

# Obstetric litigation – time to reflect?

Invariably there is an unhappy story behind every case of litigation involving obstetric care where a child has been compromised. Families live with the consequences, and, if litigating, obviously feel somebody is at fault and the claimants deserve compensation. Even if the doctor's care was exemplary, the doctor too will be distressed at the outcome, but, if sued, will have to cope with the tensions of litigation. However, the effect spreads further than just those directly involved.

Obstetric indemnity is expensive. Even a successful defence can easily run to six figures with little or no chance of recuperation. Inevitably the family's financial reserves are drained caring for the child. Admitting liability and settling is exponentially more expensive, but may be prudent if at real risk of losing. Losing in court is the worst and most expensive outcome of all. While the risk to an individual being sued may be low, the financial consequences of litigation exceed what any single individual can afford and obstetric indemnity becomes a group endeavour.

Obstetricians will be aware of the steady increase in indemnity costs over the years. Due to a deteriorating obstetric claims experience, things are unfortunately only going to become more expensive for obstetricians. What was once an expensive reassurance purchase is going to become ever more prominent. While the reasons for the deteriorating claims experience are multi-factorial and require addressing, those practicing obstetrics will have to reflect deeply on their care. Certainly the worst outcome for all is that obstetric indemnity becomes unaffordable.

In South Africa, inappropriate management of fetal distress during labour resulting in hypoxic ischaemic encephalopathy, followed by cerebral palsy, is one of the major reasons for successful obstetric litigation. An essential message of a recent clinical opinion section in the *American Journal of Obstetrics and Gynecology* opined that "Oxytocin is the drug most commonly associated with preventable adverse perinatal outcomes".<sup>1</sup> About half of all paid obstetric litigation claims in the USA involve allegations of oxytocin misuse.<sup>2</sup> Recently oxytocin was added to the list of high-alert medications designated by the Institute for Safe Medication Practices ([www.ismp.org/Tools/highalertmedications.pdf](http://www.ismp.org/Tools/highalertmedications.pdf)).

In an editorial in *Obstetrics and Gynaecology Forum* in 2002, the potential misuse of oxytocin for the augmentation of labour was addressed and, at the end of the editorial, the hope was expressed for a reduction of perinatal deaths caused by asphyxia.<sup>3</sup> According to the Fifth (2003-5), Sixth (2006-7) and Seventh (2008-9) Saving Babies Reports of South Africa ([www.ppip.co.za](http://www.ppip.co.za)), intrapartum asphyxia and birth trauma was the primary cause of death in 2.31/1000, 2.37/1000 and 2.97/1000 respectively of fresh stillbirths in

South Africa. Some of these are most likely associated with the unsafe use of oxytocin during labour. As the ratios of intrapartum asphyxia and trauma have not improved recently one has to conclude that management of labour has not become safer during the last 7 years. In addition, it has been found that 2.8 perinatal death deaths per 1000 births are related to intrapartum asphyxia. The number of avoidable factors per case file increased with the severity of the hypoxic event, from 0.91/1000 in hypoxic ischaemic encephalopathy survivors to 1.29/1000 in stillbirths or neonatal deaths.<sup>4</sup> It is further important to note that intrapartum asphyxia occur 4 times more frequently in HIV+ mothers as compared to HIV- mothers (OR 4.2; 95% confidence intervals 1.13-14.3).<sup>5</sup>

In a recent review the use of augmentation of labour in the multipara was addressed.<sup>6</sup> The use of oxytocin for augmentation of labour in the multigravida was strongly discouraged as no randomized trial could be found where its use for this purpose is recommended. In spite of the lack of scientific support for the use of oxytocin to augment labour in the multigravida, it was found that 91.9% of obstetricians in South Africa, who responded to the questionnaire, would use oxytocin for this purpose.<sup>7</sup> Continuous cardiotocography was not used by 31.7% of obstetricians during induction of labour. Several other unsafe practices in the stimulation of the uterus were also identified. Unfortunately the use of oxytocin in HIV+ mothers was not addressed in this study, but, from the findings alluded to in the previous paragraph, it is clear that oxytocin should be used with utmost care in HIV+ mothers.

A recent review on the effect of uterine activity on the condition of the fetus alludes to the fact that maternal blood supply to the placenta is intermittently interrupted when intra-uterine pressure is more than 30 mmHg.<sup>8</sup> As this pressure is exceeded during the active phase of labour, it is clear that the fetus is not adequately oxygenated during contractions. They recommend that oxytocin is administered with care and one must achieve a good quality uterine contraction trace. The use of oxytocin<sup>9</sup> or prostaglandin<sup>10</sup> is often associated with frequent uterine contractions. As the duration of the contractions do not reduce when they become more frequent, it is obvious that the time between the contractions, when the fetus is oxygenated, becomes limited. As excessive uterine contractions could cause fetal acidemia, uterine contraction monitoring is essential when the uterus is stimulated, in addition to continuous fetal heart rate monitoring.

You will have noted that the title of the article ended with a question mark and was formulated as a question, inviting the reader to reflect. We are convinced, and hopefully we

have convinced you, that the title is actually slightly inappropriate. The question mark should be dropped thus making the title prescriptive, Obstetric litigation – time to reflect. The time has come to reflect seriously on obstetric care and obstetric indemnity.

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