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Birth Injuries and Fetal Heart Rate Monitoring:
Will New Guidelines Make it Harder to Sue for Compensation?

ACOG Issues New Practice Guidelines

In the July 2009 issue of Obstetrics and Gynecology, the American College of Obstetricians and Gynecologists (**ACOG**) issued practice bulletin No. 106: Intrapartum Fetal Heart Rate Monitoring.

The new bulletin is the most recent statement from the College on interpretation of fetal heart rate tracings and management of labour.

Electronic Fetal Monitoring (EFM) has grown dramatically. In 1980 it was used on 45% of pregnant women to more than 85% of pregnant women in 2002. However, one of the authors of the study, Dr. George Macones, stated:

> “Although EFM is the most common obstetric procedure today, unfortunately it hasn’t reduced perinatal mortality or the risk of cerebral palsy.”

Unfortunately, for those of us who represent children who have been injured during birth, it appears that the bulletin has been drafted to be even more protective of the practice of physicians than past clinical guidelines on the same subject.

While the data for the study may have been collected for the purpose of providing clinical guidance to obstetricians in managing labour, I have no doubt that the guidelines will be

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used in future medical malpractice claims to establish the standard of care for how doctors should interpret and react to different fetal tracings.

The revised guidelines have created a 3-tier classification system for EFM tracings:

- Category 1 tracings are classified "normal" and do not require specific intervention.
- Category 2 tracings are classified "indeterminate". They require further investigation and surveillance.
- Category 3 tracings are classified "abnormal" and require immediate intervention. For example, providing oxygen to the mother, changing her position, stopping labor stimulation, treating maternal hypotension, or initiating prompt delivery if the tracings do not return to normal.

The guidelines contain a number of clinical recommendations including the following:

- The false-positive rate of EFM for predicting cerebral palsy exceeds 99%.
- The use of EFM is linked to higher rates of both vacuum and forceps operative vaginal delivery, as well as of cesarean delivery for abnormal FHR patterns and/or acidosis.
- Recurrent variable decelerations on the FHR tracing should lead to consideration of amnioinfusion to relieve umbilical cord compression.

One of the most controversial statements in the study is that:

> "Re-interpretation of the FHR tracing may not reliable; especially once the neonatal outcome is known.”

In other words, the guidelines suggest that the medical opinions of experts who have been retained to help injured plaintiffs shouldn’t be accepted because their evidence "may not be reliable".

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The Guidelines fail to point out that the opposite is also true: re-interpretation of tracing may be reliable. It depends on the facts of each particular case.

Simply put, the guidelines suggest that medical experts are not entitled to "second guess" the opinion of the doctor in charge of the delivery.

The plaintiff in a medical malpractice claim often faces challenges finding experts willing to testify on their behalf. These guidelines appear to be a transparent attempt to limit the evidence of experts who are willing to "do the right thing" and support injured plaintiffs.

It remains to be seen what weight, if any, the courts place on the guidelines.

John McKiggan is a personal injury and medical malpractice lawyer practicing in Halifax, Nova Scotia. For more information about medical malpractice claims in Canada, you can receive a free copy of his book: **The Consumer's Guide to Medical Malpractice Claims in Canada:** *Why 98% of Canadian Medical Malpractice Victims Never Get a Penny in Compensation* by calling toll free **1-877-423-2050**.

July 15, 2009 by John McKiggan