Midwifery 33 (2016) 55–63

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

An exploration of the effects of clinical negligence litigation on the practice of midwives in England: A phenomenological study

Judith H. Robertson, PhD, LLB (Hons) (Qualified Midwife)*,
Ann M. Thomson, BA, MSc., RM, MTD (Professor Emeritus of Midwifery, Editor Emeritus of Midwifery)

University of Manchester, UK

ARTICLE INFO

Article history:
Received 29 May 2015
Received in revised form
2 September 2015
Accepted 12 October 2015

Keywords:
Midwives
Litigation
Clinical practice
Blame culture
Adverse event
Phenomenology

ABSTRACT

Objective: to explore how midwives' personal involvement in clinical negligence litigation affects their midwifery practice.
Design: descriptive phenomenological study using semi-structured interviews.
Setting: in 2006–2007 in-depth interviews were conducted in participants' homes or at their place of work and focused on participants' experience of litigation. Participants were recruited from various regions of England.
Participants: 22 National Health Service (NHS) midwives who had been alleged negligent.
Findings: clinical practice affected was an increase in documentation, fear of practising outside clinical guidelines and electronic fetal monitoring of women at low obstetric risk; these changes were not widespread. Changes in practice were sometimes perceived negatively and sometimes positively. Forming a good relationship with childbearing women was judged to promote effective midwifery care but litigation had affected the ability of a minority of midwives to advocate for women if this relationship had not been established. Litigation could result in loss of confidence leading to self-doubt, isolation, increased readiness to seek medical assistance and avoidance of working in the labour ward, perceived as an area with a high risk of litigation. A blame culture in the NHS was perceived by several midwives. In contrast an open non-punitive culture resulted in midwives readily reporting mistakes to risk managers. Litigation lowered midwifery morale and damaged professional reputations, particularly when reported in the newspapers. Some midwives expressed thoughts of leaving midwifery or taking time off work because of litigation but only one was actively seeking other employment, another took sick leave and one had left midwifery and returned to nursing.
Key conclusions: litigation can have a negative effect on midwives' clinical practice and morale and fosters a culture of blame within the NHS.
Implications for practice: education regarding appropriate documentation, use or non-use of electronic fetal monitoring and the legal status of clinical guidelines will enable midwives to respond proportionately to the threat of litigation. A culture of openness and sharing the problem when adverse events occur would help to extinguish the current blame culture in the National Health Service. Litigation must be recognised by management as capable of inducing loss of confidence and reluctance to work in the labour ward. Promoting teamwork will help support these midwives. The potential for litigation in maternity care could affect retention of the midwifery workforce.

Introduction

In our previous paper (Robertson and Thomson, 2013) we described how personal involvement in clinical negligence litigation affected 22 National Health Service (NHS) midwives in England emotionally, psychologically and physically. We now describe the reported effects on their clinical practice. Most commentators have discussed the effects of litigation on medical practice (Ennis et al., 1991; Studdert et al., 2005; Kessler et al., 2006; O'Dowd, 2015); primarily that fear of litigation may lead to defensive medicine, described by Kessler et al. (2006, p. 240) as 'medical practice based on fear of legal liability rather than patients' best interests.' Our study has focused on midwives who

* Corresponding author.
E-mail addresses: j.robertson11@btinternet.com (J.H. Robertson), ann.thomson@manchester.ac.uk (A.M. Thomson).

http://dx.doi.org/10.1016/j.midw.2015.10.005
0266-6138/

care for all childbearing women in the UK (The King's Fund, 2011). For women at low obstetric risk, the midwife is the lead professional (Department of Health (DH), 1993, 2007). If complications arise in childbirth the midwife is under a duty to seek assistance from 'health or social care professionals' with the necessary skills and experience to assist (Nursing and Midwifery Council (NMC), 2012, p. 15).

Maternity claims are not widespread. Analysis of births in England and Wales between 2000 and 2009 found that less than 0.1% of births in the NHS resulted in claims of negligence (NHS Litigation Authority (NHSLA), 2012). However, clinical negligence claims, including maternity claims, are rising with an overall increase from 10,129 in 2012/2013 to 11,945 in 2013/2014 (NHSLA, 2014). Obstetric and gynaecological claims are the highest in value at almost 8 billion pounds in compensation and costs paid out by the NHS between 1995 and 2014 (NHSLA, 2014). The cost of premiums paid by Trusts to insure against maternity clinical negligence claims equates to nearly a fifth of their spending on maternity services (National Audit Office (NAO), 2013). Maternity claims are often contentious and prolonged and stressful for both claimants and defendants (DH, 2003). Thus apart from the fiscal imperative to understand this problem it is important to understand the effects on the individuals involved.

Research seeking to understand how litigation affects midwifery practice has conflated participants with a general fear of litigation and those with actual experience of being alleged negligent. Midwives have admitted to defensive clinical practice whereby interventions are carried out, not when clinically indicated, but to provide evidence to counter possible future negligence claims (Symon, 2000b; Hindley and Thomson, 2007; Larsson et al., 2009; Surtees, 2010) for example electronic monitoring of the fetal heart during labour in women at low obstetric risk (Hindley and Thomson, 2007). A survey of obstetricians and midwives, the majority based in Scotland with a smaller sample in England, found 45% of obstetricians and 53% of midwives said that they had changed their practice in response to the threat of litigation (Symon, 1998a). From the midwives' group 41.5% ($n=742$) cited this change as improved documentation, followed by 7.6% ($n=136$) as obtaining permission for all procedures, 4% ($n=73$) obtaining medical advice earlier and 2% ($n=37$) adhered more to unit policies. A majority of midwives also said they would insist on electronic fetal monitoring in circumstances where a woman did not want this but the clinical circumstance warranted it (Symon, 1998a). Other responses were avoidance of working in the labour ward and 5% of both obstetricians and midwives had considered leaving their profession (Symon, 1998a).

Two consecutive nationwide surveys of members of the American College of Nurse-Midwives (McCool et al., 2007, Guidera et al., 2012) sought to track the incidence of midwives' involvement in litigation, their coping mechanisms and the effect on their practice. Guidera et al. (2012) found that while being named in a lawsuit can have a 'dramatic emotional and personal effect on the individual' (p. 350) the effects on professional practice appeared less severe and most midwives had not changed their practice. Of 1340 responses (response rate of 23%) 425 had been named in a law suit. Changes of practice for midwives named were: decreasing the number of high risk patients for whom they cared 8% ($n=33$), changed protocols or guidelines for practice 6% ($n=26$), felt less confident or fearful in practice 3% ($n=12$), increased the number of referrals made for probable caesarean births 6% ($n=27$), improved documentation 3% ($n=12$) and were more quick to consult with collaborating clinicians 2% ($n=9$). Additionally, 3% ($n=13$) had changed to a career other than midwifery and 8% ($n=32$) found a new midwifery position. The first survey (McCool et al., 2007) did not focus on changes to midwifery practice but found 7.2% ($n=11$) of 152 American midwives named in a law suit took a different midwifery position and 7.2% ($n=11$) left midwifery altogether. Other studies have found that the threat of litigation can influence those involved in providing maternity care to cease practising (Symon, 1998a; Ball et al., 2002; Xu et al., 2008). Hood et al. (2010) interviewed 16 midwives who experienced an external review of maternity services at an Australian tertiary maternity hospital. Their methodology has been questioned regarding the recruitment of participants (Fahy and Robinson, 2011). However, the study provides some insight into responses of midwives who perceived their practice was being scrutinised by lawyers and those in authority over them. Midwives lost confidence and felt vulnerable to litigation when working in the labour ward, with some ceasing to work there and others left midwifery altogether. Midwives adhered more closely to guidelines and increased the use of electronic fetal monitoring which they judged to be defensive and detrimental to individualising care for women. Relationships became stressful with women who did not want to conform to the institution's model of care. Midwives then found difficulty in advocating for these women during childbirth.

Clinicians' fear of litigation has been cited as a barrier to openness following adverse events or near misses; this prevents learning from mistakes (Department of Health, 2000; Kennedy, 2001; Department of Health, 2003). Kennedy (2001) advocated abolishing the present system of clinical negligence because it encourages secrecy and cover up; in its place an 'open non-punitive environment' (p. 359) should be fostered in order that errors can be examined. Criticisms by doctors of litigation are that it destroys the doctor–patient relationship and the doctor's professional reputation, is prolonged and therefore stressful, does not encourage openness and encourages defensive medicine (DH, 2003). However, reform has not taken place and there still exists an adversarial system of litigation which the midwife will encounter if allegations of negligence are made. Exploring how and to what extent midwives respond to personal involvement in litigation is important because of the implications for morale and retention of the midwifery workforce and the quality of care these midwives deliver to the women and babies in their care. Our study is the first to focus exclusively on the effects of personal involvement in litigation of NHS midwives in England. In comparison to previous studies which have used survey methods (Symon, 1998a; McCool et al., 2007; Guidera et al., 2012) we applied a qualitative approach to facilitate a deeper, nuanced understanding of the problem.

Methods

The study methods are reported in detail in our previous paper (Robertson and Thomson, 2013). Therefore, a brief description is reported here. Husserl's (1964) descriptive phenomenology was our theoretical perspective which seeks truth by describing what appears to the consciousness of the 'experiencer' (Moran, 2000, p. 4) as broadly and faithfully as possible. Ethical approval was given by a Multi-centre Research Ethics Committee. In addition the United Kingdom Government requires NHS organisations to scrutinise and approve applications for research so that the dignity, rights, safety and well-being of participants is safeguarded (DH, 2005). This approval was obtained prior to interview for 18 participants who were currently employed by an NHS Trust. Using purposive sampling we recruited 22 NHS midwives in England with the lived experience of 'being alleged negligent' in a clinical negligence claim. The reported experiences included writing a statement, attending case conferences and appearing as witnesses in a civil court. Data collection ended when sufficient 'rich and thick material' was obtained to enable the first author to 'intuit and see essential structures' (Todres, 2005, p. 100).