Editorial

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The use of an Intrapartum Cardiotocograhic Score Index (ICSI) in Cases of Cerebral Palsy Jurisprudence

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The history of cerebral palsy litigation at Court leaves much to be desired for many reasons including the scientific aspect particularly in reference to the causation of cerebral palsy. One cannot ignore the 1960s when science held that the preponderance of cerebral palsy is the result of oxygen deficiency in labour. The wrong teaching soon left the science classroom and pervaded the Courts where quick- thinking lawyers extrapolated the teaching to wrongly benefit their clients' cases with great alacrity. These cases often were and are studies in human suffering and misery. However, truth must out and justice be served irrespective of all factors. One cannot assuage suffering by perverting the course of justice such that someone alleviates a wretched existence by being made a scapegoat and paying for it.

Intrapartum Cardiotocography (IP CTG) also clinically born in the 1960s further compounded the element of junk science associated with the presumed hypoxic causation of cerebral palsy. One could write volumes about how IP CTG contributed negatively in major ways to cerebral palsy jurisprudence. However, cutting to the chase, let us concede and specify that most of the more eyebrow raising heresies about the subject have been sifted out over the last fifty years or so. There does remain the Shifting Sands Phenomenon (Buttigieg 2015) which refers to the negative medico-legal impact resulting from a combination of intrinsic CTG drawbacks (such as the high inter and intra-observer errors, low sensitivity and high specificity) with a high degree of propensity to IP CTG mismanagement of many various kinds. To these one may also add the marked hegemony in importance of IP CTG in cerebral palsy jurisdiction.

This IP CTG hegemony is not uncommonly a serious matter and this unhappy state of affairs often passes unnoticed by both lawyers of the involved parties as well as the Court itself. It is partly a vestige of the wrong concept arising in the 1960s where CTG was thought to be the great elixir central to the hypoxia-cerebral palsy saga. Irrespective of the origin, we speak of not rare situations where IP CTG argumentation essentially rules the stage. Reviewing Court cases from both sides of the Atlantic, one finds cases where IP CTG seems to be equated with the very standard of care of the case.]

If science moves slowly, the Law prudently moves slower still. However, it is time for the establishment to review the tenets of cerebral palsy jurisprudence and take full on the required paradigm shift. This shift is multi-faceted, but here reference is strictly limited to the proposal of an index concerning the review of an IP CTG tracing. The proposal here is that an arbitrary index is created - an Intrapartum Cardiotocograhic Score Index (ICSI)- which is decided on at a Pre-Trial Hearing (PTH).

The rationale of the creation of such an index is based on the fact that in a case of cerebral palsy, the role of IP CTG review is to determine whether the tracing is compatible with fetal hypoxia and acidosis. The worst of IP CTG disturbances can only serve as an indication for confirming/excluding hypoxia and never, unless the situation is one of urgency, is it to be assumed as confirmatory of intrapartum fetal hypoxia. Hence the most that one may say is that a particular IP CTG strip tracing is compatible with hypoxia/acidosis and there the matter stands. Whether action in any form was taken on that is another aspect of management to be scrutinised along the Court decided standard of care. The proposed index will only answer the question as to whether the IP CTG tracing in question may be considered normal, suspicious or overtly abnormal. No more and no less. Even so such a simple affirmation may save the Court much time and argumentation.

If the notion of an ICSI is accepted then ideally it should be effected at a PTH where Court representatives, lawyers of plaintiff and defendant and Court appointed medical expert(s) can work in parallel sessions to the Court hearing. Such a PTH must decide on the particular IP CTG strip tracing. However, useful elements may emerge which may also be useful regarding say a particular obstetric unit's training or supervision. For this reason, it may be advisable for a representative member of the local OBGYN College to attend such a PTH. The importance of the latter may become clear when one remembers the universal and persistent call by numerous stakeholders regarding that aspect of IP CTG mismanagement relating to misinterpretation.

The final details of the arbitrary points employed to reach the the particular Intrapartum Cardiotocographic Score Index may be

explained to the Court in as much detail, or lack of it, as the Court desires. The discussions and argumentations required to work out the significance of a particular IP CTG at a PTH rather than the main Court hearing will also contribute to diminishing the hegemony of IP CTG by diminishing the often long and vitriolic argumentation at Court. It will also allow more time and opportunity for the more modern and scientifically acceptable concept of Hypoxic Ischaemic Encephalopathy to commence making its long overdue presence felt in such cases.