Proceed with reasonable care: when legal principles inform training to prevent harm during the childbirth – draft V1

M. Petrovic, J. Nicholls, D. Siassakos

Maternity claims represent the highest value and second highest number of clinical negligence claims reported to the NHS Litigation Authority (NHSLA). The three most frequent categories of claim were those relating to **management of labour** (14.05%), **caesarean section** (13.24%) and **cerebral palsy** (10.65%). Two of these categories, namely cerebral palsy and management of labour, along with CTG interpretation, were also the most expensive and together accounted for approximately 70% of the total figure of £3.1 billion, paid out on or expected to be paid, for all maternity claims of the total value of all the maternity claims[1].

Something about the US context at the very least (and maybe anything global)

What is what we can do to prevent this?

Reducing preventable harm to mothers and neonates is a universal goal[2]

A. *Standard of Care, definition by law* - Jackie

B. *Standard of care, clinical*

i. <u>Antenatal care</u>

NHS Litigation Authority "Ten Years of Maternity Claims" report has shown that the majority of claims were with patients who were not identified as high risk[1].

This highlights the importance of accurate and timely information about what to expect during labour and giving birth (including explanation what emergency interventions might be needed and when they might be needed), even when the pregnancy is not classified as

high risk, and it is a step forward in minimising risks of complications and medico-legal implications. This should ideally be included in Antenatal Classes and supported with adequate Information Leaflets, as discussions during the labour often may be time-limited and constrained by pain and stress.

Considering the unpredictable nature of catastrophic emergencies in pregnancies previously considered low risk, it is even more important for maternity teams to train how to deal with these emergencies; and to train to support practices that would be considered reasonable by a body of opinion.

ii. Labour and Delivery

Clearly, avoiding an intervention would also avoid its related medicolegal consequences. There are numerous evidence-based recommendations[3,4] to increase the chance of spontaneous vaginal birth and avoid intervention, including:

- Continuous support during labour
- Positioning during the 1st and 2nd stage of labour supporting effective progress of labour
- Delayed pushing in women with epidural analgesia
- Empty bladder prior to active pushing
- Encouragement[4] or "coaching", guided active pushing
- Use of oxytocin for nulliparous women[4] if contractions are inadequate at the onset of second stage

Training programmes should support these and other elements of supportive and preventive care. For example, training in rotational birth should start by training prospective accoucheurs to use oxytocin judiciously to resolve malposition thus avoiding the need for rotation.

C. Decision-making in complex settings

Decision on timing and mode of delivery in complex cases or an emergency requires situation awareness, timely anticipation of possible, especially serious, complications, and respect of woman's wishes and values. In these situations, ideally delivery and postnatal plan should already be finalised and easy accessible (e.g. for women with complex history)

and senior advice should be sought, including involvement of multidisciplinary team decision making in case of emergency.

Common obstetric dilemmas include:

- Abnormal CTG spectrum
- Operative vaginal birth vs caesarean section
- Subsequent instrument use vs caesarean section

Training should aim to familiarise maternity teams with scenarios needing complex decision-making, so that they have the opportunity to err, learn, and improve in simulation before dealing wwith similar situations in real life.

D. Training in Communication to prevent litigation

Team Communication

Handover

Having different teams looking after the same patient between shifts has made Handover a vital part of practice in order to minimise the risk of medical errors. It is important to optimise communication of critical information as an essential component of risk management and patient safety[5].

Effective handover is a duty of each member of staff involved in patient's care as poor or incomplete information can cause delay in care, miscommunication and confusion, or even lead to poor outcome and/or severe consequences.

Training in handover should focus on the use of SBAR in both elective and emergency sitiations. SBAR tool[5] is an effective way to handover the patients, and for efficient communication within multidisciplinary teams and during emergencies. SBAR stands for[5]:

Situation: description of specific situation about a particular patient, including name, consultant, patient location, vital signs and any specific concerns.

Background: information about patient's background, including date of admission, diagnosis, current medications, allergies, laboratory results, progress during the admission and other relevant information.

Assessment: involves critical assessment of the situation, clinical impression and detailed expression of concerns.

Recommendation: involves the management plan, making suggestions and being specific about requests and time frame.

Certainly, the amount of the information and details included in SBAR depend on the level of urgency of the situation. Although SBAR use may seem simple, it takes considerable training from both an individual and an organisational point of view[5]. This investment is worthwhile; using SBAR between staff has been associated with patients, who experience the structured team communication feeling safer (Conrthwaite Siassakos et al).

Team leaders should be trained to enquire using SBAR when teams do not relay the relevant structured information spontaneously.

Communication with the patient

Shared decision making, good communication, and positive continuous support during labour and birth have the potential to reduce psychological morbidity following birth[3].

Patient should be provided with up-to-date and Good Practice guidance relevant information in a clear, understandable and non-medical language. Ideally, this should be supported both verbally and in a written form.

What is also often needed, especially if emergency is anticipated or already occurring, is just a couple of well-timed sentences explaining events as they occur.

Training should focus on these simple pieces of information, specific to each emergency, that make all the difference. Examples include:

- Warning women with 'turtling' that the shoulder may get stuck, and subsequent actions may be very quick and uncomfortable
- Explaining to women with cord prolapse they have to be transferred to theatre very quickly and in an awkward position
- Explaining to women with a bradycardia that the bell will be pulled, several people will run in, and if it does not recover then they may all have to run to theatre together for fast delivery
- Explaining to women where the diagnosis of stillbirth has just been made, that if the accoucheur runs away to <u>another</u> emergency they will return as soon as they can to look after them.

Consent

Shared decision making and consent are fundamental to good medical practice[6].

The consent process should always represent an informed and meaningful dialogue rather than one side decision. The implication of the 2015 Montgomery ruling is nowadays the legal expectation of the way in which information is shared. There is a clear requirement to ensure women are aware of the management options and the risks and benefits of each approach. The risks that are especially expected to be explained are those:

- which staff would consider material because of their high likelihooh
- which women and their families would consider material because of their own experience, interest, concern, or the experience of close friends and family.

In practice, this means that every healthcare professional must[7]:

- Clearly outline the recommended management strategies and procedures to their patient, including the risks, benefits and implications of potential treatment options in a timely manner
- Discuss any alternative treatments
- Discuss consequences of not performing any treatment or intervention
- Ensure patients have access to high-quality information to aid their decision-making
- Give patients adequate time to reflect before making a decision
- Check patients have fully understood their options and the implications
- Documented the above process in the patient's record

Ideally, written consent should always be obtained, but more importantly the risks and benefits discussed should be documented. This is clearly much more challenging in an emergency situation. However, for procedures in the birth room and in the emergency situation verbal consent witnessed by another healthcare professional is sufficient and considered to be in the best interest of the woman or baby[8].

Consent during the labour has to be taken with a special consideration, particularly if women are in pain or under the influence of narcotic analgesics. Also, for women with limited English language skills, an approved translation service should be provided.

Therefore, training to prevent litigation should focus on:

- Using translation early in the process, even before the emergency occurs: e.g. discuss with women with risk factors for operative birth before it is needed urgently.
- Starting all discussions with women, and their families, with what their particular concerns are
- Treating decision-making as a team process, where obstetricians, midwives, women, their families and/or their birth companions are all part of the same team

Duty of Candour and Debrief

It is a professional responsibility to be honest with patients when things go wrong[3].
Duty of Candour is not a tick-box exercise. It is an opportunity to explain what happened, offer a sincere apology to the women and their families for the adverse event with reassurance that measures will take place.

Training should focus on candid disclosure and discussion.

Importance of follow-up appointment

Ideally, obstetrician involved in care during labour and birth should review the woman before discharge home and offer her and her birth partner to discuss again events before, during and after the procedure, including possible complications and consequences for the future. This would allow them to understand the events and address all their concerns. Postnatal debriefing does not replace but completes advanced planning and discussion (with use of translators where needed), and good communication during the events.

This is a key lesson to be included in training programmes: Debriefing after the events alone is unlikely to prevent litigation. Explaining marks of forceps only after the delivery is rarely an easy situation, whereas parents rarely complain when they have been mentioned in advance of the procedure, during verbal consent. Ditto for perineal tears.

Training

Safer Childbirth[9,11] and *Standards in Maternity care*[10,11] have clearly stated that one of the main principles for the provision of safe maternity services is that intrapartum care should be provided by appropriately trained individuals.[11]

Confidence in performing spontaneous vaginal deliveries, theoretical knowledge, simulation training and clinical training under supervision are pillars of safe practice during childbirth.

Principles of effective evidence-based training

Skilled emergency care in response to obstetric complications is critical in the reduction of maternal mortality[12].

The current evidence base for effective training supports local, unit based and multi-professional training, with appropriate mannequins, and practice-based tools to support the best care. Training programmes based on these principles are associated with improved clinical outcomes[13,14].

Skills&Drills Training, is a multidisciplinary team-based simulation training where different clinical scenarios in obstetric emergencies are presented in order for participants to develop, apply and integrate clinical, communication, teamwork and leadership skills. In most clinical settings this is a part of the mandatory training.

How should training address reasons for litigation

Increasing investment of physical and human resources in simulation-based education has been well documented in response to concerns about patient's safety, health workforce shortages, and clinical education capacity[15].

Ideally, simulation-based training should have effect on participants':

- Knowledge and confidence
- Clinical skills
- Communication skills
- Individual and team behaviours

- Leadership skills
- Teamwork

and most important – patient and organisational outcomes.

Legal principles - Jackie

Reference to law and understandings of patient safety

Understandings of harm

Negligence

Defensive Practice

Conclusion – once we have the final draft

References

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