AIMS For a better birth...

Medical litigation in maternity care

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Conferences on any aspect of birth and midwifery tend not to attract huge numbers in Scotland. Yet, 120 midwives booked into this conference and many more were turned away. Fantastic? Interesting? Depressing? All of those for different reasons?

Breda Seaman, risk-management facilitator with the Forth Valley NHS, organised and introduced the day. Fiona Dagge-Bell, senior midwife from the Nursing and Midwifery Practice development unit then provided an overview entitled 'Why are we here? Historical, practical and litigation perspective'. Litigation is increasing and costing NHS Scotland £6-9 million each year. Defensive practice has been part of the response. Fiona talked about the responsibilities of practitioners and referred to a number of recent professional guidelines, including the Code of Professional Conduct designed to protect both professionals and the public.

She discussed moves in Scotland to improve and standardise care, and suggested that midwives can protect themselves by gaining informed consent, developing their knowledge and skills, and practicing within their Code and Trust policies, protocols and procedures. Fiona ended her talk with a quotation from A Framework for Maternity Services for Scotland (2001):

"All health professionals must have a clear understanding of the concept of risk assessment and management to improve the quality of care and safety for mothers and babies, while reducing preventable adverse clinical incidents."

Thus, Fiona's talk also identified the heart of the problem today: the tension between a social midwifery approach to birth and the more widely practiced obstetric model. Avoiding litigation through adhering to accepted birth practices and minimising risk assumes a consensus of opinion that is highly contested. Equally problematical is the notion of informed choice within this contested medical model that assumes moral and scientific rightness. Litigation occurs within a social context - the issue is therefore less about litigation and more about defining midwifery practice, debating definitions of risk and safety, and developing a climate in which individual beliefs and morality are respected.

Andrew Symon, lecturer at the School of Nursing and Midwifery, University of Dundee, gave a detailed talk entitled 'Litigation in Scotland and what it means for midwives', based on recent events and the

findings of a survey of 2000 midwives and obstetricians in the mid-1990s. Andrew highlighted some of the complexities between finance driven litigation, defensive practice, the threat to clinician autonomy and the desire to respect individual women's needs. He also raised the difficulty of guidelines remaining guidelines in a litigious society, and the likelihood of rules and dogma leading to mechanistic practices and conformity. As one of the midwives in his study remarked, "Litigation probably means you're practising more defensively where before, you could treat people as individuals and adapt your practice to suit the individual... Now there may be a tendency to control from a policy document."

Andrew suggested that, fortunately, many outdated protocols remain buried under piles of paperwork and are thus ignored. However, there are some good examples to be found, such as the New Guidelines for Midwife-Led Care in Labour (www.fons.org/networks/ebm/guidesm.pdf)*(Note from AIMS webmistress - we can't find this document anywhere on the internet; if somebody knows where it now lives (or its replacement), please let us know)*

The net result of increased litigation appears to be more caesarean sections carried out at an earlier stage and increased documentation - but Andrew maintains that the risk is minimised by good care, communication and trust.

Gillian Lenaghan, professional officer for the RCM Scottish Board, gave a down- to-earth detailed account of "Oh my God! I'm being sued!" She tabled the different areas of law that might impact on midwives: criminal, civil, fatal accident inquiries, employment tribunals and various discrimination acts. She discussed vicarious liability in terms of the employers' responsibilities as well as their duties, which include a duty of care and providing a safe system of work. Employees' duties include obeying reasonable and lawful orders, exercising reasonable care and skills, and acting in good faith. Her sympathetic and straightforward manner suggested that she would provide accurate information and support to midwives in these circumstances.

Norma Shippin, managing partner, Central Legal Office, spoke on the 'Process of litigation and the importance of documentation'. Norma discussed the categorisation of claims, in which obstetrics accounts for 65 per cent of principal sums. She explained various types of liability, and when and how claims are made and viewed. While she stressed that documentation should be primarily for the benefit of the client rather than the courts, she also emphasised the importance of documentation should a case come to court.

She explained the notion of 'normal practice' and that, if a practitioner's actions or omissions fall outside of such normal practice, then the court must demonstrate that no professional with ordinary skill would have done the same - an apparently wide scope of practice that may have costs and benefits for parents and professionals, but which, in AIMS' experience, usually only benefits practitioners who adhere to medically orientated practices while penalising dissenters. Norma suggested that the factors giving rise to risk are intrinsic and include interventions, inadequate training, inappropriate delegation, and inadequate communications and records. Personal risk factors include ignorance, lack of insight, inattention, irritation, interruption, idleness and inertia.

Valerie Stacy, a QC from the Faculty of Advocates, presented a step-by-step account of being a witness in a court case, and explained why a witness may be called and how to provide useful evidence. She then provided detailed information on fatal accident inquiries, and why, how and where these take place. She discussed civil cases with or without medical negligence; and the role of a sheriff, judge and jury. She then went on to describe how to prepare to be a witness, how evidence is taken and examined, and the different types of evidence, including the role of records. Valerie stressed the importance of honesty, clarity and the need to admit when one simply does not know or remember.

Vinit Khurma, a practising GP and advocate, spoke next about 'Viewing both sides: Getting acquainted with the legal system'. Vinit gave examples of successful court actions and how sums of money are arrived at. Compensation is to cover the costs of the claimant's needs and leaves no surplus for relatives. He then went on to define medical negligence, who might be sued, the time-frame involved and how negligence is proven.

The reality, however, as AIMS well knows, is that a tiny minority of people obtains any compensation - a survey in 1987 of 100 cases showed that nearly three- quarters were withdrawn, and only one was successful in court. Vinit reiterated what most of the speakers had already said with his tips for survival: keep legible notes, ensure continuity of care, have at least 'ordinary skill' and be experts in court.

Finally, Donna O'Boyle, of the Risk Management Executive, CNORIS, gave her presentation on 'Why mothers die and substandard care'. Donna talked about the value of the Confidential Enquiries into Maternal Deaths and the lessons that can be learned from these. She also suggested looking at risk management outside of the healthcare system, such as in the aviation and oil industries, rail services and sports.

A major concern remains that, while all of the speakers attempted to reassure practitioners that litigation is still relatively unusual and that there is support for those who are the subject of litigation, the underlying fear is pervasive and certainly fuelled by the talks. Both sessions highlighted the inconsistencies and contradictions between a medical model of healthcare and professional and public agencies, and the contradictions between best practice, and the perceived need for practitioners to protect themselves against litigation through defensive practice and conformity. At present, risk management and autonomy seem mutually exclusive.