Malpractice in obstetrics: a contribution of cases in Southern Italy

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Summary: Looking ahead to the abolition of many intra-European frontiers the Authors offer this contribution to the discussion of the medico-legal aspects of gynecological activity in the United Europe of 1993.

It is to this end that they present the data from a review of the material which has been the subject of litigation on the part specialists in Southern Italy, also commenting on the case series in the light of the Italian provisions in force up to date.

Key words: Malpractice; Obstetrics.

INTRODUCTION

In view of the approaching extension of the boundaries of Europe in 1993 it seemed to us opportune to report a case series of litigation relating to obstetrical practice in the Campania Region of Italy, whose capital is Naples.

Thus we offer a small contribution towards the extension of the debate on the medico-legal responsabilities of all gynecologists in the United Europe of 1993. In fact in recent years the practice of medicine has been undergoing profound modifications, besides being conditioned to new relations with social realities.

Changes in the technico-scientific content of medicine ([1]) and those attendant on the formal-psychological relations between doctor and patient, together with the expectations of positive results from medical activity have caused an increase in the legal involvement of doctors regarding facts (real or presumed) connected with the exercise of their profession ([2, 3]).

Such judicial involvement bears particularly heavily on certain categories of practitioners and, above all, on surgical specialists ([4, 5]).

Obstetric and gynecological practice comes within the category of those specialities most exposed to the litigation for (presumed) incompetence or « malpractice ».

The risks of the doctor's exposure to claims for damages through malpractice

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are, in fact, always greater when attendance during pregnancy and at delivery is under consideration. The impending risks of claims for damage both to the mother and her fetus or newborn, above all at a time of particular emotional involvement, make detrimental events even less acceptable to patients and their relations.

In this study we have therefore considered a series of cases relating to obstetric and gynecological practice which have been the object of judicial proceedings.

It is notorious that the avoidance of pre-term delivery is considered one of the most important tasks in contemporary obstetrics, just as the instrumental monitoring of labour is now considered indispensable in the prevention and early diagnosis of pre-eclampsia.

Such situations (together with the problems inherent in the voluntary interruption of pregnancy) thus lend form to as many hypotheses of the professional responsability of the gynecological specialists as when they do not appear to have been specifically faced ([6, 7]).

MATERIALS AND METHODS

We considered 51 cases which had been the subject of litigation between 1985 and 1989. In the examination of these cases the following parameters were studied:

- age;
- course of the pregnancy;
- place and modality of delivery and its complications;
- type of damage suffered and its cause.

RESULTS

In these 51 cases we faced the problems encountered during pregnancy, labour and delivery. In 21 of them there was damage to the mother, in 5 cases to the newborn, in 17 cases to both (table 1).

In 21 cases grounds of professional responsability were found.

Table 1. — *Damage sustained by the patient, the fetus, both.*

Damage to the parturient	Damage to the newborn	Damage to both
21	5	17

Table 2. — *Summarising the incidents during obstetric practice.*

Total cases	Total n. of deaths		Cases of proven responsibility
51	Mothers	37	21
	fetus/newborn	19	

Table 2 summarises the incidents of the whole case series. In 37 cases the death of the mother was reported.

There were 19 cases death of the fetus and/or the newborn.

The complications occurring in pregnancy, confinement and delivery where damage ensued are reported in table 3.

With regard to the modality of delivery, out of 35 cases, 19 gave birth spon-

Table 3. — *Complications arising during pregnancy, confinement, delivery, following which damage ensued.*

Complications	N. cases
Rupture of the uterus	9
Preeclampsia	7
Uterine atonia	9
Abruptio placentae	3
Placenta praevia	2
Pathological placentary adhesions	2
Pre-term labour	5
Renal failure	1
Uterine vagino-perineal lacerations	4
Uterine inertia	2
Fetal distress	3
Intra-uterine full-term dead fetus	1
Cardiac arrhythmia	1
Sepsis from missed abortion	1
Cerebellar haemorrhage	1
Total	51

Table 4. — *Modality of delivery.*

Spontaneous delivery	19
Urgent cesarean section	10
Scheduled cesarean section	1
Application of forceps	4
Oxytocin stimulation	1
Total	35

Tabre 5. — *Damage to the newborn.*

Endouterine asphyxia of full-term fetus	11
Endouterine asphyxia of pre-term fetus	3
Deaths following premature delivery	5
Peri-natal asphyxia	2
Dislocation of the humeral scapula with brachiad plexus lesions	1

taneously, 11 by cesarean section, 4 with the application of forceps, and one was a case of oxytocin stimulation (table 4).

In 14 cases the patients had been admitted to private clinics, in 27 to public hospitals, while in one case delivery took place at home.

Damage to the newborn is reported in table 5.

A careful analysis of the case series seems to present interesting points regarding premature delivery, procured abortion and rupture of the uterus.

Altogether there were 5 abortions. In 3 cases they were spontaneous, in 2 cases procured (table 6).

With regard to the terms, in both cases of procured abortion professional responsability was recognised. In fact the perforation of the uterus in one case proved to have been in a woman with undiagnosed extra-uterine pregnancy, and another case where the gynecologist was unaware of the perforation reaching far enough to injure the intestinal loops (table 7).

In both cases responsability was attributed to medical incompetence.

In 5 cases the contention concerned premature deliveries, on the basis of which gestosis was involved. In none of these cases was responsability recognised (table 8).

In 9 cases rupture of the uterus had occurred. The site of the lesions, type of lesions and the pathological causes are reported in table 9.

The rupture of the uterus occurred in 2 cases during pregnancy, in 2 cases in labour, in 2 cases during delivery, in 2 cases during voluntary interruption of pregnancy, and, finally, in one case spontaneously.

With regard to rupture during pregnancy, in labour and during delivery (there were 6 cases altogenether) in 4 of them there was intra-uterine death of the fetus.

In 5 cases rupture of the uterus was followed by the mother's death; in one

Table 6. — *Abortions.*

Spontaneous abortions	2
Failed abortion	1
Procured abortions (VIP)	2
Total	5

Table 7. — *Complications in abortions.*

Retention of placenta with filtration from previous hysterectomy scar	1
Sepsis from missed abortion	1
Spontaneous perforation with peritonitis	1
Perforation during Voluntary Interruption of Pregnancy	1
Total	4

Table 8. — *Premature deliveries.*

Pre-eclampsia	4
From unknown causes	1
Deaths	5
Total	10

Table 9. — *Rupture of the uterus.*

Total cases	9
Site:	
body	3
fundus	3
lower uterine segment	3
Type:	
Complete rupture	2
incomplete rupture	4
perforation	3
Pathogenesis:	
placenta accreta	2
feto-pelvic disproportion	1
oxytocin excess	1
spontaneous	1
in eclampsia	1
traumatic	3

case from disseminated intravascular coagulation (D.I.C.), in 4 others from hypovolaemic shock.

In at least 4 cases the damage could possibly have been foreseen and/or reduced. In fact in one case no diagnosis was made of placenta previa; in another case a situation of placentary failure due to senescence was not diagnosed; while among the patients submitted to Voluntary Interruption of Pregnancy in one case it appeared that diagnosis of an ectopic pregnancy had not been made; while in another retroversion of the uterus had not been diagnosed, so that the perforation was followed by lesions of the intestinal loops and an anastomotic operation was required.

Another interesting aspect of our case series relates to D.I.C. and/or hypovolaemic shock. In only 2 cases was it possible to save the womens' lives by the prompt performance of hysterectomy. In the other cases the operation failed to save the patients' lives on account of the complications encountered. Sepsis occurred in 6 cases and in 5 others shock was the cause of death. In one case sepsis followed the retention in the uterus of a dead full-term fetus, and in another it followed a missed abortion; in 2 cases post-surgical peritonitis was associated with the death and, finally, one case was verified post partum.

In one of the cases of post-surgical sepsis, this followed the execution of a scheduled Cesaren section, where placentary fragments had infiltrated the myoetrium and only hysterectomy succeeded in saving the woman's life.

Professional responsability was directly attributed in 21 cases to the doctors who had attended the patients (table 10), while in one case responsability was attributed to the doctor who had been in attendance during the pregnancy, since it was considered that if he had diagnosed placenta praevia it would have been possible to plan a Cesarean section, and to avoid the woman's death. In this case it is interesting to remark the fact that responsability was also adduced to the doctor who had admitted the patient and, through failure to perform an ultrasound examination, had not become aware of the clinical situation.

Negligence was admitted in 11 cases, incompetence in 8 cases, and both incompetence and negligence in 2 cases.

The elements characterising the professional responsability of the doctors attending the patients are also reported in table 10.

Finally, it is of particular interest to note the co-responsability attributed to the hospital managements in 9 cases (table 11).

CONCLUSION

The case series examined in this study offers an occasion for some consideration of that «dramatic complex — delivery» ([10]) which, besides the doctor, involves two other parties contemporaneously — the mother-to-be and her

Table 10. — *Professional responsability of hospital staff who assisted the pregnant patients.*

Negligence:	
Delay in application of urgent treatment measures (cesarean section, haemotransfusion)	5
Lack of monitoring in labour	1
Sepsis from retained abortion	1
Lack of clinical chocking post-partum	4
Total	11
Incompetence:	
Failure in detection of ruptures	1
Failure in detection of ectopic pregnancy	1
Mistaken maneuvers	3
Post-operative septic complications	1
Error in oxytocin administration	1
Failure to diagnose D.I.C.	1
Total	8
Negligence + incompetence:	
Transfusion of incompatible blood	1
Perforation of the intestinal loops	1
Total	2

Table 11. — *Responsability of Hospital Management* *.

Lack of obstetric medical attendance	3
Lack of defibrillator	1
Lack of instrumental monitoring of delivery	4
Lack of a centre for the screening coagulopathies	1

* Sentence of the Supreme Court 28-11-1973, n. 166.

unborn child. Naturally the number of cases studied does not allow for wide generalisations, but it does at least allow us to establish a basis for the recognition of the most frequent occurrences among obstetric and gynecological accidents.

Such conditions assume special importance in the light of recent Italian regulations on the subject of penal proceedings, which have weighed so heavily on medico-legal jurisdiction.

On the other hand our own case series essentially highlights the special expectations that civilised society maintains in regard to the figure of the doctor, Specialist in Obstetrics and Gynecology, and also on the necessity for such a civilised and advanced society to be guaranteed Health Departments specifically structured and adequately equipped, whether they be public or private or by co-operational covenant with the National, and, before long, Community Health Service.

Quite recently in fact evidence has shown that much is still lacking in Italian Health Service legislation ([2]) whereby the directives of article 13 of the Italian Constitution have not yet been effectively carried out in regard to the standards of means and of apparatus to be brought into line with the regulations concerning the functioning of delivery wards.

In Italy it has, instead been considered easier to influence the obstetric and neonatal services by the application of the Law 108/88 to the standards of hospital staffing per number of beds and to hospital planning ([2]).

We therefore consider it necessary that direct comparison be made with the situation in other community countries, both in order to bring the performance of the Health services up to a level effectively similar in all the Countries of United Europe, and also in the aim of establishing professional security margins within which the individual gynecologist may regulate the excercie of his own profession.

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