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EC NEUROLOGY
Editorial

Court New-Born Neurological Litigation: Recording, Maintaining and Safeguarding Clinical Data

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Received: July 28, 2017; **Published:** August 17, 2017

The dictum that in Court, one's management is as good as what is on record, holds special value in cases of litigation centred around new-born neurological damage. This subject has numerous multi-lateral aspects, none of which may be ignored, if one is called to answer to alleged liability for an adverse clinical outcome. The clinical file, be it as a hard copy or in digital form, or both, attains supreme importance regarding the defendant's role in the commission and omission of all that constitutes the medical management in question. There can be no going back on what is recorded in files, and such records comprise information from at least, the mother, defendant, other doctors such as neurologists, obstetricians, paediatricians, anaesthetists, nurses, and any specialists involved in cross consultations.

A unique period of evolutionary management

Maybe few clinical neurologists realise the implications, both clinically and medico-legally, currently taking place in the management of neurological damage of the new-born. Units which *are* undergoing such metamorphosis, need to appreciate the significance of such evolution. Units which are *not* moving with time, may realise the cost, if, or when, a legal challenge to management does arise.

One may briefly exemplify this evolution, by reference to Cerebral Palsy and the defining criteria established for Hypoxic Ischaemic Encephalopathy as laid down by the 2003 ACOG Task Force report on Neonatal Encephalopathy and Cerebral Palsy and its 2014 amendment by the ACOG Task Force report entitled Neonatal Encephalopathy and Cerebral palsy: Defining the Pathogenesis. Needless to say, the performance of investigations demanded by such criteria, needs meticulous recording and the safeguard of such records. They include Apgar scores, fetal umbilical artery pH's/ acid base status, intra-partum cardiotocographic (I-PCTG)tracings, numerous biochemical parameters reflecting organ function, and brain MRI or MRI spectroscopy as a minimum. Not to be downplayed are all antenatal care records, labour records and Pediatric ITU records. In *AW Pursuer against Greater Glasgow Health Board Defenders* [1] we find an excellent UK example of how all these parameters come into play in building a case for Court to assess the Standard of Practice of the defendant. Without actually referring to the ACOG criteria, the exemplary litigation centred on such criteria in a beautifully tapestried expertly discussed scenario.

This is a far cry from simply preserving the CTG tracing for analysis and a subsequent Court debate thereon, a phenomenon which may lead to difficulty in establishing true medical negligence. The situation is unfortunately still rife in many instances. One example, out of a myriad, comes from *Tippett v Guy's and St Thomas' Hospital NHS Foundation Trust* [2]. One may not be categorical and state that a Court case based solely on Intra-Partum Cardiotocography (I-P CTG) may not result in the correct jurisprudential outcome. However, as science reveals more facts about Cerebral Palsy, one needs to determine the presence or absence of Hypoxic Ischaemic Encephalopathy underlying the particular case and this is where the 2003/2014 ACOG criteria establishment of HIE makes its invaluable contribution. And this is why the term *evolution* is stressed here, for a change in the attitude and psychology of such management is in process, both at clinical as well as well as medico-legal level.

One should also note that bearing in mind the ACOG criteria requirements may also help (in retro fashion), by guiding the performance of the recommended investigations and their meticulous recording in the patient's file. Accurately recorded data may save the day in

Court. In *Baynham v Royal Wolver hampton Hospitals NHS Trust* [3], where intra-uterine hypoxia was confirmed, accurate and well kept clinical records convinced the Court that no medical negligence could have prevented the responsible cause of the damage, namely abruptio placentae.

Availability and accessibility of medical records.

All retained information, be it as a hard copy or in electronic form, once recorded, attains immediate legal status for whatever might arise in the future, including its application to medico-legal litigation. Any missing information may constitute one aspect of *spoliation*, defined, as the intentional, reckless, or negligent withholding, hiding, altering, fabricating, or destroying of evidence relevant to a legal proceeding. With regard to neonatal neurological litigation alleging obstetric negligence as a cause of intra-partum hypoxia, one may take as an example the missing I-PCTG tracing. This is, by no means, a rare phenomenon. Ennis., *et al*. [4] reported that 19 CTG tracings were missing in an analysis of 64 case records of serious obstetric litigation held by the Medical Protection Society. Court is not likely to take the situation lightly, for "*the fetal monitoring strips would give fairly conclusive evidence as to the presence or absence of fetal distress, and their loss deprives the plaintiff of the means of proving her medical malpractice claim against the Hospital*" [5]. This statement is quoted here to illustrate the Court's high opinion of I-PCTG, which opinion, in all truth, has played a rather rogue-like role, by inadvertently(sometimes) misdirecting and limiting argumentation in Cerebral palsy Litigation [6]. However, a missing I-PCTG tracing in any Court case trying to evaluate intra-partum hypoxia, almost certainly will shed negative light on the defendant. In *London Strategic Health Authority v Whiston* [7], it is hardly surprising to read that "*The judge put in the scales the prejudice that the defendant would suffer by reason of the loss of the CTG*".

Needless to say, I-P CTG tracings may not be available to Court for reasons other than purposeful disappearance. Bearing in mind the nature of the discipline being considered here, Court action may even not commence, decades after the birth incident, when the assumed malpractice occurred. For example in *Gossland v East of England Strategic Health Authority* [8], the plaintiff was a seventeen year old. Retrieval of a clinical file, after seventeen years and hoping that the original I-P CTG tracing is still in the file's folder and has not deteriorated, may, at times, be a tall order indeed. However the UK NHS Health Service demands a minimum retention period of 25 years for all obstetric and midwifery records, including CTG tracings. The practical truth may be different in any specific file, dug out for legal scrutiny.

The Statute of Limitations varies from country to country and in the USA, from State to State. However, a plea for consideration of liability for an adverse fetal neurological outcome may be accepted by Court, even beyond the official Statute of Limitations, for this is the Court's prerogative and is influenced by a number of factors. Firstly, the Statute, may only be deemed to commence at the time that the damage is discovered. Secondly, the nature of the assumed medical practice for fetal neurological damage is often not considered as of the *ordinary* nature of medical malpractice which may be only, for example in California, of three years. Generally speaking, judges will not, normally, throw out a case just because the Statute of Limitations has been exceeded. Individual cases are assessed individually. In such cases, whatever original evidence will be available, will constitute whatever precious objective evidence exists from the 'records' aspect.

In *Davis v City and Hackney Health Authority* [9], a man with Cerebral Palsy, born in 1963, learnt of the likely suable causation of his medical condition through a law student in 1985, and commenced action in the same year, a writ being issued on 1 April 1987. The UK Court ruled that for the purposes of section 14(1) of the Limitation Act of 1980, the test was not what a reasonable man would have known, but what an individual of the claimant's age, background, intelligence and disabilities would have been expected to have known.

In *Whiston v London Strategic Health Authority* [10], a sufferer from Cerebral Palsy, born in 1974, only learnt from his mother, in 2005, that the cause of his condition could have been a negligently performed forceps by a junior doctor. Proceedings were commenced in 2006 and the Court, accepted the plea. After 32 years, one would hope that the clinical records had been safely kept, were found when looked for and were in good and decipherable condition.

Other examples may be cited, but the point is clearly made. In considering the storage, availability and accessibility of all types of records, especially those which are not digitally stored, it behoves all, to ensure, that all is kept, safe and clearly usable in all cases where the

causation of the neurological outcome of the new-born is likely to be challenged in Court. Bearing in mind that, in such cases, dating back decades, the litigation almost certainly will be I-PCTG oriented. In spite of all the pitfalls of CTG interpretation [11], Court jurisprudence is not likely to be involved with securing evidence of criteria such blood gas, acid base status, Brain MRI's etc pointing to Hypoxic Ischaemic Encephalopathy, in cases dating back say 20 years, although this does vary from one Obstetric/Paediatric Unit to another.

The hand written clinical file, comprising antenatal, intra-partum, operative and paediatric notes and neurological assessment of the new-born all play crucial roles. Daily and down to earth information, such as antenatal care details may attain superlative importance in Court – information such as confirmation of dates of pregnancy, uterine size, maternal blood pressure, blood group, haemoglobin level, maternal height, weight profile, urinalysis and investigations such as ultra-sound scan results, Doppler *studies…It is time to shift, or at least share the focus of vision and evaluation from the labour ward events to the whole pregnancy story*. Anyone facing Court on new-born neurological damage and who does not, will, most likely, be caught short as the "multi-faceted evolution" proceeds.

Further points relating to the clinical file.

Bearing in mind the 2003/2014 ACOG Task Force Reports (especially the 2014) amendment, stressing ante-natal care, one must remember that as the medico-legal evolution progresses, aspects of ante-natal care are likely to gather strength in fetal neurological damage liability. Hence, the clinical file, is crucial from day 1 of contact between doctor and patient. The point of legibility should hardly be mentioned, were it not of crucial clinical and medico-legal importance. In *Constable v Salford and Trafford Health Authority and another* [12] poor legibility led to cocaine rather than procaine being dispensed, and in *Collins v Hertfordshire County Council* [13], Daonil, wrongly dispensed instead of Amoxil, led to a fatal hypoglycaemic coma. May quote an example from the European Court of Justice, where, in *Velikanov v Russia*, we find the very humiliating comment: *The physician and neuropathologist who examined the applicant noted their findings in the above-mentioned report … They are barely legible*.

In scrutinising the patient's records, one expects to find that all entries should have been clearly dated and timed. An important point regarding operative notes, written substantially after the event, say 'over a cup of coffee', is that the entered time should be of the actual delivery and not of writing. This may be overlooked especially if the new-born's adverse birth condition has distracted all and the last thing on anyone's mind is the 'notes'. The simplest of corrections in the clinical file, especially in the operative notes, attains ominous implications in Court. Hence, all corrections should be effected by a simple 'strike through' which maintains their legibility, if challenged. Needless to say, no additions, modifications etc must be effected once the case has attained legal status. It is also relevant to remember that all medical information disclosed to the doctor or hospital should be included in the notes and the source, dated and timed and the mode of communication noted e.g. phone call/text message/ e-mail…

The future

The subject is by no means exhausted here. In fact, this is but the basis, of what may be a whole week's symposium! It is also a subject which is evolving in nature, pari passu with the clinical and medico-legal evolution already referred to. The topic of patient records is likely to see massive future changes at a number of fronts, including the mode of recording and retrieval, legal status restrictions comprising data protection acts, as well as specific data legislation. The subject of new-born neurological damage has much to offer to most of the future clinical data changes and legislation, especially in the light of effecting and storing data relevant in establishing 2003/2014 ACOG Task Force new-born HIE criteria. The ACOG is to be commended on these reports, which are yet to be fully integrated across the board on both sides of the Atlantic, both in new-born cerebral damage management and their jurisprudential application. Already thus employed in many cases, they need to be further disseminated, analysed, and adjusted to the local needs across the international scene. Subsequently, they need to be maintained in tandem with data recording, storing and relevant legislation. This is crucial and the future will show their unescapable inevitability.

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