Costly broken promises

Obstetric negligence: Lorin Lakasing reports on the cost of over-promising & under-delivering

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The soaring cost of medical negligence is a major national financial liability which diverts resources from healthcare improvement. In 2018-2019 the NHS paid out £2.4bn in compensation with over £83bn set aside for future claims (NHS Resolution Annual Accounts 2019/20). High value obstetric claims related to neonatal brain injury account for over 50% of settlements with costs likely to exceed the budget for provision of maternity services.

Obstetricians look after at least two patients, automatically doubling the risk. But our demographic is young and human reproduction is a physiological and generally successful process. Training requires regular skills and drills updates, we have had national audits since the 1950s and extensive clinical guidelines ratified by our Royal College and NICE. Risk management operates in all maternity units with easy access to external review. With all these advantages one might expect near perfect outcomes and yet we find maternity units disproportionately represented in independent inquiries. But why?

After decades of perinatal meetings and expert witness reporting it saddens me to say the stories are all the same. The problems arise almost without exception due to the belief that all will be well until it is not. Midwives are committed to support maternal choice to the extent that subtle warning signs are unintentionally overlooked. Failure to connect findings that cumulatively cause disaster is common. Escalation often occurs after the opportunity to be pro-active was missed so emergency protocols are actioned. In a crisis staff must quickly articulate words and concepts the mother may never have considered, knowing that the countdown on the hypoxic ischaemic encephalopathy clock has begun. Whatever is said and done thereafter matters not. If instrumental delivery results in a third degree tear the obstetrician will not be thanked for saving the foetus from brain damage. If transfer to theatre for trial of instrumental delivery incurs delay the neonatal metabolic acidosis may worsen. Staff can only hope that neither mother nor baby are harmed which, although more often than not the case, will provide little comfort and no justification if damage to either occurs. After the delivery parents and staff are devastated. Then comes the investigation. It is disheartening to be judged by those who were not there, often seniors in managerial roles with little or no clinical commitment. They make fleeting public relations trips to the Labour Ward but are never seen out of hours or at weekends despite being the first to extol the virtues of a seven-day service. Serious cases need external review, hours of interviews conducted by equally non-patient facing staff the only difference being that they are employed elsewhere. Reports consist of pages of 'cut and paste' paragraphs and nebulous recommendations. Neither parents nor staff are satisfied.

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Misapprehension

The misapprehension of analysing poor outcomes by focusing solely on intrapartum events is born of laziness and a poor understanding of the service. Precursors to poor outcomes lie in the antenatal period but these remain largely unscrutinised. To do so would be complex, unpopular and onerous. The pervasive narrative surrounding childbirth accessed through social media, special interest groups or charities promotes views which are at best outdated and at worst peddle coercive and undermining misinformation with damaging consequences. They empower women to make choices without context. But who can blame mothers for relying on these sources? The fragmented nature of NHS antenatal care denies women easy access to experienced professionals who could provide a more balanced or individually tailored view. Staff do not have time for prolonged discussions and feel inhibited about raising issues associated with obstetric risk for fear of causing alarm or being accused of scare-mongering. Yet the intrapartum process is fraught with unpredictability and care might have to be re-routed in a matter of minutes. Some UK Birth Centres transfer >30% of women to hospital, maternity units report epidural rates of >50%, instrumental deliveries in 10-20% women, Caesarean section rates of 20-35% with many done as emergencies, and term neonatal admission rates are rising. How many first-time mothers are told this?

It is not only women who have been misled. Maternity staff are also subjected to a dishonest narrative. A commitment to on-going learning, regular audit and complying with guidelines are supposed to improve outcomes. We are told that engaging with the risk management processes will help us 'learn from our mistakes' yet the stories are all the same. There is always something that could / should have been done differently. There is never a woman who in retrospect considers herself 'fully informed', and we have yet to define what this means, otherwise she would have allegedly made different choices. Most importantly, there is no intrapartum concern where earlier delivery, in particular by Caesarean section, would not have benefited the foetus.

Comment

For too long we have over-promised to both mothers and maternity staff. For too long we have under-delivered because the misleading narratives surrounding childbirth have set unrealistic, unachievable, and frankly dangerous goals. For too long staff have put their trust in processes which have failed to improve care and left them vulnerable and defenceless. We need to build a partnership with women based on a candid dialogue that puts safety of mothers and babies above all else. Failure to re-imagine and refashion maternity care may render the service unsustainable. NLJ

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