Poor intrapartum care

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Facts

A complaint was received by the Council alleging poor management of an obstetrics case during delivery resulting in the birth of a "flat" baby who was subsequently admitted to the Neonatal Intensive Care Unit and eventually developed multiple complications resulting in cerebral palsy.

A total of five registered medical practitioners comprising of one specialist, three registrars (two Obstetrics & Gynaecology registrars and one Paediatric Neonatology registrar) and one house officer were allegedly involved in the management of this case.

Chronology of events

The case involved a primigravida who was admitted to the institution in active labour at 40 weeks plus one day and found to have moderate meconium stained liquor on admission. There was one specialist, two registrars and one houseman on duty during this period. She was seen antenatally by a different team and during her labour, the team on duty had attended to her.

The patient was first seen and examined by Registrar A at about 10 am in the labour room. Subsequently she was seen by the specialist on duty and the team which included Registrar B, the houseman on call and the nurses at about 10.30 am. The specialist noted the cardiotocograph (CTG) and ordered fetal blood sampling if the CTG tracing continued to show a non reassuring tracing and to continue with augmentation of labour.

Between 11.15 am and 1 pm the houseman was alerted by the nurse on the abnormal CTG tracing. The houseman informed Registrar B who was performing a Caesarean section in the operating theatre and he gave verbal instructions to position the patient in the left lateral position and to continue with hydration and oxygen.

Registrar A was not around at that time in the labour room but was involved in another ward.

There was evidence of several episodes of decelerations between 11.15 am and 1.30 p.m., indicative of possible fetal distress.

Registrar A was subsequently informed by the nurse at about 1.40 p.m. of the decelerations. She came to see the patient and found her fully dilated. Before any instrumental delivery could be performed the baby was delivered spontaneously at 2.58p.m. The baby was born "flat" and immediately sent to NICU for further management.

There was a gap of about four hours when the patient with significant risk factors was not reviewed by any senior doctor.

The issues

- There was no clear ownership of the patient's care especially between the Registrars on duty. It was presumed and an understanding that whoever sees the patient first would be responsible for the patient's management. Hence this led to a situation where no specific doctor was in charge of the patient.

- The absence of a comprehensive protocol or Standard Operating Procedure on the management of patients in the labour room contributed to the lack of ownership and default in the chain of command in the labour room, thus leading to a communication failure.

- Registrar A saw the patient first but failed to review the patient subsequently although the patient was already noted to have risk factors that could affect the baby's outcome. There was a span of about four hours between the time she first saw the patient and her subsequent attendance at her delivery.

- The houseman was clearly unaware of the chain of command as he should have consulted Registrar A who was not doing any surgical procedures during that time instead of Registrar B who was involved with a Caesarean section in the operating theatre.

- There were obvious sign of fetal distress as the abnormal CTG tracing between 11.15 am and 2 p.m. did not improve despite the actions taken by the houseman through verbal instructions of Registrar B who was in the operating theatre at that time. None of the Registrars had attempted to review the condition of this patient and undertake appropriate action to prevent untoward complications.

Findings

After separate inquiries, the Council found that no case has been made out against all practitioners, and the charges were dismissed pursuant to Regulations 31(5) of the Medical Regulations 1974.

The grounds for the dismissal for all the cases were the same:

- It was agreed that there was definitely a breach of the duty of care;
- The Council was unable to determine which practitioner(s) breached the duty of care, and whether there was an ethical dimension to the breach.
- The labour room procedure did not necessitate a need for any practitioner to be responsible or assigned for the said patient.

The Council noted that:

- It appeared that there was no Standard Operating Procedure available for the whole process from the time a patient is admitted to the time of discharge.

- Not all the medical practitioners were aware of any Standard Operating Procedures in the labour room, if any.
- There was no clear allocation of cases to doctors to be in charge in the labour room.
- There was poor documentation of findings, instructions and plan of management in the case notes.

Lessons Learnt:

- The Council noted that the substance of the complaint revolved around negligence arising from a system failure.
- The patient was not well attended to as she was not assigned or delegated to any particular practitioner.
- This was due to a shortfall in the Standard Operating Procedure.
- Documentation of findings and plan of management should be improved.

Recommendations

- Every health care facility providing obstetric services shall have a proper and clear Standard Operating Procedure for the management of all women in labour.
- The Standard Operating Procedure shall state explicitly that a specialist should be made responsible to each patient at all times.
- There shall also be clear guidelines on the delegation of responsibility towards patients admitted between senior practitioners on duty at all times.
- The Standard Operating Procedure shall not only be in place but shall be regularly reviewed and training conducted on a regular basis for all staff especially the new staff.
- The Standard Operating Procedure of the health care facility shall comply with the Obstetrics and Gynaecology Policy of the Ministry of Health.
- Clear documentation guidelines shall be instituted and implemented.

The Council adopted the recommendations on 13 September 2011 and directed the secretariat to ensure that its decision be communicated to all Directors and Persons in charge of public and private health care facilities providing obstetric services respectively.