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Case Report
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Masking Medical Error in Obstetrics – Clinical Forensic and Bioethical Considerations

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Abstract

A case is presented of inadequate hospital care in a pregnant woman with fetal growth restriction (FGR) and oligohydramnios, which resulted in intrauterine fetal death with the cause of death concealed by the obstetrician.

Keywords: Birth; Intrauterine fetal death; Malpractice; Obstetrics; Concealed

Introduction

Performing procedures that are at odds with good clinical practice and passive behavior in antenatal care belong to rather frequent problems in forensic clinical perinatology. Inadequate diagnostics and unnecessary procedures during antenatal and peripartum care are a segment in most common litigations due to the intrauterine fetal death (IUFD) or permanent neuromotor damage in the neonate [1,2].

Disguising criminal offenses against human health, in obstetrics in particular, is a severe bioethical and criminal violation. Fortunately, such events are quite infrequent. A case is presented of inadequate hospital care in a pregnant woman with fetal growth restriction (FGR) and oligohydramnios, which resulted in IUFD with the cause of death concealed by the obstetrician.

Case Report

A 25-year-old primigravida was admitted to the gynecology and obstetrics department during the 37th week of gestation for surveillance due to FGR, oligohydramnios and breech presentation. Previous course of pregnancy was normal, free from comorbidities. On serial ultrasound (US) examination, fetal growth was verified at 10th percentile without increase, along with oligohydramnios. Neither Doppler US nor complete biophysical profile was performed. Cardiotocography (CTG) records were obtained twice daily and interpreted as normal. Laboratory findings, somatogram and vital functions of the patient were normal. During the 40th week, the woman felt considerably weaker fetal movements with some hyperactive movements, which she reported to the midwife and ward physician, who ordered CTG. On CTG, the midwife could not identify fetal heartbeats, so she called the ward physician. The physician performed US examination and found failure of the fetal heart action with anhydramnios. Fetal body mass was estimated to about 2,200 g. The physician obtained hemogram and coagulogram, which both were normal. In agreement with a consultant, labor was not induced on the same day but next day, with prostaglandin gel due to Bishop score <4, as ordered by the head of department. Labor pains and amniotic sac rupture failed to occur upon one intracervical gel application. The consultant arrived in the afternoon and told the woman that cesarean section would be performed because labor pains failed. The woman signed the informed consent form for cesarean section. A dead child with scant meconium stained amniotic fluid was delivered by cesarean section. The postoperative course and puerperium were uneventful and the patient was discharged from the hospital, with ablactation agents recommended. The consultant explained to the woman and her husband that the baby had asphyxiated due to the true umbilical cord knot. Pathologically, the macro morphological finding indicated a true umbilical cord knot and meconium imbibed amniotic membrane, without paying due attention to the placental histopathology apart from the placental fibrin lesions. Autopsy of the 2,200 g hypotrophic stillborn with grade I maceration lesions did not point to malformations or meconium aspiration. The ward midwife, a distant relative to the puerpera, had seen the operator tying and tightening umbilical cord true knot after delivery. She informed the puerpera and her husband about it; the parents reported the case to Medical Chamber and Ministry of Health, and filed charges against

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the consultant. Revision of the placental histopathology revealed multiple old and new infarctions of the placenta, which weighed only 245 g at term. Maternal laboratory findings indicated the presence of thrombophilia (MTHFR and factor V Leiden mutation), which must have caused multiple placental thromboembolisms and infarctions with consequential uteroplacental insufficiency, oligohydramnios and FGR in the otherwise healthy young woman free from any adverse manifestations.

Discussion

Patient safety, in this case maternal and unborn child safety, is the main postulate of clinical forensics and bioethics [3]. Providing appropriate antenatal care and procedures undertaken in line with the respective guidelines reduce undesired outcomes of recognized pathologic pregnancies. Obstetrics is a high-risk profession where a great number of litigations ensue due to the above-mentioned transient or permanent damage caused by perinatal hypoxia/ischemia or inflammation, or IUFD. Failures associated with inappropriate care may occur in outpatient (antenatal) care, or in inpatient (antenatal or peripartum) care [1,3].

In the present case, primary gynecologist detected FGR and oligohydramnios and referred the patient for pregnancy monitoring and termination. Antenatal surveillance was performed according to the good clinical practice principles. At the hospital, however, care for the pregnant woman with FGR and oligohydramnios was not carried out according to the modern perinatal medicine and good clinical practice rules; fetal biophysical profile (FBFP) and Doppler US were not performed to objectify fetal hemodynamic and neurologic state. Accordingly, IUFD occurred due to totally inadequate diagnostic set of procedures and inadequate care during three-week hospitalization. Analysis of CTG recordings taken for three weeks twice daily revealed pre-pathologic to pathologic Fischer score in the last two weeks, which was not objectified by FBFP and Doppler US either.

In conclusion, there was obvious failure in the antenatal care of high-risk pregnancy by inappropriate, neglecting and passive behavior, while labor induction and unnecessary cesarean section were performed against the good clinical practice rules for IUFD delivery, most probably to show care for the mother carrying a dead child. In these circumstances it is recommended to perform vaginal delivery as the most saving procedure in cases of IUFD and no indications for urgent labor termination by cesarean section [4].

In addition, forensic investigation revealed repeated recidivism of medical errors in the consultant involved; taking advantage of his high position and authority, as well as political connections, he had made a number of bioethical failures and disguising malpractice with umbilical cord knotting, state and complete medical documentation forgeries, thus committing a series of direct criminal offenses against human health, including lethal outcome in the child and unnecessary operative procedure in the mother. In this case, the error was due to passive behavior and malpractice rather than a complication, which resulted in the adverse event and criminal-forensic evaluation.

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