be considered carefully and fully by the obstetric staff with the risks and benefits being fully discussed and with time for thought and reflection being given. If, after such discussion and appropriate advice, a woman nevertheless states that she wishes to have a caesarean section, then, she would be entitled to have one. However, the situation seems to me to be quite different where a woman is in labour and in extreme pain. As the midwife and the doctors confirmed, such a request is frequently heard and is more a cry for help because of the pain. In those circumstances, the appropriate response, as here, is to deal with the pain and then review the matter and see whether the request was or was not "serious". By that I do not intend to suggest that any request for a caesarean section is not serious but an obstetrician or a midwife would be failing in their duty to both mother and baby if they simply took every such request at face value without exploring and addressing the underlying reason … … … It would in fact be impossible to have the kind of discussion of risk and benefit envisaged by the claimants expert and the NICE guidelines with a woman who is not wholly coherent and thinking straightforwardly and logically because of the extreme pain she was in and it could be regarded as irresponsible for a midwife or obstetrician to attempt to have such a discussion with a woman before her pain had been addressed. It seems to me that this situation is qualitatively different to the situation in the ante-natal clinic where a request for a caesarean section is made."

This is helpful guidance for clinicians as it identifies that the obligation is not to blindly agree with any request but to consider why that request is made, deal with any issues that lead to the request and then to provide information before the issue is revisited and a decision is made. This does not mean that a reasonable request should be delayed but it does mean that options should be explained. The documentation of the discussions and actions will be very important in any subsequent consideration of the case.

Causation

When there are criticisms about the standard of care a judgement has to be made as to when appropriate care would have led to birth. This usually involves careful consideration of the timings in the particular case in question. In a typical case, this would reflect when CTG abnormalities should have been identified. How long would it have taken for medical review and then for a decision to be made. Then time has to be allowed for further investigation, such as fetal blood sampling, before considering the time to achieve birth either vaginally or by caesarean section. Each element of the process may be debated, particularly if the unit is busy and if there were other cases in theatre. These timings should be based upon the performance of a reasonable practitioner and how quickly they would, on the balance of probability, have achieved those actions. So if a caesarean section should have been performed, but wasn't, then generally 30 mins would be allowed for that procedure after the decision should have been made. However, if a caesarean section was actually performed and the decision to delivery interval was 20 mins, then it is likely the court would decide that if an earlier decision had been made that the decision to delivery interval at that earlier time would still have been 20 mins.

The reason timings can be so important is that earlier birth, by even a few minutes, can make a substantial difference to outcome in some cases. There are two predominant patterns of brain injury occurring as a result of hypoxia in a baby in term labour. These can be described as chronic partial hypoxia and acute profound hypoxia. Chronic partial hypoxia causes injury in the peripheral parts of the brain and, typically, takes an hour or more to cause injury. This would be the pattern of injury as a result of prolonged hypoxia due to contractions in labour, possibly exacerbated by drugs used for induction or augmentation of labour. There would usually be significant CTG changes and fetal acidosis. The time frames of hypoxia leading to damage in these cases is very variable and determining when injury first developed and the effect of any reduction in duration of hypoxia is challenging. In these cases, a legal concept of material contribution often applies. The degree of injury caused by the delay in birth cannot be divided. When an injury is indivisible the claimant recovers full damages. That means the claimant will be paid in full if the delay makes a material contribution to the injury.

An example of how this indivisibility operates is also illustrated by the woman who presents with an abnormal, often antenatal rather than intrapartum, CTG. Clinicians do not take into account the low likelihood of achieving vaginal birth, or the fact that an abnormality on a CTG prior to labour is often of greater significance than changes on a CTG in labour. The birth is delayed and when the baby is damaged the clinicians often consider that the outcome was probably not caused by what may seem a relatively short delay. However, because the defendant cannot identify the proportion of injury they caused by the delay, the claimant recovers full damages.

The second type of injury is acute profound hypoxia. The causes include placental abruption, uterine rupture, cord events, maternal collapse and shoulder dystocia. There is typically a fetal bradycardia of around 60 bpm. The baby will develop injury in the deep grey matter after 10 mins and after 25 mins the outcome is likely to be death. This means that delivering the baby even 5 mins sooner can make a significant difference to the outcome. It is usually paediatric experts that decide whether earlier birth would have altered outcome, assisted by obstetric experts interpreting CTG changes, and commenting on the appropriate timings for birth.

Summary

From a clinicians' perspective, it is important to be aware of how care will be viewed by the court in the event of an adverse outcome and a claim. It has always been the case that good record keeping assists in the defence of a claim. Particularly in consent cases, this will be increasingly important. You cannot alter your previous records but you can ensure you adequately document your care in the future.

It is important to avoid inappropriate delays in achieving birth. Procrastination on the labour ward leaves clinicians vulnerable to criticism. Resource and organisational deficiencies that manifest in medicolegal cases often occur because there have been delays in dealing with other cases meaning that suddenly there are a number of problems to be resolved at the same time. If clinicians deal with issues promptly then simultaneous problems are less likely to occur. Proactive management does not mean that intervention is required in more cases, it means that once a decision is made it is actioned promptly. ◆

Practice points

- Medicolegal claims are very expensive in obstetric cases where the baby requires life long care
- Brain injury can occur in as little as 10 min and cases will be analysed very carefully when there is an adverse outcome
- Consent issues are increasingly important in claims with a shift in the law towards a requirement to inform women of any risks the woman may see as material, rather than what a doctor may think is material
- Record keeping is paramount, particularly around issues of treatment plans and the approach agreed with the woman
- Be proactive on the labour ward and resolve issues promptly to avoid simultaneous cases requiring medical input