Intrapartum management & risk aversion

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SUMMARY
Medicolegal litigation is increasingly prevalent in Malaysia. While the exact number of cases remains unclear, there are approximately 1,500 complaints annually across the public and private healthcare sectors. Although only a small proportion reach the courts, damages awarded have reached RM9.45 million, significantly impacting medical indemnity costs. Obstetricians and gynaecologists are disproportionately affected, particularly as their fees are capped under the Akta Fi. Some relief has come with Siow Ching Yee v Columbia Asia Sdn Bhd [2024] CLJU 404, where the Federal Court ruled that private hospitals owe a statutory, non-delegable duty of care to patients. This landmark judgment should catalyse a paradigm shift in the delivery of obstetric services within private healthcare.

Most adverse obstetric outcomes occur during labour. Though rare, such events are often unpredictable. Typically, women are admitted only when labour begins, having been followed regularly by their obstetrician on an outpatient basis. In emergencies, however, they may suddenly require care from other specialities and departments—often under duress. A patient with amniotic fluid embolism, for example, may need an anaesthetist, neonatologist, haematologist, intensivist, and coordinated paramedical response. These are beyond the obstetrician's direct scope. Institutions should ensure that every patient registering for delivery is counselled on the full provision of maternity services. Obstetricians should remain focused on obstetric emergencies to optimise outcomes.

Intrapartum risk is further compounded by the lack of real-time documentation, a major weakness in medico-legal defence. In emergencies, a staff member should be designated to document directives, observations, and interventions. If unavailable, obstetricians should consider maintaining a running verbal commentary. Informed consent for labour interventions should ideally be completed antenatally.

Evidence-based practice should guide all interventions, including induction of labour (per MOH guidelines), amniotomy, augmentation, cardiotocography (CTG), episiotomy, and instrumental or caesarean delivery.

CTG monitoring remains a paradox. There is no strong evidence supporting its use in low-risk pregnancies where continuous one-to-one care is provided. Therefore, one-to-one monitoring should be the preferred standard. CTG abnormalities should be confirmed by fetal scalp blood sampling, as CTG alone is a poor predictor of fetal hypoxia. Despite this, CTG is frequently used in court as definitive proof of fetal compromise. When used, it should be interpreted and described using contemporary frameworks, such as the UK's NICE Intrapartum Guidelines.

Simulation-based training for obstetric emergencies enhances team response and improves maternal and neonatal outcomes.

In emergencies, an array of multidisciplinary tests may be required from the mother, baby and placenta to aid diagnosis or rule out hypotheses that may be put to you eventually in court.