Lessons from Litigation in Obstetric Anaesthesia

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Declaration of interests

Expert witness reports for NHSLA, Claimants, Coroners, Police

St Petersburg 2018

Outline

- Trends in litigation against the medical profession and obstetric anaesthetists

- Lessons from
  - Cerebral palsy cases
  - Pain during surgery
  - Neurological damage
  - Awareness during general anaesthesia

- Medical manslaughter
- Suggestions for minimizing medicolegal risk

NHS Resolution: Total number of claims

Total number of reported CNST claims by specialty as at 31/03/17
(since the scheme began in April 1995, excluding "below excess" claims handled by trusts)

NHS Resolution: Total value of claims

Total value of reported CNST claims by specialty as at 31/03/17
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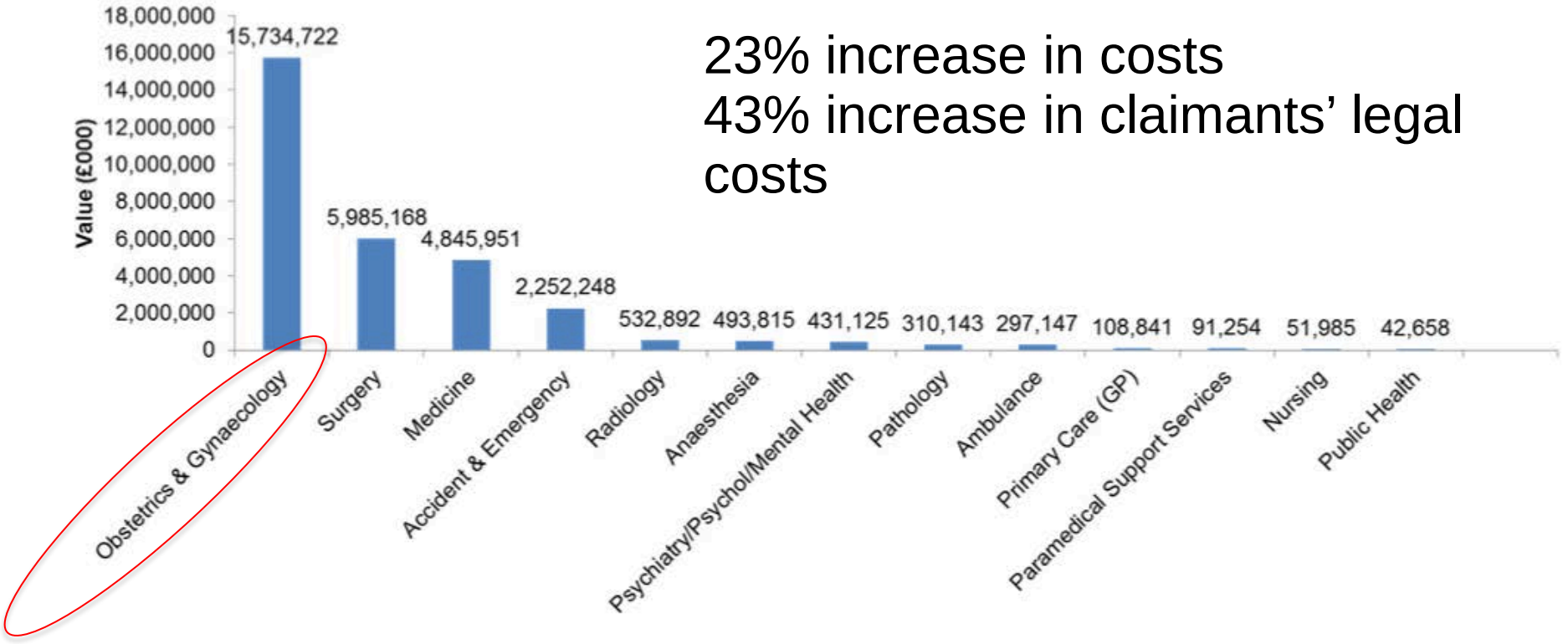


23% increase in costs
43% increase in claimants' legal costs

Anaesthesia Closed claims project

Obstetric Anesthesia Liability Concerns

JOANNA M. DAVIES, MBBS, FRCA, and
LINDA S. STEPHENS, PhD
Department of Anesthesiology and Pain Medicine, University of Washington School of Medicine, Seattle, Washington

Maternal death/ brain-damage claims

	n [%]		
	1980	1990	2000
Damaging event			
Regional anaesthesia			
Excess blood loss	**0 [0]**	**3 [6]**	**14 [25]**
High block/ total spinal	1 [3]	16 [31]	11 [20]
Embolic events	3 [9]	9 [18]	11 [20]
Neuraxial cardiac arrest	9 [28]	6 [12]	3 [5]
General anaesthesia			
Excess blood loss	**4 [7]**	**12 [32]**	**17 [53]**
Embolic event	2 [4]	4 [11]	5 [16]
Respiratory	37 [66]	14 [38]	4 [12]

Sharing the blame for
Cerebral palsy?

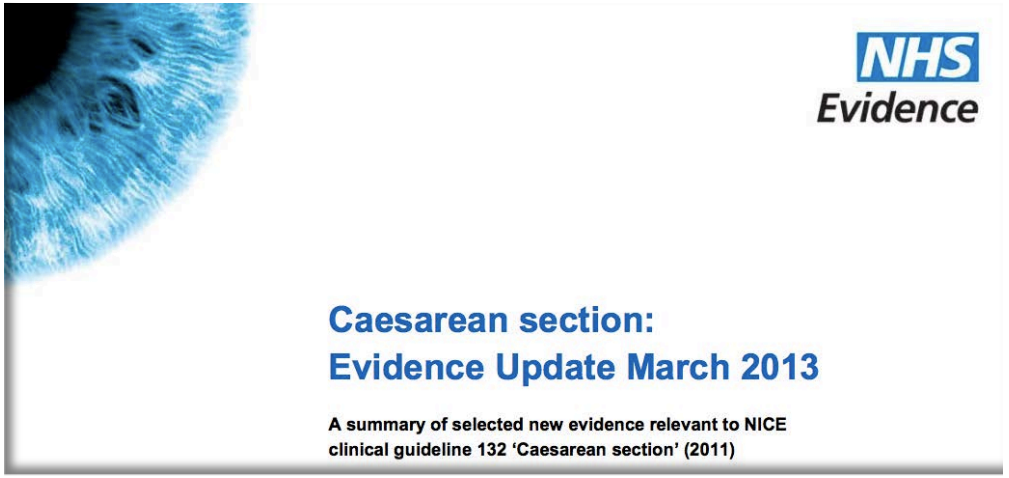
Sharing the blame for Cerebral palsy?

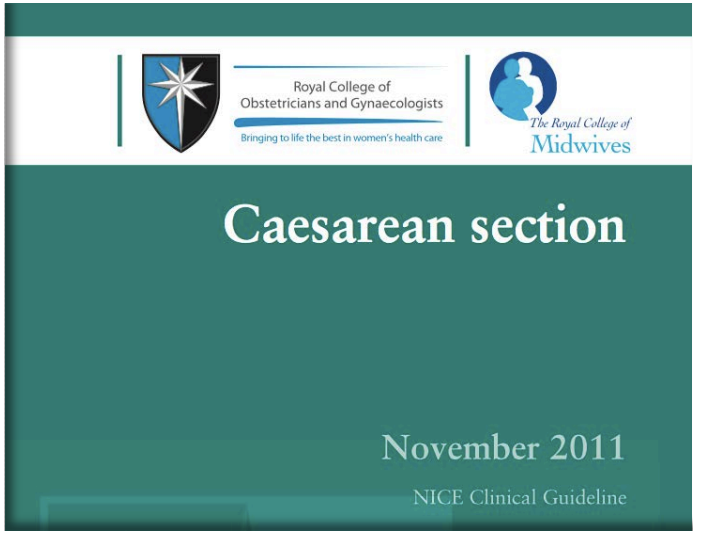
1. What is the appropriate decision to delivery interval for Category 1 C section?

2. Where should you top up an epidural?

2. Should all Category 1 Caesarean sections be performed under general anaesthesia?

Which decision to delivery interval for category 1?





RCoA audit standards:

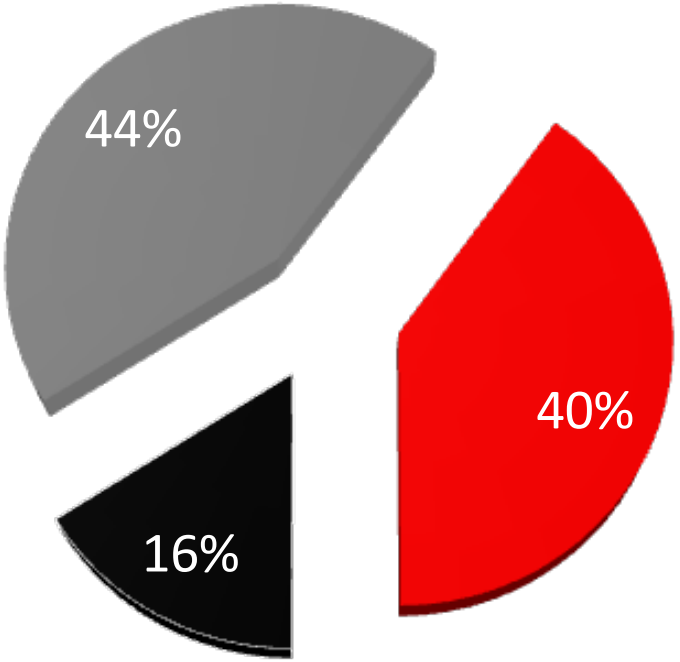
≥ 90% Cat 1 DDI ≤ 30 mins

≥ 90% Cat 2 DDI ≤ 75 mins

Type of anaesthetic?

Neonatal deaths due to anaesthesia

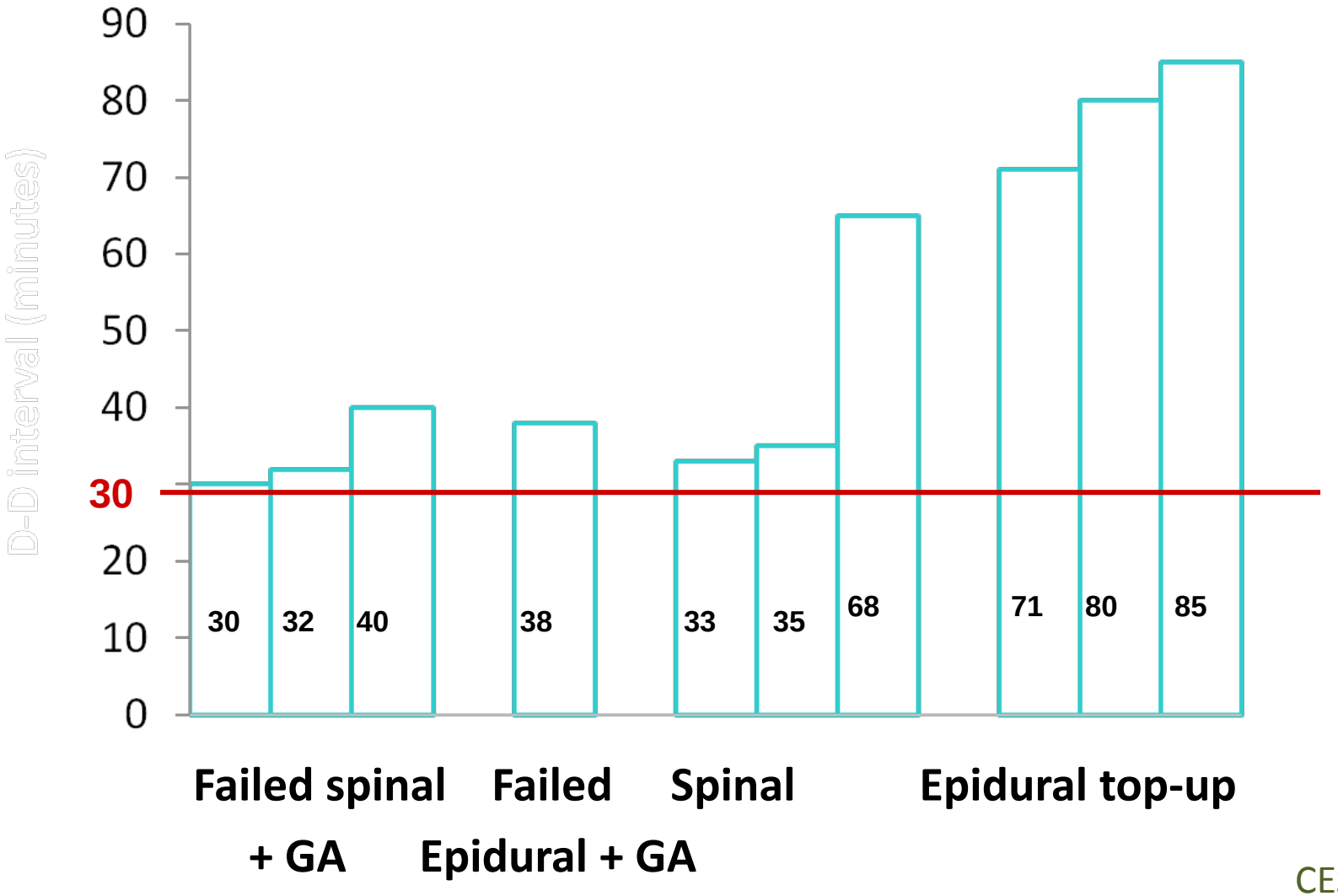
N -= 25 [3%]



- anaesthetic complication
- Personnel delay
- anaesthetic delay

CESDI 7th Annual report 2000

Failure to provide anaesthesia in time



CESDI 2000

Prevention: assembling personnel

Anaesthetist able to attend <5 minutes of an emergency call
OAA 2013, GPAS 2016

Trained, dedicated assistance available at all times

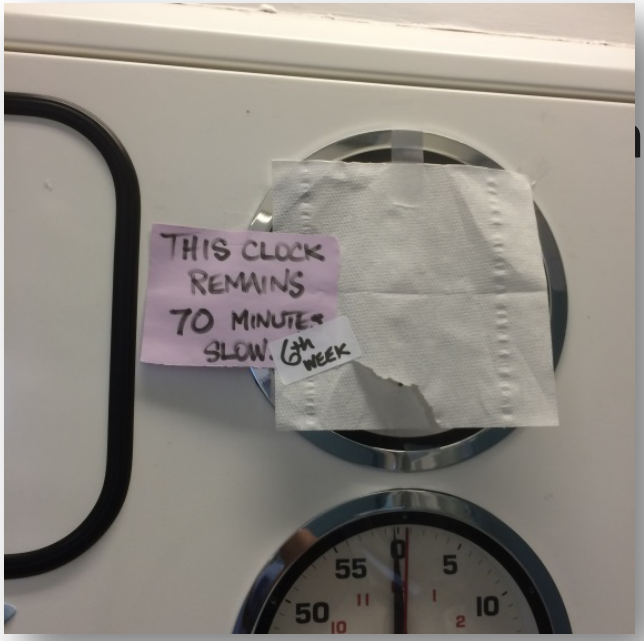
OAA 1998

List of staff & methods of contact, for on-call and back-up teams

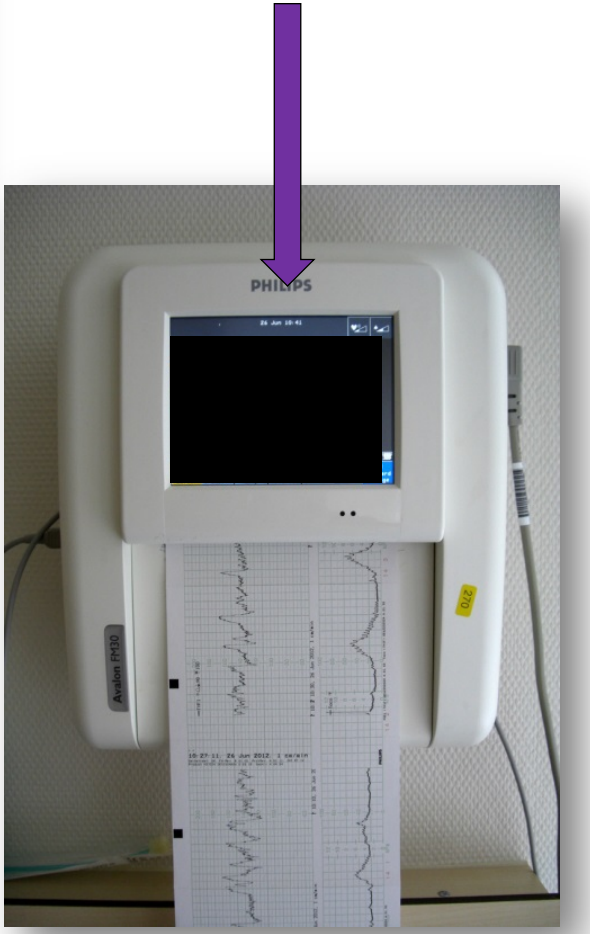
CESDI 2000,

A matter of seconds

Labour room

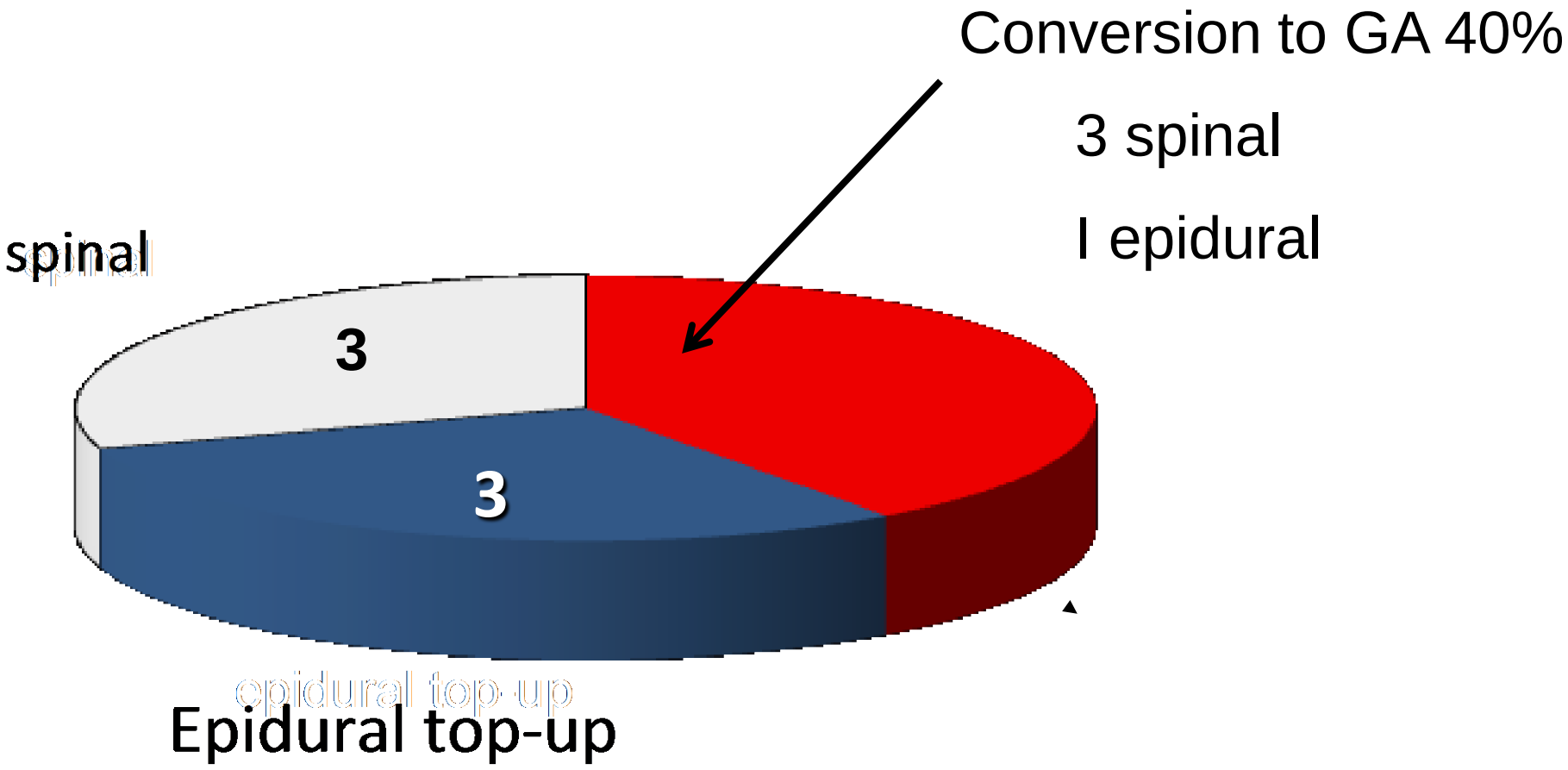


summertime



Theatre

Anaesthetic delay - 10 deaths



CESDI 2000

Urgency of Caesarean section

Category	Definition
1 ‘emergency’	Immediate threat to life of woman or fetus
2 ‘urgent’	Maternal or fetal compromise which is not immediately life threatening
3 ‘scheduled’	Needing early delivery but no maternal or fetal compromise
4 ‘elective’	At a time to suit woman and maternity team

Lucas J Royal Soc Med 2000

Urgency of Caesarean section

Category	Agreement between obstetricians & Anaesthetists
1 ‘emergency	39%
2 ‘urgent’	42%
3 ‘scheduled	43%
4 ‘elective	86%

Kinsella IJOA 2003

Communication – telling the anaesthetist

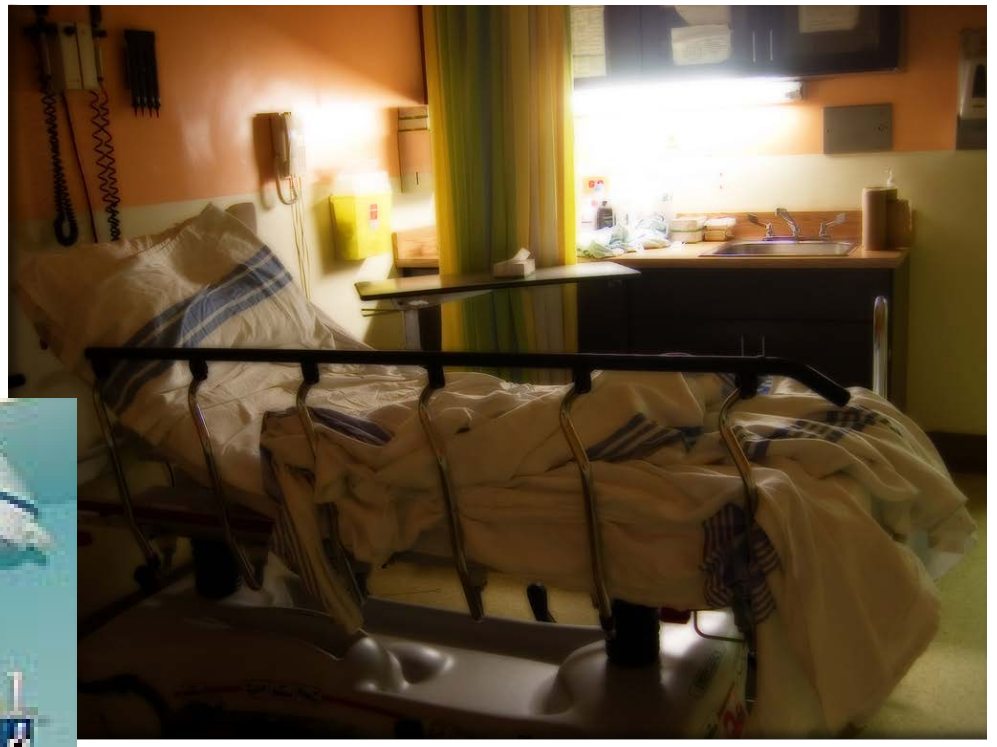
Category	Decision made – anaesthetist informed/ mins mean (range)	Patient in theatre
1	1 (0* - 10)	30%
2	10 (0* - 43)	13%
3	3 (0* - 15)	

* Anaesthetist already present when decision made

QCCH 2010

Where should you top up the epidural?

When / where?



Topping up the epidural

What with?

‘FAST MIX’

2% lignocaine

Adrenaline 5mcg/ml

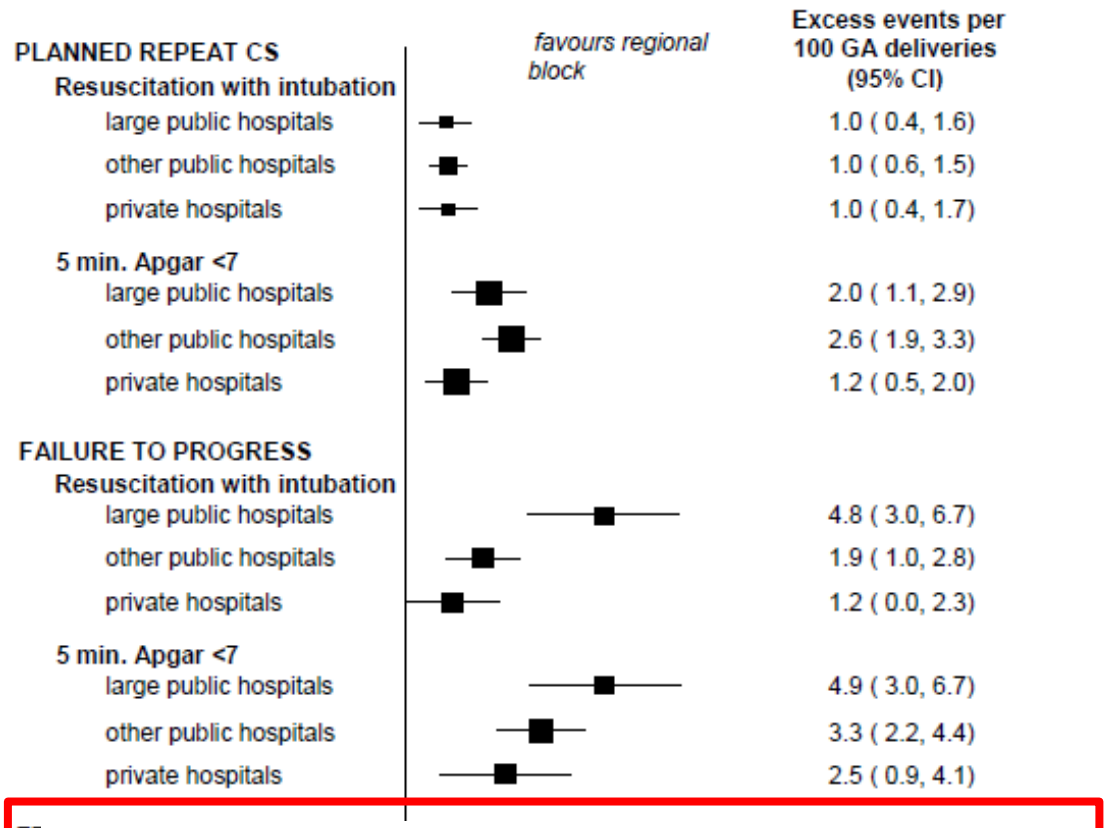
Sodium bicarbonate 8.4%

Should all Category 1 Caesarean sections be performed under general anaesthesia?

	CAT 1-3	CAT 1
Reg. anaesthesia	>85%	>50%
Conversion RA → GA	< 5%	<15%

RCoA Audit Standards

Effect of GA on fetal outcome



- ↑Risk of intubation
- ↑Risk low Apgars
- ↑ESPECIALLY in the distressed fetus

Algert BMC Medicine 2009; 7:20

Prevention: management

Communication: agreed classification of urgency

Close attention to labour RA in high risk cases

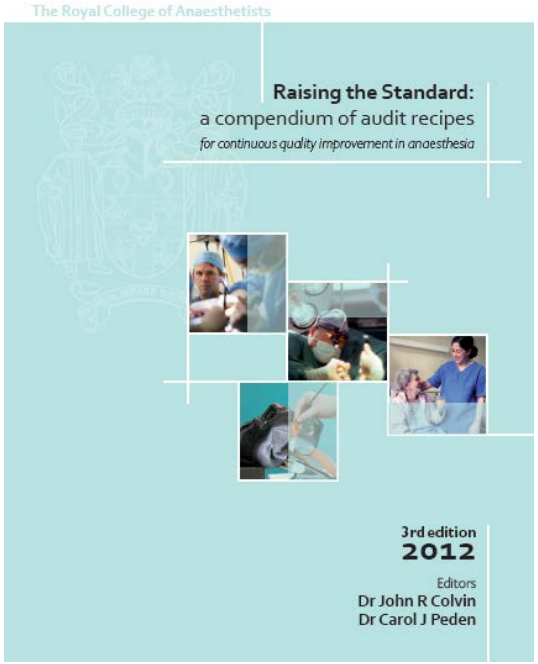
Epidural top ups
Top –up before transfer
Fast mix

Pain during surgery

Damages paid in 75% cases

Pain during surgery

- **Consent [10%]**
- Technique & dose
- Testing the block
- Managing breakthrough pain
- Follow-up



Pain during surgery

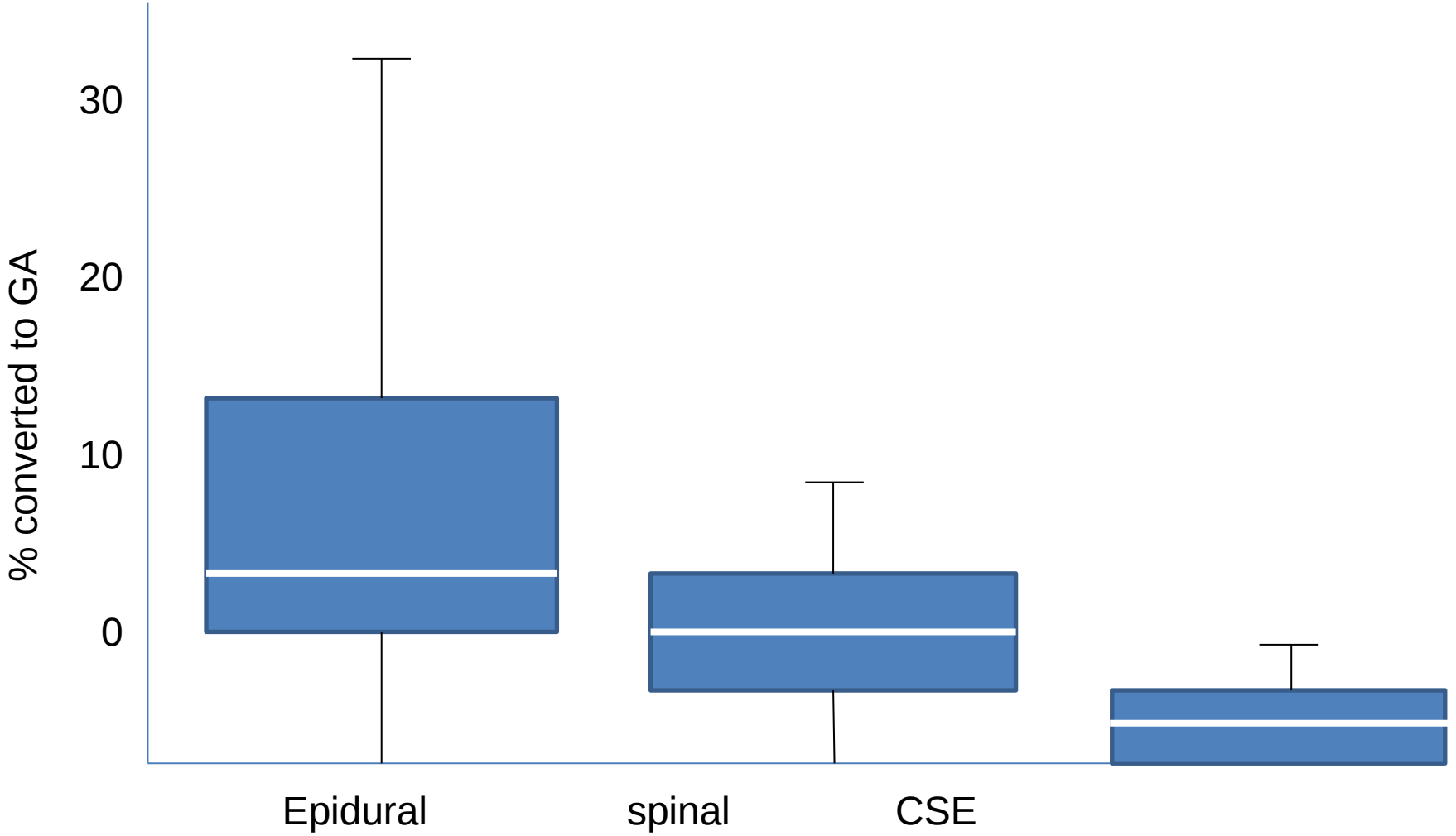
	CAT 4	CAT 1-3	CAT 1
Reg. anaesthesia	>95%	>85%	>50%
Pain during surgery	< 5%	<15%	<20%
Conversion RA → GA	< 1%	< 5%	<15%

OK?

Pain during surgery

- Consent
- **Technique & dose**
- Testing the block
- Managing breakthrough pain
- Follow-up

Which technique?



Shibli IJOA 2000

The indwelling epidural

- Nurture your block – check regularly
- Topping up the epidural

Pain during surgery

- Consent
- Technique & dose
- **Testing the block**
- Managing breakthrough pain
- Follow-up

Assessing the block

Check top and bottom end of block

- Touch
- Sympathetic
- Motor especially if epidural

Sensory block to light touch T5- S2

Motor block – unable to straight leg raise

Bilateral sympathetic block [warm feet]

Offer general anaesthesia

Believe the patient

Managing breakthrough pain

Apologise

Stop the surgery

Offer general anaesthesia (document each offer)

Tell the patient what you are giving & why

Ketamine

Pain during surgery

- Consent
- Technique & dose
- Testing the block
- Managing breakthrough pain
- Follow-up

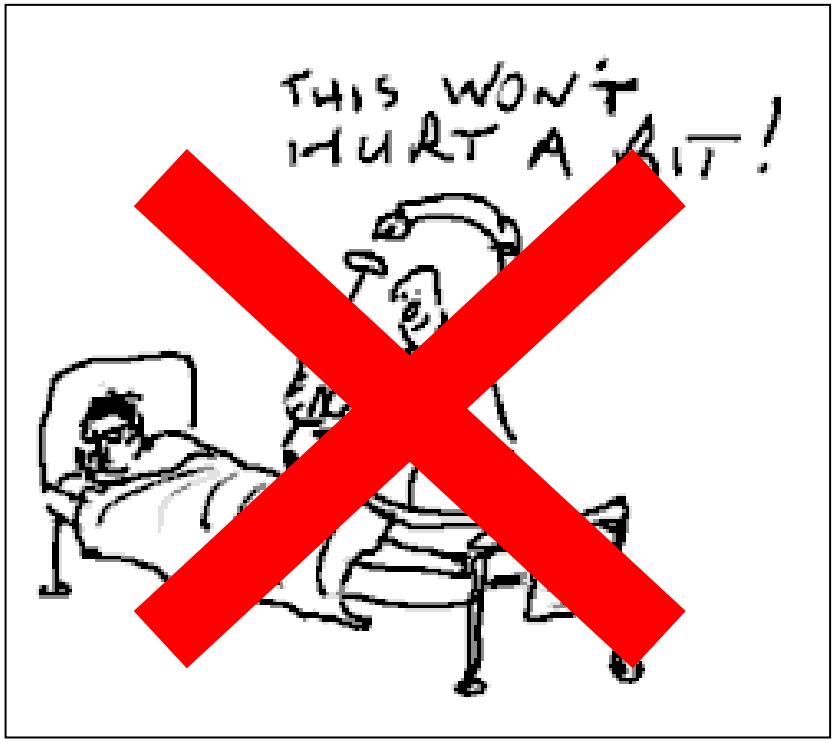
Ask the surgeon to stop

Consent

Drugs, fatigue, pain or anxiety may compromise the capacity of an adult parturient, but do not necessarily lead to incapacity unless the degree of compromise is severe.

AAGBI: Consent for anaesthesia 2017

Consent to anaesthesia



Consent in an emergency

‘Ask my husband’

No one can make decisions on behalf of a competent adult

Consent in an emergency

‘I don’t want to know – just get on with it’

Risk discussed

Failure / pain/ GA

Do not force information onto a patient

Permanent

Infection

Consent - documentation

10 years ago: Consent ✓

5 years ago: Consent

procedure ✓

risks ✓

Today: Consent

procedure CSE/ epi

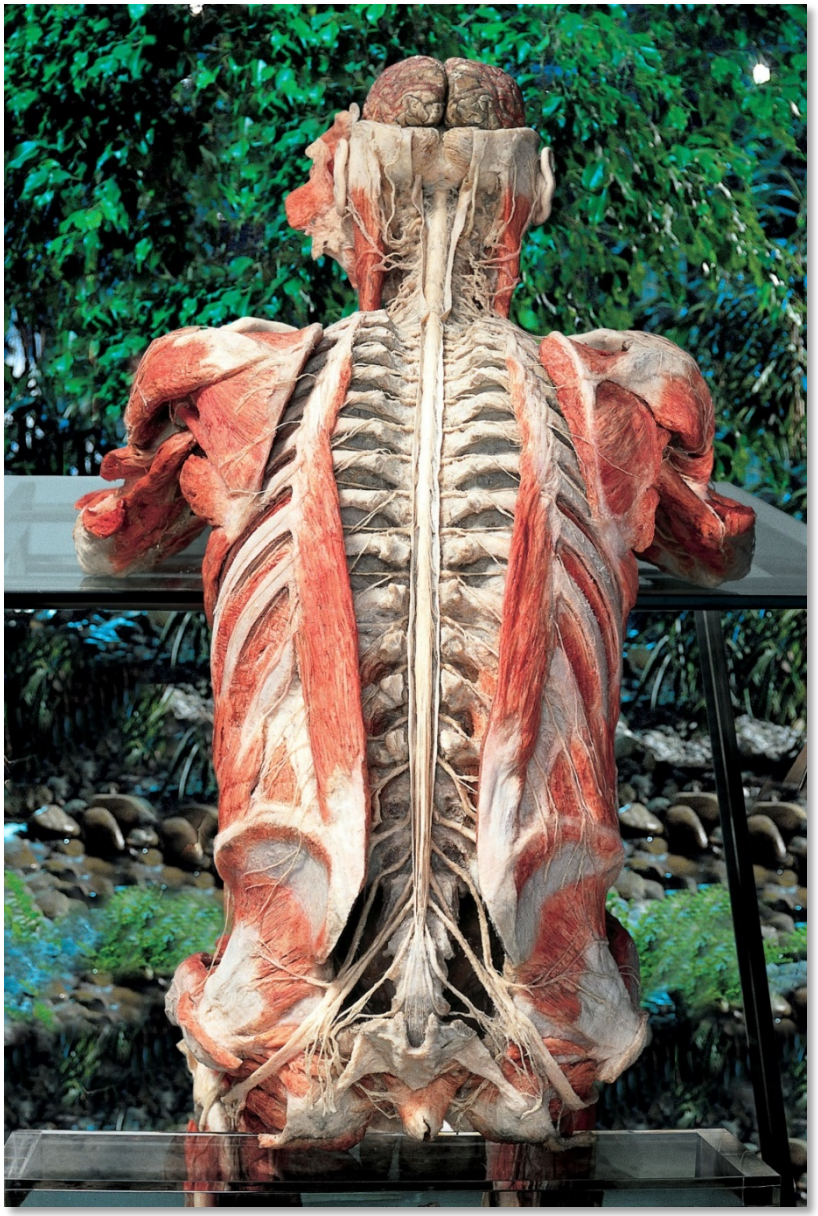
risks – failure/ pain / GA ✓

neurological damage ✓

headache, N+V ✓

...

Neurological damage



Bodyworlds
2002

Reynolds F. Anaesthesia 2001; 56: 238

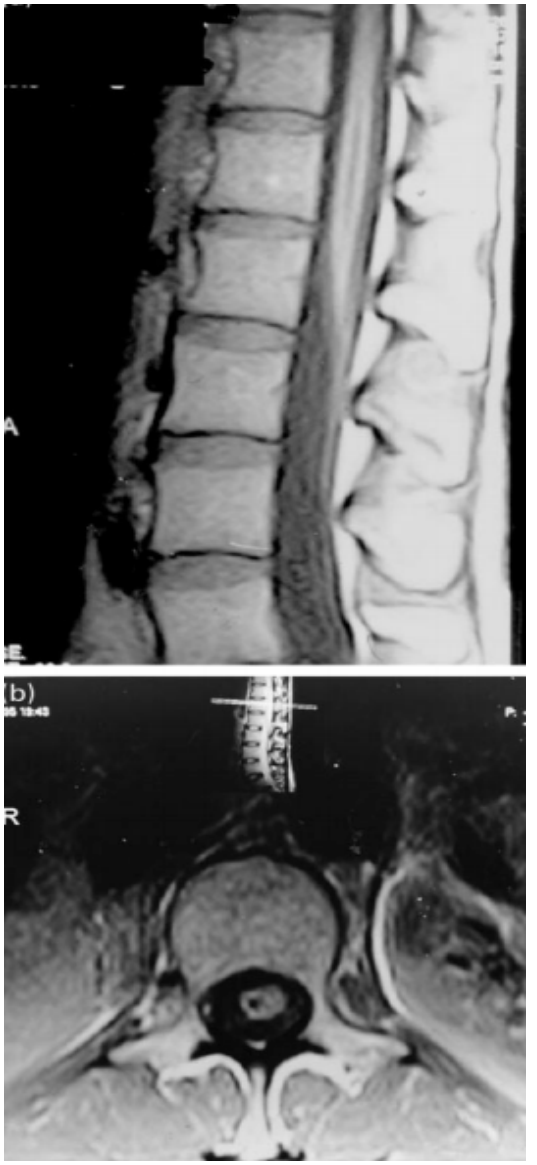
7 cases of neurological damage

3 spinal, 4 CSE

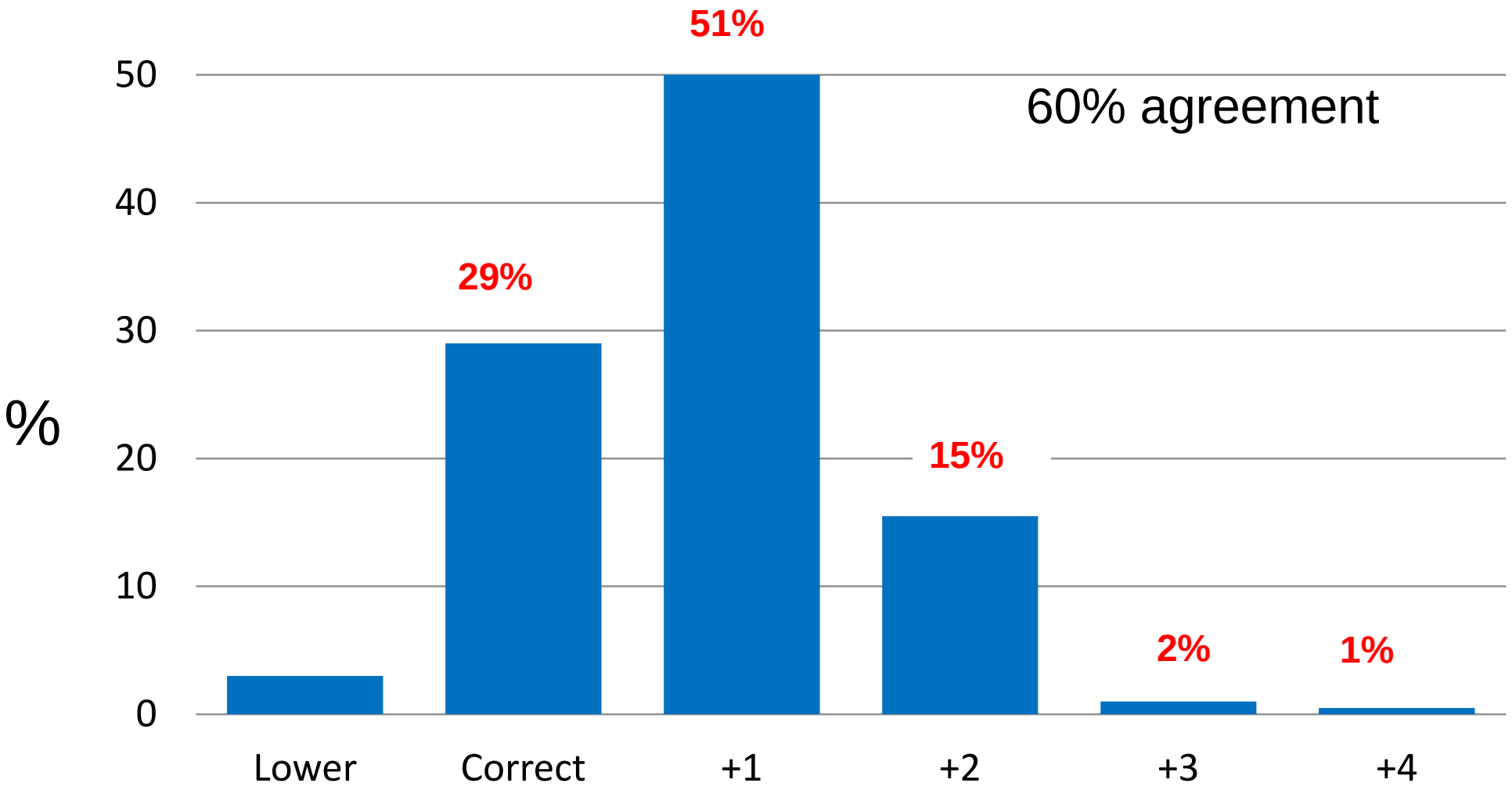
All – pain on insertion

6 – lesions in conus of cord

ALL cords normal length on imaging

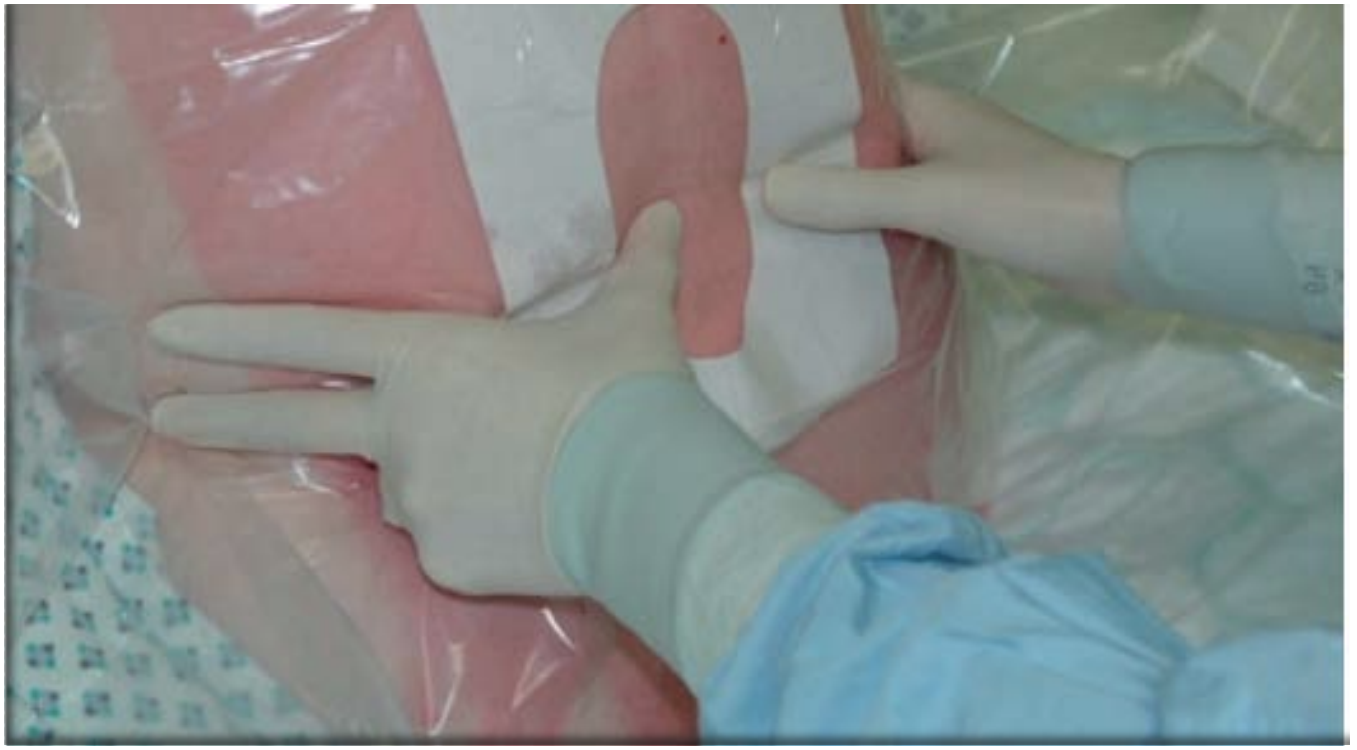


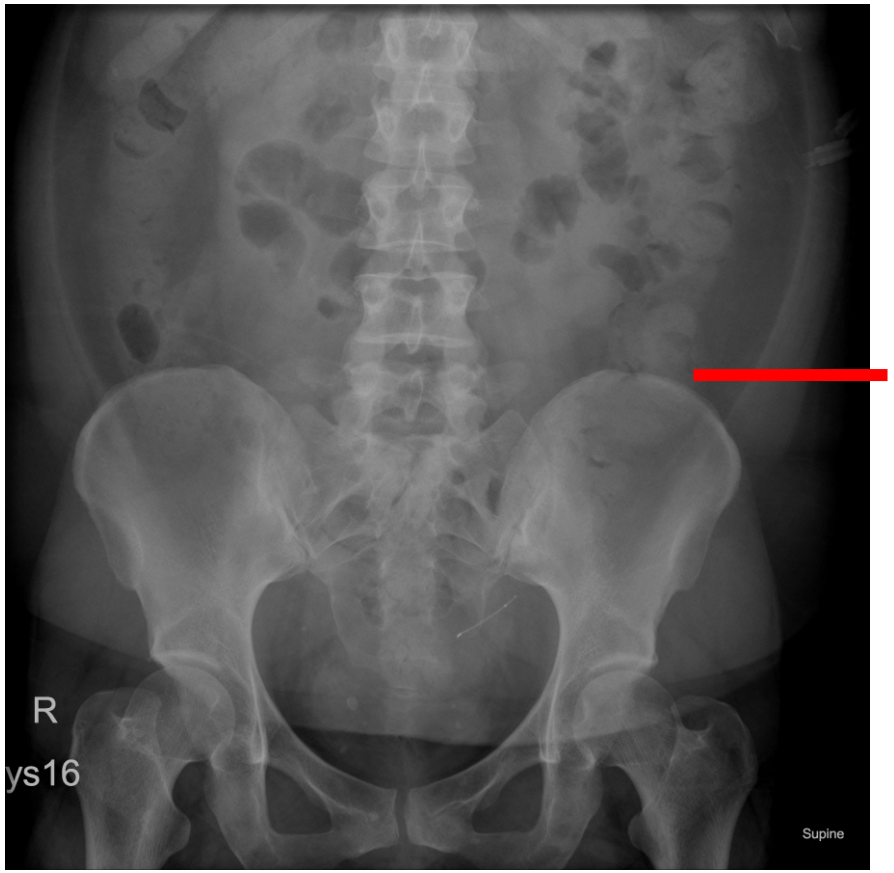
Accuracy of spinal space estimation



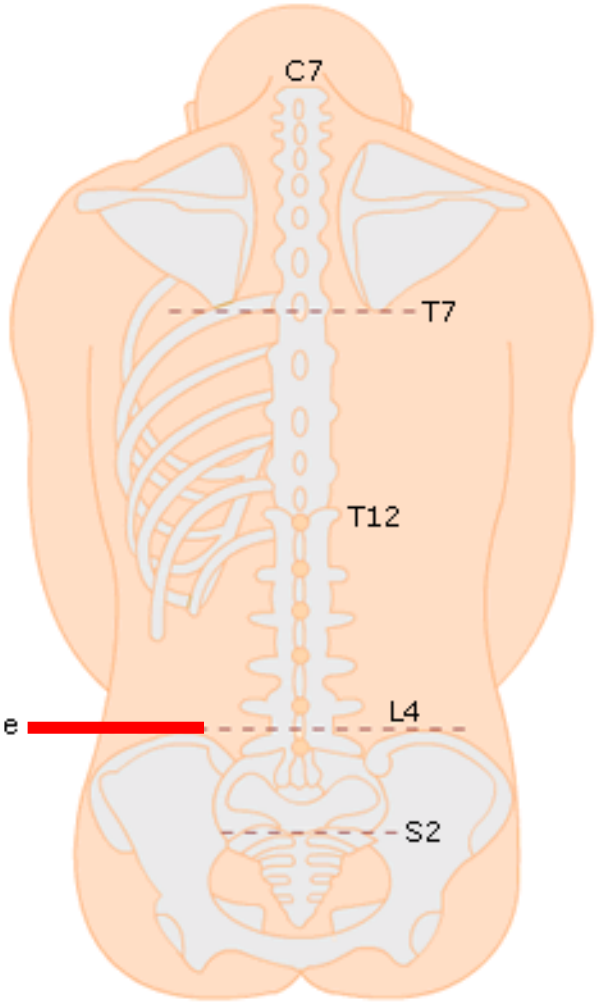
Broadbent Anaesthesia 2000: 55: 1122

Why are we so inaccurate?





Tuffier's line

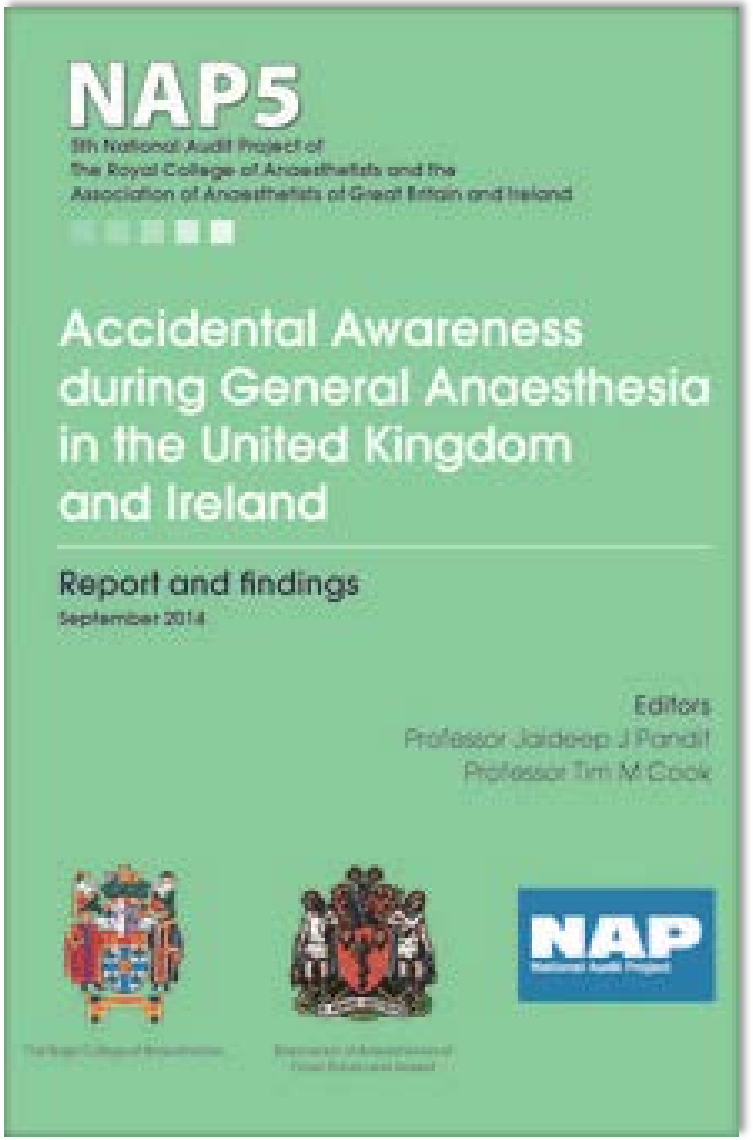


Is your patient more than skin and bone?

- *"The anaesthetist who is unfortunate enough to hit and damage a normally-terminating cord with a spinal needle is likely to find himself in a difficult position when it comes to a claim for medical negligence"*

Bogod IJOA 2014; 23: 201

Awareness during general anaesthesia



Gross negligence manslaughter

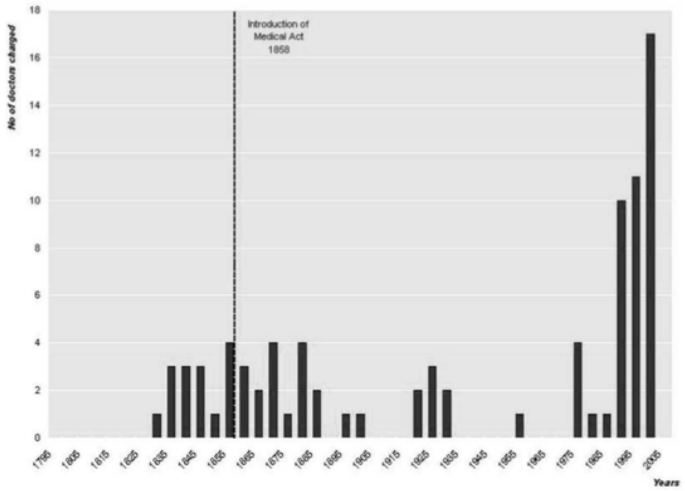
When is an error so serious it is a criminal offence?

Violations deliberate deviation from safe practice ✓

Mistakes **?**

Slips/ lapses ?

Technical errors ?



	1995-2005	2005-2015
Cases	28	15
Convictions	30%	55%

Fenner & McDowell JRSM 2006

Avoiding disasters

- Consent
- Communication with patient & colleagues
- Teamwork
- Follow current practice & guidance
- Document **obsessively**

Thank you for your attention