Osgoode Hall Law School - Professional Development CLE
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The *Osgoode* Certificate in
Clinical Risk, Negligence and Claims Management in Health Care

Day 4 - Managing Risks in Maternity Care

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OBSTETRICAL LITIGATION

The Plaintiff's Perspective

- Types of Claims
- Challenges to Proof
- Expert Witnesses
- The Business Side

Types of Claims:

- Perinatal Asphyxia
- Shoulder Dystocia
- Other complications (infection, cord prolapse, haemorrhage, etc.)

PERINATAL ASPHYXIA

1. Standard of Care
    - Need for intervention and onset of neurological injury
    - Matching obstetrical evidence to causation evidence
2. Causation
    - Obstetrical Issues
    - Neonatal Issues
    - Neuroimaging
    - Professional Guidelines

PERINATAL ASPHYXIA AND CAUSATION

1. Single Biggest Challenge Facing Plaintiff

2. Qualified Experts Rare

3. Professional Guidelines Major Obstacles
   - Are they valid?
   - Ulterior Motives
   - Changing Landscape

ESSENTIAL CRITERIA TO RELATE NEUROLOGICAL HARM TO PERIPARTUM ASPHYXIA

SOGC[1]

The essential characteristics of the newborn response to asphyxia of such a degree as to be likely to cause harm are:

1. Apgar score 0 to 3 for ≥ 5 minutes;
2. Neonatal neurologic sequelae (e.g. hypotonia, seizures, coma);
3. Evidence of multiorgan system dysfunction in the immediate neonatal period;
4. Umbilical cord arterial pH < 7.0; and
5. Umbilical cord arterial base deficit ≥ 16 mmol/L.

All of these conditions must be present. In cases where such evidence is lacking, we cannot conclude that hypoxic acidemia existed or had the potential to cause neurologic deficits.

[1] SOGC Clinical Practice Guideline No. 43, December 1995; see also SOGC Clinical Practice Guideline No. 112, March 2002, Table 1, page 2.

ACOG[2]

Essential Criteria (must meet all four)

1.Evidence of a metabolic acidosis in fetal umbilical cord arterial blood obtained at delivery (pH < 7 and base deficit ≥ 12 mmol/L;

2.Early onset of severe or moderate neonatal encephalopathy in infants born at 34 or more weeks of gestation;

3.Cerebral palsy of the spastic quadriplegic or dyskinetic type;

4.Exclusion of other identifiable etiologies, such as trauma, coagulation disorders, infectious conditions, or genetic disorders.

[2] ACOG, neonatal Encephalopathy and Cerebral Palsy (Jan. 2003)

ACOG

Criteria that collectively suggest an intrapartum timing but are non-specific to asphyxial insults:

1.A sentinel (signal) hypoxic event occurring immediately before or during labour;

2.A sudden and sustained fetal bradycardia or the absence of fetal heart rate variability in the presence of persistent late or variable decelerations, usually after a hypoxic sentinel event when the pattern was previously normal;

3.Apgar scores of 0-3 beyond 5 minutes;

4.Onset of multisystem involvement within 72 hours of birth;

5.Early imaging study showing evidence of acute nonfocal cerebral abnormality.

CONCERNS RE CAUSATION CRITERIA

- ACOG and SOGC differ, bringing both into question;
- Stricter threshold for BD in Canada (16 mmol/L) vs U.S. (12 mmol/L) is inappropriate;
- Low Apgar essential in Canada, suggestive in U.S.
- Multiorgan dysfunction essential in Canada, suggestive in U.S.
- Spastic quadriplegia essential in U.S., not mentioned in Canada;
- ACOG guidelines only deal with term babies;
- Good reason to believe the quadriplegia criteria is wrong based on:
  - Literature used by ACOG unsupportive
  - Recent literature suggests spectrum of neurological harm

- Metabolic acidosis criteria fails to consider intrauterine resuscitation;
- SOGC fails to recognize the role of the differential diagnosis, likely the most reliable criteria;
- Both fail to consider pre-term babies;
- Both fail to distinguish between prolonged partial asphyxia and profound total asphyxia (that might be caused by uterine rupture or placental abruption);
- SOGC ignores importance of neuroimaging;
- Are ACOG guidelines only applicable to connect CP and intrapartum asphyxia in term babies but not other neurological injury;
- Preface to ACOG guidelines:

> "The criteria to define an acute intrapartum event sufficient to cause cerebral palsy . . ."

OBSTETRICAL ISSUES

- ASSESSING FETAL WELL-BEING
  - Fetal Heart Tracing
  - Uterine Contractions
  - Oxytocin
  - Internal Scalp Clip
  - Scalp Sampling
- EVIDENCE TO INTERVENE
- WHEN TO INTERVENE

NEONATAL ISSUES:

- NEONATAL ENCEPHALOPATHY
- NEONATAL RESUSCITATION
- TIMING OF INJURY
  - Prolonged Partial vs. Acute Total
  - Rate of Change of Base Deficit
  - The Differential Diagnosis

NEUROIMAGING:

- BRAIN EDEMA IN FIRST 7 DAYS
- DIFFUSE BILATERAL DAMAGE TO CEREBRAL HEMISPHERES IN TERM BABIES
- RELATING IMAGING TO INTRAPARTUM CLINICAL PICTURE
- EXPLAINING TO TRIER OF FACT

- EXPERTS IN OBSTETRIC MALPRACTICE LITIGATION
  - OBSTETRICIAN
  - NEONATOLOGIST
  - PEDIATRIC NEUROLOGIST
  - NEURORADIOLOGIST
  - GENETICS
- EXPERTS MUST BE COORDINATED
  - STANDARD MUST MATCH CAUSATION
  - NEED TO BRING EXPERTS TOGETHER

RECORDS

- CRUCIAL TO SUCCESSFULLY DEFEND
- ADVERSE INFERENCE FROM MISSING OR POOR RECORDS
- ESSENTIAL TO ADEQUATE COMMUNICATION
- TRACINGS
  - NEED CONTINUOUS
  - NEED READABLE
  - NEED UTERINE CONTRACTIONS

THE BUSINESS SIDE

- DISBURSEMENTS
- COMPLEXITY
- RISK
- FEES
- DAMAGES