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Time to Focus on Preventable Pharmacological Damage

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COLUMN ARTICLE

There is little doubt that the obstetric specialty carries a very heavy liability potential. In essentially all countries and legal jurisdictions, obstetrics will be found to lead or be among the foremost of subjects with the highest medico-legal action, including formal Court procedures. There are many reasons for this and although this editorial is not the ideal place to discuss these, suffice it to say that delivery of, say, a brain damaged child is hardly likely to pass without relevant questions being asked.

The point of this editorial is to stress one aspect of potential harm which is often forgotten. For a number of factors such as instrumental deliveries, a botched up assisted breech delivery and a delayed caesarean section, may all come to mind as causes of peri-partum fetal damage. Yet, how often is a pharmacological cause reflected upon? And because the answer is that we rarely remember this common and potentially lethal cause of fetal damage, we have one factor which doubles the danger of which we speak.

Taking as an example the use of syntocinon (oxytocin), suddenly everyone remembers that there *are* serious risks associated with it. One should know that these risks are everyday potential dangers which may easily lead to intra-partum hypoxia, resulting in stillbirth or hypoxic ischaemic encephalopathy preceding cerebral palsy. Courts, both in the USA as well as in the UK abound with cases where syntocinon hyper-stimulation has led to such disasters. The use of syntocinon is so common, that as in most things familiar, contempt is not far off. It is worth while reminding some points about the use of this agent.

- The bearing in mind of situations where syntocinon is contra-indicated e.g. a history of two or more C-sections, the presence of cephalon-pelvic disproportion.
- The avoidance of concomitant use of prostaglandins and syntocinon.
- Familiarity with preparing the required dose of syntocinon infusion.
- Familiarity with the infusion pump.
- Familiarity with the dangers of on-going syntocinon and serious hypotension such as that associated with regional analgesia.
- Knowledge of the dangers of over-frequent or hyper-tonic contractions.
- Knowledge of I-P CTG interpretation and management including when to stop the syntocinon infusion.

There are many other points one could delve in, but at this juncture one must also remember that medico-legally, disclosure of the risks of the use of this dangerous agent must never be forgotten. The patient has every sacrosanct right to know what dangers may be associated with the use of syntocinon to induce or augment labour. This must be

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doubly stressed in the post-2015 climate generated by the ruling of *Montgomery v Lanarkshire Health Board* [2015] UKSC 11. It is the author's opinion that such risks should not only be disclosed to every patient on whom syntocinon is used, but that consent should be expressed *in writing* by the patient.

It is worth bearing in mind that numerous Court cases exist where cases of cerebral palsy have been presented to Court claiming liability from damage resulting from intra-partum hypoxia resulting from syntocinon mismanagement. Details of such cases always shock audiences in classes of Legal Medicine. The fact is, that only by learning about past recorded cases of negligence can one hope to prevent or minimise future disasters.