Some lessons (and comfort) for obstetricians and gynaecologists

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It is worthwhile revisiting the 2014 Supreme Court of Appeal judgment in the matter of Sibisi and Dr Maitin for the positive lessons it holds for obstetricians and gynaecologists. The doctor was successful both in the lower court and on appeal in defending the action for alleged medical negligence against him.

The Plaintiff, the mother of a baby daughter who had suffered an injury to the brachial plexus resulting in Erb's palsy, alleged negligent conduct on the part of the doctor in delivering her child. Shoulder dystocia had occurred.

The daughter was very large at birth, weighing 4.68 kg and, on the probabilities, that was the cause of the shoulder dystocia. The doctor had performed a manoeuvre to release the shoulder. The Plaintiff argued that a combination of the failure to accurately estimate the weight of the baby, to perform a Caesarean section instead of proceeding with a trial of labour, and the incorrect use of the McRoberts' manoeuvre amounted to negligent conduct – which caused the injury to the brachial plexus and the resultant Erb's palsy.

There are a number of elements of the alleged negligent conduct, which deserve consideration and attention.

The misestimation of the baby's weight

The doctor estimated that the baby's weight was 4 kg, when at birth she weighed 4.68 kg. The Plaintiff argued that the doctor was negligent in that estimation before he induced labour.

The Plaintiff's expert evidence was that the doctor was negligent in assessing the weight at 4 kg and in not excluding the possibility of diabetes. If she had diabetes, a C-section should have been performed. The evidence was that the Plaintiff had never suffered from medical diabetes and that there was nothing in her medical history to suggest that she might be diabetic. The doctor tested the patient's urine throughout her pregnancy. While he had not done blood tests to ascertain whether she did have diabetes, there was no indication he should have done so.

The doctor was surprised by the difference between his estimate and the actual weight of the baby. His evidence was that once a baby is over 4 kg in weight, it is difficult to be accurate He had done ultrasound examinations and assessed the baby's weight by palpation. The Plaintiff's own expert testified that an experienced obstetrician might over or underestimate weight, especially where a baby is large, and that an underestimate of 500 g is not surprising. A senior maternal and childcare expert for the Plaintiff also accepted that an estimate could be out by 500 g or more, and that it could not be said that this misestimate was negligent.

The doctor's expert, a senior and very experienced gynaecologist and obstetrician, testified that there is no acceptable medical standard for determining foetal weight and that an estimation that was 600 g out was not unusual. He said that the best a doctor could do to establish foetal weight was to palpate in order to ascertain whether the baby was below average, average or above average weight. The estimate was a 'fatuous exercise', because it would not determine how one would manage the delivery of a baby.

Ultimately, it was common cause that the doctor's incorrect estimate was not in itself negligent.

The foreseeability of shoulder dystocia

The December 2012 guideline issued by the Royal College of Obstetricians and Gynaecologists, which deals with shoulder dystocia, advises that while there is a relationship between foetal size and shoulder dystocia, "it is not a good predictor. The large majority of infants with their birth weight of (more than) 4 500 g do not develop shoulder dystocia and, equally importantly, 48% of incidents of shoulder dystocia occur in infants with a birth weight of less than 4 500 g". This guideline also points out that clinical foetal weight estimation is unreliable. Even ultrasound scans have a 10% margin of error. The guideline also states: "Elective Caesarean section is not recommended for suspected foetal macrosomia (estimated foetal weight over 4.5 kg) without diabetes."

The Plaintiff's expert did not dispute the validity of the guidelines, and accepted that foetal size is not a good predictor of shoulder dystocia.

Both Courts found no reason why the doctor should have foreseen that the baby would present with shoulder dystocia.

The advisability of delivery by Caesarean section

The doctor's experts and literature referred to opined that a Caesarean section carried inherent risks not only to a baby, but also to a mother. Vaginal delivery was always preferable. The literature on the subject was clear that unless the mother was diabetic or had a history of problems with shoulder dystocia, a Caesarean section was not advisable. If that route were to be recommended, it would entail doing in the region of 2 000 Caesarean sections to prevent one shoulder dystocia (an estimate borne out by the guidelines discussed earlier).

The risks inherent in the procedure, including septicaemia and the death of the mother, are high. The Plaintiff's expert's suggestion that in all cases Caesarean sections should be performed could not be accepted, said the court. It was accepted that, by the time the doctor saw the patient, it would have been dangerous to perform a Caesarean section – this was because the baby's head was, by that stage, already four-fifths through the pelvic rim.

On the evidence, the court accepted that the reasonable obstetrician in the doctor's position would not have foreseen the possibility of shoulder dystocia and would have proceeded on the same basis that he, in fact, did. There was no mismanagement of the patient's labour and certainly no negligence.

The McRoberts' manoeuvre

It was contended that even if there was no negligence in the management of labour, the doctor was negligent in performing the McRoberts' manoeuvre with some modification and applied excessive force in releasing the baby's shoulder.

The doctor modified the procedure by placing the patient's legs in straps on lithotomy poles, instead of pushing them down towards her abdomen. This was done because she had had an epidural anaesthetic and was unable to control her legs. The doctor's expert was of the opinion that the objective of the manoeuvre was achieved in this way. The shoulder was released and the baby delivered.

The Plaintiff's expert disagreed, in that he contended an assistant should have been called to push down the Plaintiff's legs. There was nothing to suggest that the outcome would have been different if the conventional McRoberts' manoeuvre had been performed. The Plaintiff's expert agreed that the necessary hyperflexion had been achieved.

The suggestion that the doctor had pulled too hard on the baby's head was mere speculation.

It was pointed out that the McRoberts' manoeuvre is a technique employed to save a baby's life. It is used in an emergency, when shoulder dystocia is preventing the delivery. The accepted evidence is that once the shoulder is stuck, the obstetrician has only a few minutes to dislodge the baby before running the risk of serious brain damage or even death. An obstetrician faced with shoulder dystocia has to use 'as much force as is required to deliver that baby'. The doctor succeeded in avoiding the death of the baby, and achieved the objective of the McRoberts' manoeuvre.

Under the circumstances, the Plaintiff had not discharged the onus of proving any negligence on the part of the doctor.

The Appeal Court determined that the High Court had correctly found that the doctor had not negligently caused injury to the baby.

Informed consent

The Plaintiff had also argued that the Court ought to extend the common law so as to recognise that the test for whether a patient had given informed consent to a procedure should be whether the reasonably prudent patient, given the information about the risks of vaginal delivery, would have agreed to it or elected to have her baby delivered by Caesarean section.

The Court pointed out, in reviewing the relevant case law on informed consent, that the question of informed consent goes to the wrongfulness element of the delictual action. The patient's consent constitutes a justification that excludes the wrongfulness of the medical treatment and its consequences. Negligent conduct on the part of the doctor would be wrongful if the patient had not given informed consent. So, negligence is also a requirement and, where no negligence is proved, the test of wrongfulness does not even arise.

Because, on the facts, it was not proved that the doctor was negligent, there was no need for the Court to determine which test should be adopted in relation to informed consent.

In any event, no evidence was led to show what the reasonable patient in the Plaintiff's position would have done if she had been warned of the risk of shoulder dystocia and advised of her choice between a vaginal delivery and a Caesarean section. The Plaintiff herself said she knew about delivery by Caesarean section and the risks attendant on it – although not anything about shoulder dystocia, brachial plexus injury or Erb's Palsy.

She placed her trust in the doctor in the sense that it was he who was going to make a decision as to the correct procedure to adopt. Accordingly, the conduct of the doctor was not wrongful.

Practitioners can take comfort from both courts' findings. While the resolution of a matter is always subject to the facts of that particular case, the general principles established provide a useful point of first reference.