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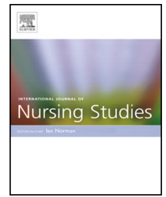

Self-reported exposure to severe events on the labour ward among Swedish midwives and obstetricians: A cross-sectional retrospective study

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A R T I C L E I N F O

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A B S T R A C T

Background: The process of delivery entails potentially traumatic events in which the mother or child becomes injured or dies. Midwives and obstetricians are sometimes responsible for these events and can be negatively affected by them as well as by the resulting investigation or complaints procedure (clinical negligence).
Objective: To assess the self-reported exposure rate of severe events among midwives and obstetricians on the delivery ward and the cumulative risk by professional years and subsequent investigations and complaints.
Design: Cross-sectional survey.
Participants: Members of the Swedish Association of Midwives (SFB) and the Swedish Society of Obstetrics and Gynaecology (SFOG).
Methods: A questionnaire covering demographic characteristics, experiences of self-reported severe events on the delivery ward, and complaints of medical negligence was developed. Potential consequences of the complaint was not reported. A severe event was defined as: 1) the death of an infant due to delivery-related causes during childbirth or while on the neonatal ward; 2) an infant being severely asphyxiated or injured at delivery; 3) maternal death; 4) very severe or life threatening maternal morbidity; or 5) other stressful events during delivery, such as exposure to violence or aggression.
Results: The response rate was 39.9% (n = 1459) for midwives and 47.1% (n = 706) for obstetricians. Eighty-four percent of the obstetricians and almost 71% of responding midwives had experienced one or more self-reported severe obstetric event with detrimental consequences for the woman or the new-born. Fourteen percent of the midwives and 22.4% of the obstetricians had faced complaints of medical negligence from the patient or the family of the patient.
Conclusions: A considerable proportion of midwives and obstetricians will, in the course of their working life, experience severe obstetric events in which the mother or the new-born is injured or dies. Preparedness for such exposure should be part of the training, as should managerial and peer support for those in need. This could prevent serious consequences for the health care professionals involved and their subsequent careers.

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What is already known about the topic?

- Midwives and obstetricians might be traumatised by severe events in the delivery ward in a way that affects their ability to provide high quality care and increases the risk of burnout, emotional fatigue, and posttraumatic stress symptoms.
- Traumatised staff are at increased risk of wanting to leave acute obstetric care.

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- Support, including peer support, may be valuable to reduce the psychological impact of severe events on midwives and obstetricians.

What this paper adds

- Findings from this study show that a considerable proportion of midwives and obstetricians are exposed to severe events during their working life.
- A substantial proportion of midwives and obstetricians will face investigation procedures and complaints procedures during their working life.
- The findings highlight how potentially traumatic events as well as potentially traumatic investigation procedures are an integrated part of working with delivery care and that awareness and preparedness must be raised.

1. Introduction

In the event of birth complications, full attention is given to mitigating any harm to the infant or mother. The ultimate goal of patient safety in obstetric care is to prevent maternal and perinatal deaths and child morbidity related to birth injury. These events are disastrous for the afflicted patients and their families. Although progress has been achieved during the last decades in Sweden severe events still occur in birth care. In 1976 stillbirths, neonatal deaths (0–6 days), Apgar score <7 at five minutes were 5.6, 5.0 and 13 per 1000 births, in 2014; 4.0, 1.2 and 13. (Socialstyrelsen, 2016) Twenty to thirty children a year are granted economic compensation from The Swedish National Patient Insurance Company due to birth-related injuries. Maternal near miss is reported to be 2.9 per 1000 deliveries, while maternal mortality is estimated to be 3.6–7.7 per 100 000 during the years 1988–2007. (Wahlberg et al., 2013; Esscher et al., 2013)

In a patient safety perspective obstetric care professionals' experiences of severe events are most important to address (Cook et al., 1998; Hollnagel et al., 2006; Woods et al., 2010; Reason, 2000). Thus, over the last few years, increasing knowledge has shown that the health care providers involved might also be seriously affected by severe events (Sheen et al., 2015a; Wallbank and Robertson, 2013; Rice and Warland, 2013). In delivery care overarching expectations are joyous life-changing moments and negative outcomes contradict public perceptions of childbirth (Sheen et al., 2015a). The death of a child is profoundly stressful for health care professionals involved (Lavoie et al., 2015; Wallbank and Robertson, 2013), even contributing to burnout and emotional exhaustion and distress (Elit et al., 2004; Hildingsson et al., 2013; Wallbank and Robertson, 2013). Working conditions are often stressful and the hierarchical structure of health care might cause frustration and hinder midwives from using their full potential of the art of delivery care (Rice and Warland, 2013; Pezaro et al., 2015). Also doctors are affected by the workload and burdened by responsibility. Delivery care is an area with a high risk of complaints or litigation procedures, affecting both midwives and doctors (Anderson, 2013). A British study showed that doctors with a recent history of complaints lodged against them report higher rates of depression, anxiety, and self-destructive thoughts than doctors with no complaints (Bourne et al., 2015). There is an increased risk of midwives and obstetricians leaving delivery care after they have experienced severe negative events (Sheen et al., 2015a; De Boer et al., 2011). A Danish survey in 2012, with a response rate of 59%, reported that 85% of midwives and obstetricians had been involved in a traumatic birth (Schrøder, 2016). A UK study reported 90% having experienced trauma, however this study had a 16% response rate, making selection bias likely (Sheen et al., 2015b).

Hence, a resilient obstetric care need to acknowledge the strain put on health care professionals. For this more comprehensive knowledge is needed to better understand the extent of exposure to severe events during a working life in obstetrics, for midwifes as well as for obstetricians. For this study we aimed to assess the extent to which providers are exposed to severe obstetric events including threats or aggression, the cumulative risk by professional years, and the risk of being involved in complaint procedures.

2. Method

2.1. Context

In Sweden, as in all Scandinavian countries, deliveries that are judged to have no complications are handled by midwives, who often work independently. When the course of labour deviates from the normal process, an obstetrician is summoned.

According to Swedish regulations, all avoidable, serious adverse events must be reported to the National Board of Health and Welfare (NBHW) or, from June 1, 2013, to the Health and Social Care Inspectorate (IVO), agencies that are subordinate to the Ministry of Health and regulated by the law (Management System for Systematic Quality Work (SOFS) regulation 2005: 28). It is the responsibility of every department manager to report serious adverse events, whether harmful or risky, to an assigned medical officer (often the chief medical officer), who assesses whether the event should be reported to the NBHW or the IVO (Ullström et al., 2014). If it is decided that a report should be filed, the hospital investigates the event using event analysis and makes suggestions for improvement. The controlling authority, decides on whether suggested organisational changes or interventions are sufficient (Ullström et al., 2014). There is also a system by which a patient or family members can report complaints to the IVO (previously NBHW). This system has some resemblances to the British clinical negligence claims reported to the National Health Service Litigation Authority (NHSLA). Until January 1, 2011, such complaints were addressed to individual health care providers. However, due to a change in regulations after that date, patients' complaints are now, through the IVO, directed towards the event and healthcare institution where it took place, in order to direct attention to the system (system approach) and not to the individuals involved (person approach). Neither the compulsory reporting system nor the patient complaint system involves civil litigation authorities. Moreover, no financial remedy can be claimed by filing a complaint, which makes the system different from that of NHSLA. To gain financial compensation under the Swedish system, there either has to be an appeal to an insurance company (commonly The Swedish National Patient Insurance Company) or, more infrequently, a lawsuit in a civil court.

2.2. Design and participants

We conducted a cross-sectional web survey of all registered members of the Swedish Association of Midwives (SBF) and the Swedish Society of Obstetrics and Gynaecology (SFOG) in January, 2014. Members with no known e-mail address did not receive the survey (28% of SBF members and 3% of SFOG members). The questionnaire went to 3849 midwives and 1498 obstetricians, followed by three reminders. The data collection continued for nine weeks. Of the responses from midwives, 192 were disqualified because the respondents were students who had not completed their training. We considered residents who have finished their house job (18–21 months of rotations between internal medicine, surgery, psychiatry and general practice i.e. family medicine) and started a residents program to become specialists in obstetrics and gynaecology (usually five to six years of training) to be eligible

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