The Rise and Fall of Perinatal Litigation:
a medico-legal examination of allegations of negligence in childbirth since 1980

Andrew Symon

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Declaration:

This thesis is my own work and no part of it has been submitted for a degree at this or any other university.

Andrew Symon
Abstract

This thesis describes the incidence, nature and effects of perinatal litigation throughout Scotland and in an area health authority and an NHS Trust hospital in England since 1980. The restricted information in the literature on the types of claim provided only a limited platform from which to begin this analysis. However, given unrestricted access to over 600 files in Scotland and the two English locations, it has been possible to paint a far broader and deeper picture of both the nature and incidence of litigation in this field. Legal claims were examined in the context of the clinical setting. Tackling the issues arising from the clinical context allows for a more informed approach to risk management. Examining the files enabled the influence of protocols, policies and supervision levels, which cannot be gleaned from merely listing the heads of claim, to be analysed in depth. Large scale postal surveys of obstetricians and midwives in Scotland and the two English locations were carried out to elicit both objective and subjective information about the effects of perinatal litigation on clinical practice.

The perceived upward trend of litigation throughout the 1980s was confirmed. However the obvious, and very dramatic, drop in incidence since 1993 was surprising. This apparent change in the trend may have serious financial implications for those Trust hospitals which are committing a significant proportion of their budgets to the Clinical Negligence Scheme for Trusts in an attempt to ensure adequate resources are available for large damages awards.

There are many different reasons why people sue, and while a brain damaged child was by far the most common reason, this head of claim accounted for only a quarter of the cases. Clinical information showed how cerebral palsy is often an unexpected outcome. This constitutes a potential worry for all staff involved in perinatal care, and has implications for the levels of investigation and intervention. Stillbirths, non-Central Nervous System (CNS) birth injuries and neonatal deaths were all fairly common reasons for suing on behalf of a baby. For mothers perineal trauma was the most common, but caesarean sections also featured prominently, as did allegations about retained products of conception, and epidural / spinal anaesthesia. It was possible to describe success rates by head of claim, information not previously available.

It is apparent that clinicians believe that more investigations and operations are being conducted as a direct fear of the possibility of litigation. This higher level of
intervention is at odds both with the 'consumer' demand for more natural childbirth, and the aim of obstetricians to reduce the number of caesareans. A matter for concern was the high prevalence of staff who believed they had had insufficient training in the interpretation of cardiotocographs.

It was intriguing that the views of respondents about defensive clinical practice (including the consideration of leaving the specialty) were not positively associated with a direct experience of litigation.

One of the most prominent features of legal actions is the time they take. While delays in initiating an action are beyond the scope of health managers, delays within the health system were, unfortunately, commonplace, and largely due to poor record keeping and administration. It is possible that the shorter time it has taken to conclude legal actions originating since the mid-1980s indicates that legal departments are becoming more efficient, but there is still a strong requirement for pursuers to be patient and resolute.

Perinatal litigation is an unpredictable area; the multitude of reasons for suing in this area of health care make simple descriptions and simplistic prescriptions inappropriate. However, the data presented in this thesis provide detailed information for a much more informed approach to both risk and claims management.
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Part I

Litigation in Context
Chapter 1

Setting the scene

It appears - although supporting evidence has been scanty - that there has been a significant increase in medical negligence litigation (and especially obstetric litigation) over the last 10-15 years. This has been blamed for a number of apparent side-effects, including a rise in defensive medicine, lowered recruitment to obstetrics, and a siphoning off of a significant proportion of the health budget to pay damages awards and insurance premiums against further potential damages. Part of the problem in trying to analyse the possible effects of this phenomenon is that until very recently there was no systematic central collation of incidents of perinatal litigation in either Scotland or England, or, for that matter, any local collations which were published. Without adequate publicly-available knowledge, the debate about the extent of litigation and the consequent use of public funds, and about what constitutes a justified response to the fear or prospect of litigation, is at best ill-informed.

This research concerns the incidence, nature and effects of perinatal litigation. perinatal meaning 'surrounding birth'. The first phase of the research analysed legal files in obstetric - midwifery cases focusing on events from the 20th week of pregnancy up to the end of the neonatal period (the first 28 days of life). This definition does blur the boundaries of what might otherwise be considered purely obstetric litigation; although there were few neonatal cases which were not also allegedly obstetric in nature, some cases concerned obstetric anaesthetists, and others only concerned midwives. The research, then, is perinatal, and not simply obstetric.

The research set out to identify the extent and characteristics of perinatal litigation in Scotland and in two identified locations in England since 1980. This involved examining legal files, and collating information on the nature of litigation - the reasons for suing, the length of time cases took to be initiated and then decided, as well as the outcome of the cases and certain demographic data on litigants. In the English NHS Trust hospital, due to boundary and other organisational changes, data for the 1980s was sketchy, and was only comprehensive from 1988 onwards. While the research can conclude with reasonable certainty what the incidence of perinatal litigation has been in this location only since 1988, it can do so for the whole of Scotland and the other (larger) English area since 1980.
The second phase examined on a large scale how clinical staff see the issue of litigation; this exploration of perceptions of and attitudes towards litigation (or the threat of litigation) was by means of two large scale postal surveys. Because of a varying incidence of litigation (over time and between different areas) and considerable job mobility among health workers, while tempting, it was not feasible to draw conclusions between the attitudes of staff working in areas of high and low incidence. Nevertheless, there was considerable scope to draw distinctions between practitioners of varying experience, and between those from units of different size or different areas of work. In both strands of the research there is a limited Scottish-English comparison.

The research poses three central questions: what has been the incidence of litigation, what are its characteristics, and what are its perceived effects. These questions are all answered, and the implications for the development of risk and claims management strategies are considered.

This research is timely, particularly in view of recent developments in the health service, which have seen financial accountability devolved to local (Trust) level. The very large amounts paid in damages when negligence has been established in certain obstetric cases may be financially crippling for Trusts; even cases which are successfully defended can incur such large legal bills that cuts in the patient care budget may have to be made. Additionally, the danger that the threat (or even the perceived threat) of litigation may be encouraging defensive clinical practice is a worry: for clinicians who see their traditional clinical autonomy being eroded; for managers who have to take account of the extra cost of the tests and treatments which such defensive practices will incur; and for the patient who cannot be sure that the treatment or investigations offered are in her (or her baby's) best interests. Thirdly there is the fact that a perceived negligence crisis in this aspect of health provision may have a damaging effect on what is still a public service.

The thesis is divided into five parts, which are now briefly described. Part I, following this introduction and overview, continues with a literature review (Chapter 2) and a discussion of methodology (Chapter 3). Part II (Chapters 4 and 5) examines the incidence and nature of litigation; Part III (Chapters 6-8) develops this theme and provides a detailed account of many of the variables involved in the origin, course and outcome of cases. This leads into an analysis of the perceptions of clinical practitioners in Part IV (Chapters 9-11). Lastly Part V (Chapter 12) draws the thesis
to a conclusion, and provides suggestions for the development of risk and claims management.

Chapter 2 contains a comprehensive literature review. It describes the legal theory which underpins the concept of medical negligence, examines the debate about possible reforms of the system, and highlights the paucity of data which have been published concerning the incidence and nature of litigation. Several issues surrounding this topic, such as communication and explanation, risk prediction, choice and control, and fetal monitoring, which are of direct relevance to clinicians, are discussed. The situation in the USA is referred to, but with caution due to the considerable differences between the health and legal systems on either side of the Atlantic.

The lack - until recently - of any systematic central collation of instances of litigation in England is referred to; the situation in Scotland, where legal files are held centrally but remain the property of the employing organisation (Health Board [HB] or Trust) is also mentioned. The fact that all the Scottish files were held on one site led the research to focus primarily on Scottish litigation.

Chapter 3 discusses some of the methodological issues which arose in the course of this research. Given its diverse nature - the documentary analysis of case files involved an essentially quantitative summary of the incidence of litigation, a mixed quantitative/qualitative exploration of the nature of litigation, and a largely qualitative assessment of the perceived effects of litigation - there was a need to use more than one research approach, and this is discussed.

To gain access to the legal files, a formal approach to every Health Board and Trust hospital in Scotland was required. One English region (formally a regional health authority) where accurate data covering several years was reputed to be held, and an English city hospital, were also identified, which opened up the possibility of a limited Scottish-English comparison.

In order to gauge the perceived extent and effects of litigation, clinicians were contacted using details principally obtained from the Royal Colleges (Royal College of Obstetricians and Gynaecologists [RCOG] and the Royal College of Midwives [RCM]). These surveys targeted all known practising obstetricians and a large majority (an estimated 85%) of all midwives in Scotland and the two English areas.
Part II explores the incidence and nature of litigation in this field. Chapter 4 describes the incidence of perinatal litigation, and relates in detail how this has changed since 1980. It compares the incidence between different health boards and different hospitals; it looks at how long it takes to raise and conclude a legal action; and provides data on the vexatious issue of damages awards. The chapter provides a comprehensive answer to the question of how much litigation there has been for Scotland and the two English areas.

Chapter 5 describes the types of case (i.e. the heads of claim) which comprise perinatal legal actions (these are explored in more detail in Appendix J), and provides a limited profile of litigants, giving particular attention to those pursuers who make claims concerning brain damaged children. Whereas Chapter 4 stipulated how often people have sued in this area of clinical care, Chapter 5 details the reasons why they do so.

Part III takes legal cases and examines them in greater detail, going far beyond the mere naming of the principal reason for suing. It is divided into three chapters which aim to highlight specific issues which arise in cases.

In Chapter 6 ('Clinical aspects') those clinical factors which affect the origins of legal actions are identified. Some of these, which include specific actions by staff as well as the role of unit protocols and policies, can in theory be targeted by improved clinical training. Levels of supervision, competence in cardiotocograph (CTG) interpretation, the standard of case records, and the notion of patient choice, are all explored.

Chapter 7 ('Critical legal matters') aims to explain some of the issues which affect the course of legal actions, such as the role and competence of solicitors, the essential question of causation, the matter of costs and damages, and reasons for settling cases. The features identified in this chapter are less amenable to targeted improvement by clinicians and their managers, but should be of interest to lawyers.

Chapter 8 examines other influencing factors, which include problems of communication and recollection, the apparent motives which propel patients to become litigants, and the troublesome matter of delays. These features may be responsible for (in turn) creating the clinical atmosphere which can predispose to legal involvement, producing the antagonism on which personal injury litigation thrives, and prolonging the conduct of a case so that pursuer and defender alike may become exasperated.
Throughout Part III possibilities for reform are suggested: these include the role of clinical education, improvements in hospital administration, and better access to competent legal support.

Part IV is based on the second phase of the research, namely the exploration of clinicians' attitudes towards litigation. It reports on two surveys (one of obstetricians and the other of midwives) which examine the perceptions held by clinical practitioners both of the incidence of litigation and of possible reasons for its occurrence. It also explores the features present in the literature concerning the possible causes or effects of litigation (defensive practice, worsening interprofessional relationships, poor levels of supervision, and inadequate training regarding fetal monitoring). It investigates the incidence of complaints against clinicians, probes the matter of communication and rapport (both between obstetrician and midwife, and between clinician and patient), and discusses counselling procedures for those patients who experience a poor clinical outcome or who are otherwise dissatisfied.

Part V brings the thesis to a conclusion, and provides suggestions for risk and claims management strategies. These relate to the education of staff and of patients, the scope of clinical documentation, and the organisation of complaints and claims bureaucracies. One of the areas studied in this research already has a risk management team, and has indicated that it would like to have detailed information on legal cases. Despite this, the research has not been commissioned by any particular agency, and so it has not been constrained by the values or requirements of any outside body.
Chapter 2

Perinatal Litigation: a literature review

Medical negligence litigation has become a much discussed topic in recent years; in particular its effects on the organisation and delivery of health care have been noted as a matter for concern. Such civil litigation occurs within the framework of the law of delict (tort in England and the USA), and is based upon the premise that practitioners ought to be accountable.

The review 1 examines the nature of accountability, and discusses current medical negligence law. It then focuses on the debate about the merits and demerits of a fault-based system, and contemplates possible alternatives, including no-fault compensation. The review then turns its attention to the incidence and nature of medical negligence litigation, and in particular obstetric litigation, and asks how it has come to be assumed that there is a crisis. It highlights the scarcity of accurate and detailed information concerning this important topic, and questions how policy can proceed without such information. It looks at cerebral palsy, one of the most notable features of perinatal litigation, and then examines the situation in the USA, since it has been claimed that Britain is likely to copy this.

Having highlighted the areas which show gaps in our knowledge about this topic, it sets out the rationale for attempting to fill some of these gaps.

Accountability and Compensation

In a modern democracy accountability is highly prized: our elected leaders and many of those in positions of power are held to be answerable for their actions. Greenfield (1975: vii) notes that accountability is an ex post concept, it is retrospective; yet as Etzioni (1975: 126) points out, it is not always equally applied - those groups with higher status or more power are able to make any system more accountable to them.

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1 This review uses references identified by bibliographic searches in the libraries of the University of Edinburgh. 'Sociofile', 'First search' and 'BIDS' in the main library, and 'Lexis' in the Law Faculty library identified socio-legal and legal articles; 'Medline' was employed in the library of the Medical Faculty to highlight both socio-medical and medico-legal publications. In addition Dingwall et al's (1991) 'Medical Negligence: a review and bibliography' provided many further references. From the reference lists in most if not all of these further articles were located.
Accountability can be linked to the notion of justice: in the formal-rational legal model we are all held to be accountable for our actions (and sometimes for our failures to act). Mashaw (1983: 28) considered three types of administrative justice which he described as 'bureaucratic rationality', 'professional treatment' and 'moral judgement'. Whereas moral judgement uses subjective considerations of deservingness, and bureaucratic rationality uses "instrumentally rational routines designed to render transparent the connection between concrete decisions and legislatively validated policy", professional treatment is harder to examine, for it involves a mixture of clinical intelligence and scientific knowledge. While this often appears opaque to the layperson, says Mashaw, "the mystery of professional judgement is, nevertheless, acceptable because of the service ideal of professionalism" (ibid. 28).

The issue of accountability within the health service has been increasingly stressed in recent years; Beech (1990: 2) advocated a radical overhaul of the whole system of complaints, and stressed the need for hard principles of accountability. Initiatives such as the Patients' Charter have focused attention on the theory of clinical and managerial accountability, and have encouraged dissatisfied patients to make formal complaints. Each hospital Trust now has a designated 'Complaints officer', and if a patient feels that redress has not been obtained in this way the Health Service Commissioner (Ombudsman) can investigate the matter. For many years the Ombudsman only had the power to investigate complaints not of a clinical nature; since 1996 this restriction has been lifted, although it will usually be required that a patient approach the hospital's own complaints system as a first step. Recent changes in the complaints framework mean that most complaints must be made within six months of the event in question (DoH 1996).

A significant diminution of the potential for attaining universally-equable administrative justice has been the devolution of responsibility to local hospital Trusts, each of which can interpret guidelines on dealing with patient complaints as they see fit. Reid et al (1995: 297) note the wide variation in such processes between different areas.

The process of accountability may be viewed as a pyramid, with initial (verbal or written) complaints at base level; the number of these which become official data is much smaller, and the number which reach the stage of formal enquiry smaller still (Reid et al 1995). This thesis focuses on those formal complaints which have involved solicitors, and which include allegations of clinical negligence. This may
be seen as a sub-set of the whole category of complaints; without official statistics which admit to the scale of complaints, it is impossible to know how large or small this sub-set is in relation to the overall incidence of complaints.

While allegations of negligence may be seen in terms of professional accountability, the intention here is to examine them from the point of view of the civil law. While professional accountability aims to ensure that the standards of a profession are maintained so that the general public benefits, and has confidence in it and so continues to accord it professional status, civil legal accountability aims to restore someone who has suffered loss through the negligence of another to the position they would have been in had that negligence not occurred. This is restoring the status quo ante.

Medical negligence
To establish negligence, the pursuer must show that there was a duty of care owed by the defender; that there was a breach of this duty of care; and that damage resulted from the breach. The ‘duty of care’ principle stems from the judgement given in the case of Donoghue v Stevenson,2 where it was stated that a duty of care would be owed, for example, by me to “persons who are so closely and directly affected by my acts that I ought reasonably to have them in contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question” (from Lord Atkin’s judgement). Brown (1985: 13) comments: “It should also be noted that the standard or degree of such care will vary....it will not be that of an outstanding specialist in a particular field of work...unless a person sets himself or herself up as exercising such skill.”

The test for medical negligence is laid down in the judgement by Lord President Clyde in Hunter v Hanley in 1955 3: “The true test for establishing negligence on the part of a doctor is whether he has been proven to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care....it must be established that the course the doctor adopted is one which no professional man of ordinary skill would have taken if he had been acting with ordinary care.” This position was reaffirmed in the case of Maynard v West Midlands RHA4 when the House of Lords held that in medicine there is room for a difference of opinion and

2 Donoghue v Stevenson, 1932 S.C. (H.L.) 31 ; 1932 SLT 317
3 Hunter v Hanley 1955 SC 200
4 Maynard v West Midlands RHA 1984 1 WLR 634
practice, and that a court’s preference for one body of opinion over another was no basis for a conclusion of negligence. Hunter v Hanley, a Scottish case, was followed two years later in English law in the case of Bolam v Friern HMC; one jurist, however believes that the Scottish and English tests for establishing an acceptable standard are slightly different. Howie (1983: 199) claims that in Scotland the test for negligence (per Hunter v Hanley) is that no doctor of ordinary skill would have acted in the way alleged; in England the Bolam principle holds that the act is safe as long as it in accordance with a responsible body of opinion. In other words he is claiming that the test in Scotland is tougher than in England. Another (anonymous) writer echoes this point (1990: 326): (s)he notes that in Maynard Lord Scarman said “I do not think that the words of Lord President Clyde in Hunter v Hanley can be bettered”, but in the later case of Sidaway referred to Bolam in detail, and tried to equate Scots law with Bolam principles. As the two are not exactly the same, this commentator claims that the law in England is “in an unsatisfactorily fluid state.” It must be said that this distinction is not a problem which seems to have troubled most writers or judges since the two respective judgements, although the applicability of this test has recently been criticised (see the following section).

Liability cannot be inferred simply because something goes wrong. Lord Ross gave express approval of this in 1981: “If medical and nursing staff were to be found liable when anything untoward occurred, that would have an adverse effect on the medical and nursing professions and on the public generally.” 7 Brazier (1987: 76) picks up on this point of muzzling innovation: “If liability in negligence automatically followed once harm resulted from the adoption of a novel method of treatment, medical progress would be stultified.”

To establish negligence, a direct causal link between the breach of a duty and ensuing damage must be established. It is usually obvious in the case of a health care professional and a patient that there is a duty of care owed; it may also be evident that damage has been caused, but the causal link may be challenged. In Barnett v Chelsea HMC it was established that a man had died after inadvertently drinking from a cup which had contained arsenic; he had presented at hospital with abdominal pains, but was not examined by the doctor but told to go and see his own GP. The

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5 Bolam v Friern HMC 1957 2 All ER 118
6 Sidaway v Board of Governors of the Bethlem Royal Hospital and others, [1984] 2 WLR 78, CA
7 Rolland v Lothian Health Board, 1981 (unreported)
8 Barnett v Chelsea HMC 1968 1 All ER 1068
duty of care owed had been breached; as the man had died it was obvious that harm had somehow been caused; but it was also established that the man would have died in any case - nothing the Casualty Officer might have done would have made any difference - and so there was no causal link.

A legal dispute will often turn to the question of what should have happened in a particular case in order to see whether there might have been a breach of the duty of care. ‘Expert opinions’ may be sought to find out what the ordinary competent practitioner could be expected to do or know, and one of the hallmarks of a profession is that it reserves the right to decide just what is acceptable, as noted by Klein (1973: 3): “It is for professional colleagues, not the user of the services, to judge the appropriateness and the competence of the skills applied.” This view does not go unchallenged, however: Norrie (1985: 187) claims that medicine should be just as accountable as other occupations - “It is nothing short of dangerous complacency to assume that they (doctors) are safe from legal criticism if they do only as their neighbours do.”

This view seemed to be backed up by Sir John Donaldson M.R. when he gave judgement in the case of Sidaway9: “the definition of a duty of care is a matter for the law and the court...in a word, the law will not permit the medical profession to play God.” Despite this courts appear to have been happy to accept, within the bounds of reasonableness, that in medical matters medical people are best placed to decide what is a satisfactory standard of care. A problem does however occur when ‘expert witnesses’ disagree with one another; in Whitehouse v Jordan10 it was felt that ‘expert opinion’ must be seen to be the independent expert opinion of a specialist, and not partisan. “While some degree of consultation between experts and legal advisers is entirely proper, it is necessary that expert evidence presented to the court should be, and should be seen to be, the independent product of the expert uninfluenced as to form or content by the exigencies of litigation. To the extent that it is not, the evidence is likely to be not only incorrect, but also self-defeating.” 11

This view was reinforced by Thomas J in Wisniewski v Central Manchester HA.12 With reference to one of the defence experts he said: "Professor Thomas'
unwillingness to criticise was in my view unjustified and an example of his general disinclination to say much that might be adverse to the defendant's case."

The test for medical negligence then is that there is such a low standard of care given by a health care professional to someone to whom a duty of care is owed, that no practitioner of reasonably competent ability could have given that care, and that damage results from this. Given that the professions themselves are able to determine what is a reasonable standard of care, the test might appear to be a very tough one. This may be seen as one of the benefits accruing to a profession - that it has a strong say in how it will be judged by the law.

Debate about the present system
There are a number of criticisms of the current system. Some argue that a free market contractual approach would enhance the deterrence of future mistakes, with a patient entering into negotiations with a doctor over the matter of liability; others claim that the delictual system neither provides an adequate guarantee of compensation for those wronged, nor deters poor clinical standards, and so advocate a combination of increased regulation and no-fault compensation; still others claim that the problem is due to a high propensity to sue, and so believe that doctors should be protected by restricting patient access to the courts (Dingwall et al 1991: 57). There are also those who question whether the tort / delict system is an appropriate means of trying to provide compensation, because of its reliance on establishing fault rather than need. Some believe that comprehensive welfare provision is more equitable, and may even be more cost-efficient.

The applicability of the Bolam test has been questioned in recent years, specifically with reference to whether it ought to be applied not only to questions of the standard of care but also to causation (the second and third requirements of the principle of negligence). Given that damage must be shown to result from a breach of the duty of care in order to establish medical negligence, Foster (1996: 1098) notes that "Expensively proved breaches of duty are of course worth nothing at all unless they can be linked to loss of a type recognised by the law of tort". Goldrein (1994: 1237) notes that the Bolam test "was nothing more than part of the summing up to a lay jury," and he goes on to characterise it as out-of-date: "The Bolam test has remained unaltered from the time before Russia launched a Sputnik, unaltered since the era before electronic calculators, fuel injected turbo charged car engines, dish washers and hi-fi equipment. Is it a medico-legal Jurassic Park - or is it a 'truth' which for ever we should hold 'self-evident'?" (ibid: 1238).
The Bolam approach is sometimes characterised unflatteringly as 'The doctor's friend', the argument being that if a doctor (or other health care professional) can find colleagues who are deemed to be responsible to say that they would have acted in the same way, then negligence cannot be established. In Hucks v Cole\(^{13}\), however, Sachs LJ explained: "Dr. Cole knowingly took an easily avoidable risk which elementary teaching had instructed him to avoid; and the fact that others say they would have done the same neither ought nor can in the present case excuse him in an action for negligence however sympathetic one may be to him."

This case was decided on the basis of what could be deemed to be taking a reasonable risk. However the law has been reluctant to define the circumstances in which a court would impose a reasonableness test upon the evidence presented to it when that evidence relates to a medical standard of care. In Bolitho v City & Hackney HA\(^{14}\) Dillon LJ said (at 392): "In my judgment, the court could only adopt the approach of Sachs LJ and reject medical opinion on the ground that the reasons of one group of doctors do not really stand up to analysis, if the court, fully aware of its own lack of medical knowledge and clinical experience, was nonetheless clearly satisfied that the views of that group of doctors were Wednesbury unreasonable, i.e. views such as no reasonable body of doctors could have held."

Dillon LJ leaves open the possibility of a court imposing a reasonableness test, but rejects such a move in the case in question, apparently finding the defence’s evidence and experts not to be unreasonable. This followed the straightforward Bolam line which concluded that an act will not be adjudged negligent if it is in accordance with a responsible body of opinion. This was not the approach of Simon Brown J in the same Court of Appeal case: he distinguished applying the Bolam principle to the standard of care criterion, and applying it to the question of causation (around which Bolitho turned). In this instance the argument concerned the failure of a paediatric senior registrar to attend a two-year old with breathing difficulties, and the fact that the child was not then intubated and ventilated. The defendants acknowledged that the failure to attend was a breach of the standard of care, but argued that she would not have intubated even if she had attended; this clinical approach was backed up by senior expert witnesses, and so it was held that causation could not be established.

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\(^{13}\) Hucks v Cole (1968) 112 S.J. 483 (CA)  
\(^{14}\) Bolitho v City & Hackney HA 4 Med LR [1993] 381
While Dillon and Farquharson LLJ both accepted that Bolam could be applied to causation, Simon Brown J dissented: "The test outlined in Bolam and Maynard arose specifically in the context of negligence, and its use as the test of causation is inappropriate. The correct approach is rather to require the plaintiff to establish that the defendant's negligence materially contributed to his injury, which requires the court to consider what probably would have occurred had the doctor not been negligent...The appropriate question was..."Should and therefore would an attending doctor probably have intubated the patient?" This...allows the court to choose between conflicting opinions of medical experts..."

This approach would give considerable leeway to the courts to disregard the evidence brought on behalf of a defender, and is a prospect which some lawyers clearly relish: Goldrein (1994: 1415) claims it is surprising that the courts have allowed the medical profession to retain this sovereignty over evidence when they (the courts) have jealously asserted their rights to determine such matters in other fields. Phillips (1997: 20) notes that "Australian law may be setting an example in asserting the primacy of the court's view of acceptable practice, diminishing the impact of common practice, in the recent decision in Rogers v Whitaker.15" He goes on to note that causation has long been a problem for pursuers. Dividing causation into two stages, the factual (would the damage have occurred 'but for' the negligence?) and the legal (is the cause in question the real or effective cause of the damage?), he observes that "The dividing line between the two stages may not always be clear, and in cases of medical negligence the limitations of scientific and medical knowledge may be such that it is difficult to establish what the causal pathways are. If so, the pursuer will not have discharged the burden of proof and the claim will fail." (Phillips 1997: 35).

Although causation is a problematic notion, attempts have been made to avoid the 'all-or-nothing' approach which the 'threshold requirement' (i.e. establishing causation on a balance of probabilities) imposes. In Wardlaw v Bonnington Castings Ltd16 the concept of a 'material contribution to the harm' was posited; and in McGhee v NCB17 the House of Lords held that a 'material increase in risk of harm' was "equivalent to a material contribution to the harm." However these cases concerned multiple possible causes of a disability, and an attempt to develop such

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16 Wardlaw v Bonnington Castings Ltd [1956] SC (HL) 56
17 McGhee v National Coal Board [1973] SLT 14
approaches received a set back in Hotson v East Berks AHA\(^{18}\): the trial judge (Simon Brown J) had held that the loss of a 25% chance of recovery justified awarding 25% of the damages which would have been awarded had the defendant's negligence been the sole cause of the disability. Logie (1988: 27) notes that "The defendant admitted negligence, but denied that the resulting delay adversely affected the plaintiff's long-term future." Although this decision was upheld in the Court of Appeal, the House of Lords ruled that to succeed the plaintiff had to show causation on a balance of probabilities. This approach was also followed in Wilsher,\(^{19}\) a case in which a child's blindness was believed to have had five possible causes including negligently administered excess oxygen. The Court of Appeal held that the excess oxygen materially increased the risk of harm, but this was unanimously reversed in the House of Lords.

It may be argued that in neither Hotson nor Wilsher was a sufficient threshold reached, but this line of reasoning has been criticised, particularly when the exact process of causation is complicated. Logie (1988: 29) claims that when experts disagree "an 'all-or-nothing' approach (is) particularly inappropriate as it is being given by someone who has little, or more likely, no experience in the area." Noting that in Kitchen v RAF Association\(^{20}\) the negligence of a solicitor was held to be grounds for a client recovering damages due to a lost opportunity, Simon Brown J states in Hotson\(^{21}\): "What distinction can sensibly be drawn between a client going to a solicitor with the chance of a good legal claim if his action is properly litigated and a patient going to a doctor with the chance of a good medical result if properly cared for, such chance in each case being lost through professional negligence?"

The all-or-nothing approach remains, however, something Phillips (1997: 154) describes as "mechanistic". He advocates a greater degree of flexibility so that the law can take account of 'causal contribution'. He also points out that liability "may depend upon an accident of physiology whereby one patient sustains harm and another does not..." (ibid: 44), which is an argument against the theoretical deterrence of a fault-based system. Quantification (measuring liability in proportionate terms) may be preferable in cases "where the causation question is complicated, disputed by both parties and to a large extent unascertainable" (Logie

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\(^{18}\) Hotson v East Berks AHA [1987] 2 All ER 909

\(^{19}\) Wilsher v Essex AHA [1988] 1 ALL ER 871, HL

\(^{20}\) Kitchen v Royal Airforce Association [1958] 1 WLR 563

\(^{21}\) Hotson v East Berkshire HA [1985] 1 All ER 167 @ 176
1988: 29). This comes back again to the matter of experts disagreeing profoundly with one another. Stapleton (1985: 251) points out that there is often poor statistical reliability in determining the causation of illness.

Bolitho remains unresolved - it has been referred to the House of Lords - and the question of whether medical evidence will retain its privileged status (following Bolam) is unclear. Foster (1996: 1100) claims that in cases such as this, where the causation requirement is practically insurmountable, "the fair way to deal with this difficulty is by shifting the burden of proof on to the defendant, and require it to prove that the saving action would not have been performed." However it could be argued that Simon Brown J's rejection of the senior registrar's testimony (and that of the experts who gave evidence on her behalf) is in fact consistent with Bolam if the evidence is rejected because it is not thought to be consistent with 'a responsible body of medical opinion'. Simon Brown J made it clear that he disbelieved the senior registrar, asserting instead that "I have no difficulty in inferring that whichever doctor had attended would have acted in the one way which would have been effective." While his approach appears to assume the clinical aspects of causation (i.e. he believes that failure to intubate made a difference) this does not seem to have been proved; Phillips (1997: 40) points out that "It seems clear that causation must be proved rather than assumed or even elided." However, Simon Brown J could have reached the same conclusion in this case - while still supporting the application of Bolam - by following Sachs LJ's approach, and holding that the failure to intubate represented an unreasonable (and therefore irresponsible) course of action.

The case law referred to here examines medical negligence generally. Comparatively few cases of allegations of perinatal negligence are available: Harpwood (1996) covers such allegations under a wide variety of headings, but has to make frequent reference to American cases, or those either unreported or reported only in the national or medical press.

By and large the public seems prepared to acquiesce in the self-regulation of the professions, although this is not a state of affairs acceptable to everyone. Where there has been more overt criticism within Britain, however, is in the sphere of legal accountability, and in particular a debate about whether a fault-based system is the best way of deciding whether there has been medical negligence. The pressure group Action for Victims of Medical Accidents (AVMA) stresses that accountability is the key, and that therefore a strict no-fault system, whilst superficially attractive, would not be adequate. Not everyone decries the delictual system, however: Fenn and
Whelan (1989) claim that litigation may have some advantages - the fear of litigation may encourage hospitals to employ more doctors and so avoid the mistakes which become inevitable when junior doctors are required to work between 70 and 100 hours a week (in theory the working week for junior doctors is now shorter). The fear of litigation may also induce greater vigilance on the part of doctors, and defensive medicine may in fact constitute safer practice (this is examined below in the section on the effects of litigation). However this view is countered by Hupert et al's survey of physicians (which is considered more fully in the section on the USA below): explaining how the adversarial legal system militates against such positive lessons, they cite an internist who claimed that "You don't improve health care by punishing people." (Hupert et al 1996: 7)

Bowles and Jones (1990: 39-40) note the supposed educative role of a fault-based negligence system, and counsel against adopting the touted panacea of no-fault compensation: "There would...be reason for concern if the policy response to the growing financial worries of medical negligence led almost implicitly to the replacement of it by no-fault." Fenn (1993) notes that removing the need to establish fault can be said also to remove a potentially important source of information about the standard of medical practice; however, he goes on to caution that "This is not to maintain that the fear of litigation is a significant factor helping to maintain standards of medical practice: that is clearly untenable" (ibid. 104).

The Association for the Improvement in Maternity Services (AIMS) is concerned about all aspects of alleged mistreatment of women in maternity hospitals, claiming that the major problem is the accountability of hospital staff. In 1982 AIMS launched the Maternity Defence Fund to help parents who believe they have been wronged to take legal action. In particular it focuses on women who have been given drugs or an episiotomy in labour against their will, and believes that hospital control over case notes and records gives the defence an unjustifiable advantage: it advocates immediate access to records for patients in addition to accountability and compensation where appropriate (see below).

The BMA (1987) point out that the present delictual system relies on establishing fault, which may mean that similar cases of injury will be treated quite differently. For example, a child with brain damage due to encephalitis will get no compensation; a child whose brain damage is due to vaccine damage may get £20,000; and a child who is brain damaged due to negligence during delivery may get hundreds of thousands (or even millions) of pounds.
Ham et al (1988: 26) note other problems with the present system: the procedure is lengthy and expensive; only a small proportion obtain compensation for medically-related injuries; the requirement to establish fault ignores need; there may be difficulty in getting a solicitor with the relevant expertise; the adversarial nature of the law may cause the defence to 'close ranks'; and the deterrent effect is weakened by insurance coverage (and now of course by NHS indemnity). Genn (1989: 33-5) advocates having specialist solicitors, since she believes general practice solicitors usually fail in medical negligence actions, even where they believe their client has a good claim. She notes that “decisions as to whether to abandon a claim, accept an offer or push on to trial are...taken in a context of risk and uncertainty,” and believes that having an experienced lawyer can make a lot of difference. Maclean (1989: 39) also notes that the supposed deterrence of the current system is weakened by the fact that the amount of damages in a case will reflect the severity of the consequences, and not the degree of the negligence involved.

Simanowitz, of the AVMA, claims that victims of medical accidents may encounter a lack of information, difficulty in finding a solicitor who really knows the field, and severe problems of finance (1986: 14): “If (the victim) does not qualify for legal aid, then legal action is virtually out of the question.” Symonds (1992: 3) adds that doctors are often reluctant to act as expert witnesses because of the time involved, the stress of court appearances, and the desire not to give evidence against a colleague: “There is also an acute awareness in all but the most arrogant of clinicians that the dividing line between success and disaster in treatment can be very narrow, and there is a corresponding reluctance to sit in judgement.” In the American context, Brent (1982) criticises the 'professional expert' who specialises in providing testimony - allegedly often unsound or untrue - for litigants, a point reinforced by Manuel (1991: 94): "We have so-called professional plaintiff's physicians, an exceedingly noxious group of individuals...What we see now is some of our most distinguished professors in the US who are testifying for plaintiff's attorneys not once, not twice, but 10-20-30 times a year."

Genn and Lloyd-Bostock (1990: 42-3) note how divisive the current system is since “criticism of a clinician’s professional skill and conduct” is involved, and in their research they cite a Queen’s Counsel: “If you’re a good doctor whose mistake is marginal you are more likely to get pounded around in public for ten days than if you are a bloody awful doctor whose case is settled instantaneously by the defence societies (and now by the employer) as soon as they look at it.” They note that patients often want explanations, not money, yet this is often the last thing they are
likely to get. One claimant noted: "It is an incredibly shattering experience, because I now have no faith, no confidence, either in medicine or the law." (Ibid.)

The introduction of NHS indemnity for hospital doctors in 1990 changed the nature of litigation to a degree. Until then hospital doctors were required to be a member of a medical defence organisation (MDO), one of whose responsibilities was to operate an insurance scheme for their members, collecting premiums and paying out damages payments when a member was held to have been guilty of clinical negligence. Introduced at a time when litigation appeared to be soaring, it was seen by some as a means of buying time for the medical profession, which feared rapidly increasing premiums and a possible haemorrhage of practitioners, particularly from high risk specialties such as obstetrics. Drastically reducing the role and influence of the MDOs, it also placed a much greater financial responsibility on health service employers; how these have responded is discussed below. An audit of NHS indemnity was carried out by Dingwall and Fenn (1994).

While claims concerning injuries to the mother are governed by the Limitation Act 1980 and so should usually be made within three years (the 'date of knowledge' clause), Acheson (1991: 159) notes that some claims concerning children can be made up to 21 years after the event, and comments that there is an "inherent improbability of a valid judgement being reached concerning happenings which occurred 20 years earlier." In addition, "where mental handicap is such that majority (i.e. a mental age of 18) is never attained, a claim can be brought later, indeed at any time during the lifetime of such a person." Halle (1997) reports one obstetric case which took 27 years to arise, and another six years to settle.

At best this may be seen as a fairly haphazard way of organising things, a view leant weight by Lawton LJ in the case of Whitehouse v Jordan22: "The victims of medical mishaps of the present kind should be cared for by the community, not by the hazards of litigation." That the financial stakes are high is illustrated by the detailed breakdown of the damages Lord Milligan would have awarded in the Geddes case had the pursuers succeeded, and these are reproduced in Appendix A. Ashcroft (1996) points out that structured settlements are a key feature of negotiations in cases where life expectancy is a major issue, as is frequently the case with children with cerebral palsy. The financial risk involved in paying out a lump sum for life-

long care was illustrated in the case of Calladine v Nottingham AHA\textsuperscript{23}: in this a child with cerebral palsy unexpectedly died just a week after her parents were awarded £700,000 by the High Court. Following the child's death, the Health Authority announced that it would appeal against the settlement (Anon 1997). Further data on damages is given in Chapter 4.

Reform of the system
The difficulties encountered by patients and parents of patients in trying to find out what has gone wrong in a particular case, and whether anyone is to blame, have led some to call for changes to the present system. The fear that we may be sliding into an American-style litigation crisis has also fuelled the debate; the situation in the USA is discussed below. From certain statements made by the BMA, it is clear that there is considerable support within the professions for the view that a change in the present fault-based system is required.

Changes which have been advocated include appeals for more openness on the part of the health service, particularly with regard to giving explanations and apologies and allowing access to case notes (Beech 1990); procedural changes to speed up the assessment of each case (Clothier 1989); organisational change in the way Trusts deal with the financial side of litigation (Fenn and Dingwall 1995: Easterbrook 1996a); attempts to encourage arbitration or mediation as an alternative to formal litigation (DoH 1991; Dyer 1995); and calls for no-fault compensation to be introduced (Ham et al 1988).

The crux of the delictual system is the notion that it represents a method of calling (in this case) practitioners to account; from the criticisms of the current system it is evident that this is a view which not everyone shares. Bolt, the Chairman of the BMA Working Party on no-fault compensation, put this very forcefully: "...one of the things that confuses us in this country terribly, is this firm belief that the tort system represents a method of accountability. This is, of course, absolute nonsense" (Bolt 1991: 56).

Pinker (1991: 60) - a past president of the RCOG - noted at the same conference that "The present system of compensation now produces very large sums of compensation for a very few of the patients who have similar needs following illness, accident or the morbidity of medical and surgical treatment...any scheme

\textsuperscript{23} Calladine v Nottingham AHA (unreported)
which we eventually devise I think must take into account all those who need, rather than all those who are victims of one or another accident."

The concept of need rather than fault may be seen to complicate matters: establishing fault in legal terms requires that certain procedures are followed; however these procedures may be criticised, they are at least well understood. Mansell (1997: 229) notes that there is a long tradition of compensating those deemed to have suffered through the fault of another, but there is no similar tradition for those who suffer through illness. Decisions based on need would almost certainly be more subjective and difficult to define. This is not to say that no such attempts ought to be made, just that the system may be much more complex.

**Openness**

Beech (1990) claims that women seeking to find out what happened in their pregnancy or labour typically encounter obstructiveness on the part of hospitals, and advocates immediate access to case notes. In theory this right already exists (under the Access to Personal Files Act 1987; the Access to Medical Records Act 1988; and the Access to Health Records Act 1990). These theoretical rights notwithstanding, she claims that “Far too many medical negligence cases involve ‘loss of evidence’, alterations to the case notes, and lying in court in order to protect the hospital or their colleagues (and sometimes themselves). It is time that action was taken to charge those involved with perjury...until the injustice of health authority representatives lying and covering up is properly dealt with there should be no discussion of no-fault compensation... (since) it will not produce answers, (although) it may well produce a smug satisfaction in some quarters, and the hope that people can be bought off and will stop complaining” (Beech 1990: 3). It may be that since this was written, defenders are more willing to provide copies of the case notes.

**Procedural and organisational changes**

One method of speeding up the legal process may be for each side to use the services of the same clinical expert (Clothier 1989). This would reduce expense (one expert’s fee rather than two), and avoid the differences of opinion between different experts which make negotiations more protracted and which heighten antagonisms between the respective sides.

More recent attempts to improve the running of the service from the NHS’s point of view have been the introduction of new arrangements for reimbursing Trusts in Scotland (Scottish Office 1993), and in England with the setting up of the Clinical
Negligence Scheme for Trusts (CNST) and the NHS Litigation Special Authority (NHSLA) in 1995; the CNST now falls within the authority of the NHSLA. This approach does not attempt to change the essential nature of the way the law operates, but aims to help Trusts spread the cost of payments for large damages actions. Effectively an insurance scheme, it requires Trusts to classify legal actions according to their likely financial impact; the data which must be provided in order to secure reimbursement will eventually allow for a degree of audit into the incidence of litigation, but it will be some time before meaningful data are available, and since membership of the CNST is not mandatory, the picture which does emerge may be unrepresentative. The NHSLA does plan to introduce 'league tables' in due course.

The anticipation of the scale of litigation (and consequent damages payments) has been criticised by Fenn and Dingwall (1995: 756) who believe that the situation is not as bad as many Trusts appear to believe. They claim that in over-estimating the scale, Trusts are allocating too much of their finances to the new scheme, so reducing the amount of money which goes to direct patient care. The scale of litigation is discussed below.

Arbitration/Mediation
Clothier (then the Health Services Commissioner) suggested a Clinical Judgement Review Board which would act as an arbiter of cases Clothier (1989). In 1991 a Department of Health consultative memorandum (DoH 1991) mooted the possibility of setting up arbitration panels which would deliberate on cases concerning alleged negligence. The panel would consist of two doctors (one nominated by each side), and a lawyer skilled in medical negligence work; it would work on paper, and have access to case notes and hospital records. Oral submissions would be unlikely, and (it being an English proposal) the Bolam test for medical negligence would be applied. Where there was not unanimity in panel decisions, a majority would suffice, with the lawyer's views carrying greater weight on legal issues. "Legal assistance in the preparation of a case would be desirable," the document notes, but since oral submissions are unlikely legal advice and assistance would be permitted under the Green Form Scheme but not through Legal Aid. The speed and relative informality of this system were intended to benefit all sides, however Capstick et al (1991: 232) claim that a specialist panel may appear attractive, but may become "an arbiter of medical practice instead of deciding the issue of liability." Morgan (1994: 185) notes that the Chartered Institute of Arbitrators submitted responses to these proposals, but no further progress has been evident.
A committee chaired by Lord Woolf, set up to find ways of improving access to justice, has strongly backed the use of mediation in its interim report (Woolf 1996). Now commonly used in divorce cases as well as small scale disputes (such as those between neighbours), it is hoped that this will avoid the adversarial nature of the delictual system. A pilot study co-ordinated by the Oxford Centre for Medical Risk Studies, and funded by a number of hospital Trusts, aims to introduce mediation into medical accident or negligence cases, with a neutral third party acting as a go-between. Backing this move, Desmond, secretary of the Personal Injury Lawyers Group, claimed "The whole thing creates tremendous potential for settling medical negligence claims before they get priced out of all sense of reality" (cited in Dyer. 1995: 770).

No-fault compensation
Perhaps the most fundamental alternative to the present system is no-fault compensation (Gallup 1989; Smith 1990; Dyer 1990). Up and running for many years in Sweden and New Zealand, and advocated for obstetrics in Australia (Fisher 1990), it has been heralded as a solution to the many problems of the delictual system, and its introduction is backed by a major consumer organisation (Which?) as well as the BMA. Ham et al (1988) note that the law is poor at encouraging doctors to do things (one of the supposed virtues of a fault-based system is that it acts as a deterrent, thereby encouraging good practice). Audit and peer review are ineffective as preventive measures, and complaints and disciplinary procedures are often not believed to guarantee accountability. Under the current system, compensation is linked to proof of negligence, so a lottery element is always present.

New Zealand was the first country to introduce a no-fault system under the Accident Compensation Scheme, which was introduced by Act of Parliament in 1974. It was not designed to deal just with alleged negligence or malpractice in medical matters. but to tackle some of the unfairness and inefficiencies of the delictual system: Palmer (1994: 272) claims that “tort law serves to obscure the real problems and prevent them from being addressed.” Under the new scheme "the right to sue for compensation for personal injury was abolished in return for the introduction of a system of 'no-fault' compensation" (Oliphant 1996: 3).
The Accident Compensation Commission (ACC) and its successors\textsuperscript{24} operate the scheme, which is funded from general taxation, and contributions from employers and the self-employed. Payments are “based on loss of earnings, reasonable medical expenses, and other out of pocket expenses. There is no contribution for pain and suffering” (Symonds 1992: 11). A claim is successful if the ACC feels there has been ‘medical misadventure’: it states “It is not necessary to show that there has been negligence on the part of the medical practitioner before a claim will lie for medical misadventure.” Brown and Smillie (1991: 249) note that payments based on loss of earnings "up to a very high salary ceiling" favour the better off disproportionately.

McLean (1988: 152; 159) notes that the ACC was gradually given more discretion, and that therefore the proposed certainty of the scheme became eroded\textsuperscript{25}. She goes on to propose that if no-fault compensation is introduced in Britain, the original New Zealand definition of eligibility should not be copied; Oliphant (1996) points out that lessons learned from the New Zealand experience may be valuable if a no-fault scheme is to be introduced in Britain. Ham et al (1988: 22) note that the New Zealand scheme proved to be very expensive, with expenditure rising sharply: between 1975 and 1988 the scheme’s expenditure rose by 313\% while its income only went up by 122\% in the same period. However, despite the increase in the scheme’s costs, not all felt that the scheme needed to be restricted: Tobin (1991) argues that the term 'accident' must be interpreted broadly - in a non-technical, everyday sense. This stems from criticism levelled at the disparity in treatment under the scheme between accident victims and those incapacitated by sickness (Brown and Smillie 1991). However, despite these views, concern about rising costs and the difficulties encountered by the courts in adopting a rigid (and therefore predictable) definition of compensatable personal injury led to the 1988 Royal Commission on Social Policy which investigated the ACC; this in turn led to the Accident

\textsuperscript{24} This was renamed the Accident Compensation Corporation in 1981. In 1992 this became the Accident Rehabilitation and Compensation Insurance Corporation.

\textsuperscript{25} An unsuccessful attempt was made in ACC v F [1991: 1 NZLR, 234] to include mental distress sustained by the husband of a woman consequent on her own personal injury by medical misadventure; but in ACC v Curtis and ACC v McKee [1994: 2 NZLR, 519] two people, both imprisoned for causing death by dangerous driving, were held entitled to compensation since they were themselves injured.

The new Act tightens the definition of medical misadventure while maintaining the original division of this concept into medical error and medical mishap. Medical error includes cases of possible negligence, which, says Oliphant (1996: 25) "seems to have been the result of a clear policy to exclude altogether the possibility of suit at common law for compensation for medical negligence." Medical mishap is defined as "an adverse consequence of treatment by, or at the direction of, a registered health professional properly given if (a) the likelihood of the adverse consequence of the treatment occurring is rare; and (b) the adverse consequence of the treatment is severe." 26 The first condition was introduced because it was felt that under the old scheme the rarity test had become so watered down by Appeal Authority decisions that costs could not be contained. Oliphant (1996) points out that the rarity test is satisfied if there is a 1% chance of the same outcome occurring under the same circumstances (a difficult point to establish given the inexactness of medical statistics); and the severity test "requires that the result of the treatment should be death, extended hospitalisation, 'significant disability' lasting more than 28 days, or qualification for an independence allowance." This, he says, is part of "a concerted effort to concentrate resources on the most serious cases" (Oliphant 1996: 26). A distinct view is given by Brown and Smillie (1991: 252) who advocate removing the accident criterion altogether, so that all disability which results in incapacity will be embraced. In order to reduce the cost of broadening the scheme, they suggest capping (to the national average level) the income-related loss of earnings benefit.

Concern had been expressed that the removal of the fault requirement had deprived patients of the means of calling negligent practitioners to account (Oliphant 1996), although Collins (1993) claims that, despite a substantial increase in disciplinary complaints against doctors, there is no empirical evidence that the scheme had adversely affected the regulation of medical practice. Under the new scheme, possible instances of clinical negligence may be reported by the ARCI Corporation to the relevant disciplinary body.

Sweden brought in a 'Patient Insurance Scheme' in 1975 which invokes an investigation of injury and resulting disabilities; this exists alongside the delictual system. As Symonds (1992: 11) points out, "the main concern of patient insurance

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26 ARCI Act 1992, s 5(1), as amended by the ARCI Amendment Act (No. 2) 1993
systems are the relatively low level of compensation and the cost generally to the community.” However, the Swedish system must be seen in relation to the existing comprehensive social security provisions. Social security benefits are already paid to victims, and the patient insurance scheme is intended to help those suffering such injuries by supplementing the benefits paid. To qualify for the scheme, a person must be ill for 30 days or in hospital for 10 days, or must suffer permanent disability. Although Simanowitz (1987: 124) notes that the Swedish system strangely does not compensate babies for brain damage which occurs at birth; it is claimed that damages in such cases would be so large as to make the system economically unviable. The Swedish system is funded by capitation payments from the local authorities which administer the health service to “a consortium of private insurers which then manages the claims and their settlements” (Maclean 1989: 38).

Brazier (1987: 146) claims that a no-fault system increases the number of claimants who will get compensation to help them adapt their lives to their disabilities; damage to the doctor-patient relationship through bitter and costly litigation would be removed; and the link between blame and compensation would be lost.

There are worries about the cost of the present system: Rosie Barnes MP, speaking in support of her National Health Service (Compensation) Bill in 1991, claimed that the current cost of litigation may amount to as much as £100m, and also noted that the BMA estimated that by 1996 (under the present system) a total of 13% of all resources available to the average health authority would go towards paying compensation for negligence claims: Easterbrook (1996b) claimed that the cost of medical negligence actions to the Legal Aid Board in 1995 was £24m. The Department of Health (DoH 1991: 4) estimated that in 1990 the NHS spent £45m in meeting medical negligence claims: in 35 cases the damages exceeded £300,000, and the total was £17m; the remaining £28m was spread over “perhaps seven thousand cases,” and averaged out at £6,500 per case. Crimlisk (1990: 947) points out that in 1990 80% of certain payments over £300,000 were met from a government fund established from NHS money held by the medical defence organisations up to January 1st 1990 (when NHS indemnity came into effect for hospital doctors), but this was a finite source and would be quickly used up. Regarding quantum, Ham et al (1988) note that the average amount for all negligence cases was £15,000 (in 1986 prices), but without subdivision into more specific categories this tells us little about how different cases may be treated.
The Pearson Commission (Pearson 1978), set up in 1972 to investigate civil liability and compensation, condemned the delictual system as unpredictable, expensive and unfair, and urged the creation of new disability allowances for all severely handicapped children irrespective of whether their handicap resulted from negligence. However it stopped short of proposing no-fault compensation for medical injuries, although it did so for motor vehicle injuries. Mansell (1997) criticises the Pearson Commission for interpreting its terms of reference too narrowly, and for failing to follow a principled approach to the question of civil litigation: "The almost ad hoc approach they favoured with a new no fault scheme for injuries caused by road accidents; with a specific benefit for severely handicapped children; and with a statutory basis for criminal injuries recommended, did not seem to reflect any clear philosophy." He argues that the opportunity to mount a comprehensive challenge to the fault based system was thereby lost (ibid. 226).

Criticism in the UK of no-fault compensation comes from a number of quarters. Simanowitz (1991: 44) claims that it doesn't address the question of accountability, a point echoed by Beech (1990). Interestingly, in submissions to the Pearson Commission the BMA strongly opposed the prospect of no-fault compensation, claiming that a fault-based system was a guarantor of individual clinical accountability; the BMA also feared state control of a no-fault system, which it felt would encroach on the profession's autonomy. The BMA subsequently changed its mind and supports a no-fault system, although its 'no-fault' proposals have been criticised (Mildred 1989), and the AVMA and AIMS remain opposed to such a scheme.

Clothier (1989: 604) points out that the right to take a fellow citizen before a judge in order to settle a dispute is a fundamental liberty, and questions why doctors (and by extension other health workers) ought to be made exempt from this: is it for reasons of principle, or simply because the current system is so inefficient? He also claims that the no-fault schemes operating in New Zealand and Sweden, far from providing certainty, merely displace the argument so that what lawyers argue about instead is what is admissible as a medical accident. Carson (1988: 7) points out that the concentration on 'cause' (i.e. what is an accident?) rather than effect can be very complicated: the arguments about whether a condition has been caused solely by clinical mistake or whether it has deteriorated through natural progression may be interminable. He claims that if social security and social services were adequately
funded and so could provide comprehensive benefits, the desire to sue could be reduced, and so the need for a no-fault system avoided.

Bowles and Jones (1990: 46) question whether a no-fault system would provide as much of a deterrent as the delictual system; as if to answer this Clements claims that "Experience elsewhere suggests that litigation is the best way forward because it's actually the bit that hurts." However he goes on to note that "It's a very poor doctor who only practises well because of the threat of litigation" (cited in Kinnes 1993); Sloan et al (1995) claim that empirical evidence shows that no systematic improvement in birth outcomes can be shown from an increased threat of litigation.

The current fault-based system for deciding questions of medical negligence has been much criticised, but looks unlikely to be changed in the foreseeable future. Concern about the low rate of compensation for those who have suffered injury or loss has led to changes directed at improving access to justice; these have concentrated on mediation and arbitration, while changes to the way Trusts deal with damages payments aim to ameliorate the financial impact of litigation on the delivery of health care. More openness in dealing with complaints may be a way forward, especially as Trusts struggle to deal with the (anecdotally) soaring incidence of complaints.

The incidence of litigation

Much of the discussion about reform of the delictual system was based on the premise that medical negligence litigation is increasing sharply, so causing financial as well as organisational difficulties for the health service. However, despite the apparent belief among clinicians that this is the case (Pinker 1991; Saunders 1992), there is a dearth of data in the literature about the actual incidence of such litigation in Britain. Tharmaratnam and Gillmer (1995) claim that "Medical litigation in the 1980s increased sharply", but unfortunately provide no references or data to support this claim. Similarly Easterbrook (1996b) asserts that "there has been a 15% rise p.a. in claims against doctors for medical negligence", but does not cite a source for this. Requests for clarification produced no new information.

Dingwall et al (1991: 2) note that the rate of medical error is not known, so its relationship to litigation is difficult to ascertain, although they conclude that only a small proportion of iatrogenic events result in litigation. Felstiner et al (1981: 633) claim that reasons for not suing include "a failure to perceive that one has been injured; such failures may be self-induced or externally manipulated." Dingwall et al
go on to note that the 'long tail problem' - the time it takes to initiate an action - makes discerning a trend problematic: in the USA, year-to-year fluctuations have been noted in some states (ibid. 9).

In 1983 Howie (1983: 193) claimed: “One of the more notable developments in the field of medical law has been the marked increase in the number of actions brought against doctors and other health service staff for professional negligence.” Such received wisdom is difficult to verify, for as Blackie (1985: 563) states, “reliable accurate information as to the number of claims for damages, the success rate, the amounts paid and their mode of disposal is unfortunately unobtainable.”

Ham et al (1988: 8) found that figures for ‘accidents’ were not routinely collected: before NHS indemnity was introduced for NHS hospital doctors in 1990, the Department of Health (DoH) left the concerns of medical litigation to the MDOs. Matters were complicated by the fact that there are three MDOs operating in Britain: the Medical Defence Union (MDU) and the Medical Protection Society (MPS) operate principally for English graduates, while the Medical and Dental Defence Union of Scotland (MDDUS) offers membership to Scottish graduates or graduates from Scottish universities. Even if these MDOs published their own litigation dealings in detail (which they did not), because each represent doctors working outwith Britain this would not have described with certainty the situation in Britain, since the figures which they do publish in annual reports do not identify the proportion of cases which originate abroad.

The Department of Health is now collecting information from health authorities and NHS Trusts on the costs of medical negligence claims, but it will be some time before meaningful figures are available. The Central Legal Office (CLO) of the Scottish Health Service collates information from Health Boards and Trusts on litigation, but is not permitted to disclose the figures involved since the information concerned is the property of the Health Board or Trust concerned. The lack of comprehensive data means that the debate about the scale of litigation has been conducted almost in a vacuum.

The claim that the incidence in the 1980s was rising was leant weight by the MPS (the smaller of the two English MDOs) who revealed that whereas in 1983 about 1,000 claims had been filed with them, in 1987 more than 2,000 claims were filed. However, MPS data are complicated by the fact that they include members in Ireland and dentists (Dingwall et al 1991: 8). Ham et al were obliged to write to regional
health authorities to try and get more information "in view of the limited information held by the DHSS", which then only collected information from health authorities on awards over £100,000; detailed replies were received from the legal advisers of six regions concerning annual claim rates for 1986/87, but this can only give an indication at best of the overall picture (Ham et al 1988: 8), and anyway is now rather out of date. In 1985 the MDU was said to have received about 9,000 cases relating to potential litigation, of which some 600 related to obstetrics and gynaecology, and approximately 80 to brain damage in the infant (Symonds 1985: 433).

From personal requests made to the three MDOs for litigation figures I was told that such are not published for reasons of commercial confidentiality; there was some concern that each might try to 'poach' each other's members, and other insurance companies were believed to be interested in acquiring some of their custom by offering low level subscriptions to doctors working in low risk specialties. Limited (unpublished) data was acquired from MDU files (Hoyte 1994), but even here many of the figures were withheld "for reasons of commercial and philosophical sensitivity" (Hoyte, personal communication).

However, some details were published, including the increase in subscriptions (Ham et al 1988: 8).

Figure 2.1

Annual subscriptions for MDOs

These rapidly increasing figures predate the introduction of NHS indemnity in 1990, and reflects the MDOs' concerns about a possible 'litigation crisis'. In 1990, subscription levels fell, but, as the following chart of MPS subscriptions shows, they
have started to rise again, and obstetrics is targeted as the most critical specialty within medicine.

Figure 2.2

MPS subscription rates 1990-95

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<td>£500</td>
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<td>£1,000</td>
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<td>£2,000</td>
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<td>£2,500</td>
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<td>£3,000</td>
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<tr>
<td>£4,000</td>
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</tbody>
</table>

NHS senior staff with non-NHS earnings:
- □ < £1000 p.a.
- □ > £1000 p.a.
  - Private practice:
  - □ Low risk
  - □ High risk
  - Obstetric risk

The non-NHS earnings limit was raised: * in 1992 to £1100 p.a.; ** in 1995 to £1200 p.a.

Costs, damages and legal expenses for the MPS increased steadily from £10m in 1985 to £22m in 1988 (MPS 1989), so it certainly appeared that the incidence of litigation, or at any rate the expense of litigation, was increasing sharply. However this does not tell us how often people sue and why.

Little, then, is available on the true incidence of litigation. With regard to the number of claims made in respect of brain damaged infants, the then Chief Medical Officer of the Department of Health, Sir Donald Acheson, revealed in 1990 that whereas in 1983 the number had been 50, by 1989 this had risen to an estimated 200, and the probable figure for 1990 was 600 (Acheson 1991: 158). Part of the problem in establishing the incidence is that the research he conducted was with the MDU, which insures about two thirds of the doctors practising obstetrics in England, and an estimate had to be made for the MPS, which insures most of the rest; this does not take Scotland into account at all, except for those doctors trained in England who elect to maintain their MDU/MPS membership while working in Scotland. The 1990 estimates also coincide with the changes in Legal Aid which allegedly led to a surge of claims (Capstick and Edwards 1990). These Legal Aid changes allowed applications brought on behalf of a child to be assessed on the child's income (almost always nil) rather than the parents', effectively allowing all such cases. Acheson notes that despite the declining rates of perinatal mortality, the incidence of cerebral
palsy has remained the same since reliable measurements were started thirty years ago (ibid, 160). What his figures indicate is that there may be a sharp increase in the prevalence of litigation in this particular area; unfortunately the information is limited, and tells us nothing of the wider area of obstetrics. It does however illustrate an apparently growing phenomenon.

A study conducted by Capstick and Edwards (1990) examined 100 obstetric cases from ten health authorities over a seven year period. These showed no particular trend in incidence until 1990 when they claim a sudden surge in numbers coinciding with changes in the legal aid rules.

Figure 2.3

Obstetric claims per year (ten HAs)

While the 1990 figure appears small, it only relates to cases brought by June; the rate appeared to be rising at that time, since the authors note that between April and October 1990 there were 26 claims. Whether this represented a sustainable increase in the number of cases or a 'one-off' surge could not at that time be said.

The number of claims, then, appears to be up, but it cannot be concluded with certainty that the limited available information is representative. Exactly what happens to these claims again is not routinely disclosed. Hawkins and Paterson (1987: 1533) took one hundred files at random from 324 medico-legal cases in the West Midlands Health Authority in 1984. After three years, 73 had been withdrawn, 12 settled out of court, one lost in court, and 14 were still pending, 9 of which were thought likely to go to court. The high rate of abandonment is very striking, and would seem to confirm the findings of the Pearson Commission of the 1970s. Pearson had found that of 500 claims made against doctors, 60% had been abandoned, 34% settled out of court, and 5% had gone to trial; this represented just 25 cases, and 20 of these were won by the defenders. This rate of success for the
pursuers (between 30 and 40%, which includes those settled out of court) compares with a rate of 86% in other personal injury cases (Fenn and Dingwall 1989: 40).

Ham et al (1988: 12), studying one health authority’s figures, claim that the rate of abandonment of claims has actually increased from about 50% in the 1970s to 75% in the 1980s; they identify temporary injuries (iatrogenic infections, fractures due to mishandling or lack of attention, and missed diagnosis of fracture) as the main reasons for claims.

The true incidence of litigation, then, is unknown; limited available information hints at a steady increase, but this is impossible to confirm, especially in England where the data is disparate. In Scotland the data are held centrally, but remain the property of the individual HBs and Trusts, and are not revealed, so in fact even less is known about the situation in Scotland than in England; the picture is very incomplete.

A related matter is the question of who initiates this type of litigation. Dingwall and Fenn (1991: 97) acknowledged that in their study they "were not permitted to link claim records with patient histories so...our data on plaintiffs is very limited." It seemed that if it were possible to obtain this information, building a profile of litigants could be a valuable tool in identifying who might become pursuers.

The nature of litigation
A little information on the nature of litigation - who is sued and why - is also revealed by MDO reports, but, like the information they give out about the incidence of litigation, this is rather piece-meal, and sadly now out of date.

Symonds (1985) reported that the MDU opened about 9,000 cases in 1985 of which some 600 were concerned with obstetrics and gynaecology. In medicine this specialty encompasses both areas, which makes identifying the incidence (or nature) of perinatal litigation difficult. Brudenell (1985) claims that obstetrics and gynaecology was particularly affected by an increase in incidence. Gynaecological cases have tended not to be as 'newsworthy' as some obstetric claims, partly because they do not involve babies, and partly because it is the baby cases which have attracted the largest damages payments, or the possibility of such (McKain 1991; Robertson 1991).

Figures revealed by the MPS in 1988 showed that obstetrics and gynaecology is the clinical specialty most implicated in damages payments:
It can be seen that obstetrics and gynaecology is the area most commonly associated with damages payments, but this doesn’t tell us how what proportion of these were obstetrics and what proportion gynaecology; neither does it tell us about the incidence of litigation, since this only applies to cases in which the pursuer is successful; nor does it tell us of the success rate for pursuers or the scale of the payments. The MPS does acknowledge that those involved in obstetrics and gynaecology made up 3% of their membership at that time, but accounted for 29% of claims made. 3% of the membership incurring 29% of the number of claims and 36% of the number of payments confirms that this specialty is a very high risk one.

Having identified obstetrics and gynaecology as the specialty with the highest risk of claims or payments, some research has gone into exploring this phenomenon. Care must be taken not to confuse the scale of litigation with the scale of payments. Capstick and Edwards (1990: 931) studied 100 obstetric claims which were made to ten English health authorities between 1983 and 1990; they looked at aspects of care to try and identify areas which might be amenable to future quality assurance or risk management programmes. They identified four common allegations concerning substandard care:
Table 2.1

<table>
<thead>
<tr>
<th>Allegations about obstetric mismanagement</th>
<th>n=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inadequate fetal heart rate monitoring..</td>
<td>58</td>
</tr>
<tr>
<td>Prolonged labour</td>
<td>40</td>
</tr>
<tr>
<td>Meconium staining</td>
<td>32</td>
</tr>
<tr>
<td>Improper use of Keillands forceps</td>
<td>20</td>
</tr>
</tbody>
</table>

Of the 100 cases studied, 49 related to a brain damaged infant; this illustrates the point that, while cerebral palsy cases may attract the headlines, there are other reasons why people sue. Unfortunately the authors do not explain what these other reasons were, and while at first it may appear anomalous that there were more cases alleging inadequate fetal monitoring than cases involving brain damage, some of these may of course have related to stillbirths. While 'inadequate fetal heart rate monitoring' claims may include the antenatal period, it is likely that most relate, as do the three other claims, to the 'intrapartum' - or labour - period.

The theme of 'inadequate fetal heart rate monitoring' is developed further by Ennis and Vincent, who looked at 64 obstetric cases in which there was either stillbirth, perinatal or neonatal death, central nervous system (CNS) damage to the baby, or a maternal death. They admit that this was "a highly selected sample that has come to litigation" (Ennis and Vincent 1990: 1365). They identified three major topics of concern: inadequate fetal heart rate monitoring, mismanagement of forceps delivery, and inadequate supervision by senior staff. The complaints made about fetal heart rate monitoring concerned CTGs (ibid. 1365):

Table 2.2

<table>
<thead>
<tr>
<th>Complaints made about CTGs</th>
<th>n=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not done</td>
<td>11</td>
</tr>
<tr>
<td>Unsatisfactory trace</td>
<td>6</td>
</tr>
<tr>
<td>Trace recorded, but missing</td>
<td>19</td>
</tr>
<tr>
<td>Abnormality ignored or not noticed</td>
<td>14</td>
</tr>
<tr>
<td>Abnormality noted and responded to</td>
<td>14</td>
</tr>
</tbody>
</table>

Ennis and Vincent "suggest that middle and junior staff are inadequately trained in fetal heart rate monitoring, and inadequately supervised in the labour ward" (ibid.
1367), and the RCOG seemed to agree that much had still to be done with regard to ensuring that staff understand CTGs and use them appropriately (Beard et al 1993).

Ennis and Vincent acknowledge that their sample is a highly selective one, a point which illustrates one of the dangers of focusing too heavily on litigation figures. An increase in the prevalence of suing for a particular reason does not necessarily indicate that the condition or type of accident in question is itself becoming more prevalent; indeed its incidence may be falling, but despite this more people may be inclined to sue for that reason. Nevertheless, without any information on the incidence of particular conditions or accidents or results, we are left with only a crude indicator of its prevalence, and perhaps a slightly less crude indicator of how society reacts to such occurrences.

James (1991) reports on a study by the Medical Research Council (MRC) which analysed 100 obstetric claims made to the MDU:

<table>
<thead>
<tr>
<th>Table 2.3 100 MDU obstetric claims</th>
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<tbody>
<tr>
<td>Type of claim</td>
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<tr>
<td>----------------</td>
</tr>
<tr>
<td>Brain damaged baby</td>
</tr>
<tr>
<td>Perinatal death</td>
</tr>
<tr>
<td>Operative injuries</td>
</tr>
<tr>
<td>Antenatal problems</td>
</tr>
<tr>
<td>Retained swabs/instruments</td>
</tr>
<tr>
<td>Perineal damage</td>
</tr>
<tr>
<td>Others</td>
</tr>
<tr>
<td>100</td>
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</table>

James (1991: 36) points out that "When studying patterns of litigation it is important to distinguish between claims notified and claims settled. The former are an indication of the patient's view of compensatable damage, the latter those cases in which independent expert advice agrees that the treatment was negligent." While this is undoubtedly true, unfortunately we are not told of the overall success rate of the 100 claims, so we cannot tell how many cases under each head of claim were successful. This is rather less than satisfactory, particularly since an article in a newspaper, reporting the original publication (in the Journal of the MDU) opens with the statement "Claims against doctors following the birth of a brain damaged baby account for fewer than 10% of settlements in obstetric legal actions, contrary to the widely-held belief that they are the main area of medical litigation" (Hall 1991). The context is lost, and the reader is left with the impression that cerebral palsy
cases are relatively insignificant. While they make up only a small proportion of successful actions, the outcome of the case is only one aspect; there is the time involved in investigating the events surrounding the birth in question; the stress and anxiety for parents and staff alike as the past is examined, often in minute detail; there is the fact that the large proportion of parents who sue unsuccessfully under this head of claim may feel hard done by, and there are the almost inevitable repercussions in subsequent pregnancies.

James correctly points out the implications for risk management from this study, including matters relating to counselling of parents, storage of CTG traces, documentation, and the reporting of 'untoward incidents'. Some valuable lessons are drawn, and the study provides much more detail about the reasons for suing than any of the other studies quoted. However, with only 100 cases it is still relatively small scale, and so cannot necessarily be taken as reflecting the situation of obstetric litigation generally.

Analysing the same survey, Doherty and James (1994) point out that the antenatal period is one area which ought to be amenable to improvements in management: the failure to diagnose growth retardation in the fetus, and failing to detect congenital abnormalities, can both in theory be improved by better targeting of screening procedures. They note that failures of communication and supervision in the labour ward may lead to claims; and identify common pitfalls relating to caesarean sections (ibid. 95-7), particularly injuries caused to mother or baby.

With regard to the large number of cases brought under the brain damage head of claim, Doherty and James (1994) note that advances in neonatal care mean that babies now survive who would not have done so previously. This has increased the problem of brain damaged infants, but they caution against seeing the obstetric situation as being predominantly brain damage related: "To concentrate on 'obstetric' brain damage claims gives a distorted view of litigation in the speciality as a whole and diverts attention away from other areas where claims could be foreseen more easily and prevented." Cerebral palsy is discussed in detail in Appendix B.

The nature of litigation has been partially described: it is evident that obstetrics is a major component. Most of the studies cited however have focused on specific intrapartum problems which, while extremely important, do not give the full picture. There is little analysis of the reasons for obstetric litigation, with the exception of the MRC study reported by James (1991) which, as stated, was fairly small scale and
may not have been representative; this is not to deny James' very sensible conclusions on risk management, but the lack of detailed information on the reasons why obstetricians and midwives are sued denies risk and claims management programmes essential information.

Preventability
The notion of preventability is one which crops up frequently in claims: the assertion that an outcome could have been avoided had staff done or not done something in particular. Weight is leant to this line of reasoning by Dillner (1995), who claims that the Confidential Enquiry into Stillbirths and Deaths in Infancy found staff error to be significant. "This human factor included insufficient skills, inappropriate attitudes and apparent lack of senior accountability...The commonest criticism of obstetricians was failure to act appropriately, whereas midwives and GPs were more likely to have failed to recognise problems. All professions are criticised for poor communication" (ibid. 757). Examining 41 cases reported to the AVMA, Vincent et al (1991) claim that many staff had a poor ability to recognise abnormal CTGs, one area which clearly ought to be amenable to improvement.

The faith invested in modern technology and staff expertise is well illustrated by Flamm (1990): "As the grieving mother pointed out, she was 'surrounded by the latest advances in medical technology.' How could such a thing happen with all the specialised medical apparatus we have available?" The large study by Gaffney et al (1994) which examined intrapartum care, cerebral palsy and perinatal death found an association between suboptimal care and cerebral palsy, "but this seems to have a role in only a small proportion of all cases of cerebral palsy. The contribution of adverse antenatal factors in the origin of cerebral palsy needs further study." Masil (1989) also points out that postnatal factors may be implicated.

The possibility that a particular outcome may have been prevented is an area over which litigants inevitably clash; the studies quoted have highlighted the fact that there are several areas which might be amenable to improvement, but as the sections on cerebral palsy below and in Appendix B demonstrate, brain damage is a complex condition for which a simple cause-and-effect analysis is rarely appropriate.

Explanation and disclosure
Of the 41 AVMA cases Vincent et al (1991: 393) note that "Five parents wrote that their primary reason for litigation was to get a satisfactory explanation of how their child was damaged and why." The claim that some people sue in order to get an
explanation has been made by others (Young 1990; Genn and Lloyd Bostock 1990), and it is one feature of claims management strategies that an early explanation of events may "substantially reduce the risk that the patient will seek redress in court" (Ritchie and Davies 1995: 888). Some of the potential pitfalls of such moves are noted by Strunin and Davies (1995).

Effects of litigation
Concern has been expressed that litigation has a detrimental effect on the delivery of health care, partly through its direct effects on staff, and partly through the knock-on effects on the organisation and management of health care. It has been claimed that recruitment to obstetrics in particular has been affected (Pinker 1991: 4), the problem being much worse in the USA (see below), and that litigation encourages defensive medicine (Simmons 1990). Dingwall et al (1991: 46) note the difficulties in assessing the scale and importance of defensive medicine through conducting self-report studies, claiming that such research tends to introduce bias. Change in practice is multi-factorial, and it is hard to isolate the effect of the fear of litigation on clinical practice (ibid. 49).

Retention within the specialty is claimed to be difficult (Ranjan 1993), although Saunders (1992) cites an RCOG study which found that medico-legal problems played a less important role in career choice than expected; however early retirement has apparently become much more attractive for obstetricians (Brahams 1991: 1597), although how much of this may be due directly to the effects of the fear of litigation is not known. Both the RCOG and RCM have responded to this issue by producing booklets for clinicians (Chamberlain 1992; Edwards and Mason 1993).

Black (1990a: 36) notes that staff who have been involved in litigation may react by adopting a 'risk avoidance' strategy: "Doctors may be...avoiding specialties, procedures, and patients that they perceive carry a high risk of leading to a malpractice claim." Alternatively, 'defensive medicine' may be seen in terms of risk reduction - i.e. doctors carrying out more tests and investigations, and intervening sooner, than they would otherwise; an increase in the number of diagnostic tests (such as CTG) and the rate of caesarean sections is seen by some as evidence of this (Francome 1986), although the temptation for obstetricians to be influenced by the plaintive 'if only a caesarean had been carried out' is criticised by Roberts (1993). In addition, Dingwall et al (1991: 50) note that the caesarean section rate has increased in countries which have not seen a similar increase in litigation.
Clements (1991: 424) points out the difficulty in deciding what constitutes defensive practice: "I suspect that one man's defensive medicine is another man's risk management." This illustrates the imprecision of the whole subject, although Ennis et al (1991: 616) claim that "Our data indicate that tests deemed to be inaccurate are used in clinical practice because some obstetricians fear litigation." If this is so, then clearly it is a cause for concern: inaccurate tests may lead to a greater level of intervention, causing greater morbidity and personal distress, as well as depleting resources unnecessarily. That the health service has a limited budget is pointed out by Lyall (1988: 334) with reference to the costs of compensation: "People don't seem to realise that in supporting the drive for compensation they could be spending their own heart attack money." A finite budget means that resources must be deployed wisely; Bowles and Jones (1989) note that the uncertainties of litigation make budgeting troublesome, a point echoed by Fenn and Dingwall (1995) above in referring to the new insurance scheme for Trusts.

A deteriorating clinician-patient relationship can be both cause and effect of an increase in litigation, according to Carson (1988: 6): "As increasing litigation takes place, clinicians become more anxious about, and more distant in, their relationships with patients. As patients feel distanced from their doctors, they feel less loyalty to them and to the NHS and will be more willing to sue." Practitioners may feel their clinical autonomy is constrained by defensive medicine, but it may be more constrained by Trusts insisting on certain policies or protocols: Miller and Harrison (1993: 973) point out that Trusts will have "a powerful financial stimulus to monitor more closely the quality of care their (employees) deliver." It is not inconceivable that Trusts may charge a department or directorate for the costs of a damages award (Dingwall et al 1991: 55). The concerns obstetricians have to safeguard their autonomy is asserted by Symonds (1987: 848): "There is a strong argument now to begin to examine critically the nature and extent of litigation in obstetric practice before it confines everyone to a straitjacket of clinical conformity."

Dingwall (1994) is less pessimistic about the effects of litigation on health care: "The claims of a litigation crisis have been vastly exaggerated...From the perspective of a health planner, medical negligence litigation ought to be no more than an irritant, a small cost which it would be desirable to control or reduce." Nevertheless, it appears from the literature that defensive clinical practice may be a significant factor; unfortunately the problem has not been quantified in any meaningful way, so that the imprecision of the term remains undiminished. This gap in the literature is a hindrance to any health managers trying to tackle the potentially expensive question
of defensive practice. The possibly detrimental effects on health care, due to increased interventions and expenditure resulting from the over-use of tests, should certainly be a cause for concern to health planners.

Risk prediction and management
If those patients who carry a high risk of a poor outcome can be identified well in advance, in theory interventions and treatment can be targeted so that such outcomes are reduced in incidence and dissatisfaction levels in patients minimised; this ought then to reduce the number of legal cases.

Dingwall (1991) identifies four components of a risk management programme: the systematic identification of risk; the prevention of adverse incidents; the minimisation of claims by rapid and sympathetic reactions to poor outcomes; and active claims management to ensure that documentary evidence is thorough. Dingwall and Fenn (1991) advocate exploring and developing a 'culture of safety' in health care to try and minimise risk.

Predicting risk is problematic, but certain definitions have been reached. Lowe et al (1987) devised a low-risk definition in order to compare mothers delivering in an isolated GP unit and a specialist maternity hospital; Gaffney et al (1994) produced a list of criteria which indicated which pregnant women ought to be considered high risk. These studies looked at a number of demographic and personal details, including existing maternal illness and previous and current obstetric history. Despite identifying such criteria, clinicians have often encountered difficulty in applying what might be termed appropriate treatment; this may be due to staff differences in interpreting the criteria, availability of resources, or the choice or consent of the woman concerned. In terms of identifying clinical aspects which are amenable to organisational change, the study cited by James (1991) above highlighted specific areas such as communication, counselling, clinical competence, and case notes. Some of the difficulties encountered in the practical application of these moves are discussed in the staff surveys.

Control and choice
These two aspects are critical in modern health care, with an increasing emphasis on the rights of the patient. Maternity care in particular has seen some of the most intense debate on this subject (DoH 1993), with a growing body of opinion demanding minimal obstetric intervention (Tew 1986). The belief on the one hand that pregnancy and labour are essentially normal life events, and the (rather clichéd)
assertion that "no pregnancy or labour is normal except in retrospect" (cf. Beazley 1995) on the other, define the battle lines from which this argument is fought. Of the belief that some cannot cope with the responsibility which comes with choice, Mander (1993: 23) retorts "this argument has a pathetically paternalistic ring to it."

There is a debate as to whether obstetricians ought to see women whose pregnancies are uncomplicated (Walker 1995; James 1995), with some claiming that the midwife is the practitioner best placed to deal with such pregnancies (Thomson 1991). One method for a labouring woman to assert control has been the implementation of birth plans; however when a labour does not go according to plan, it is vital that changes to the anticipated course of events are carried out with the consent of the woman (Dimond 1993).

Whether the desire among obstetricians to ensure a good clinical outcome derives from a paternalistic desire to maintain control, or from a fear that each woman is a "potential litigant" (Bastian 1990: 340), is a matter for debate, and is explored in Part IV. The view that a good clinical outcome (a healthy mother and baby) is the only criterion for evaluating the success of a pregnancy is one criticised by Beech (1986), who takes the view that maternal morbidity (both emotional and physical) in particular has been a problem invisible to most obstetricians. If the problem is largely invisible, then the dissatisfaction expressed by mothers will be largely unintelligible to the clinicians involved, yet this may be a factor in deciding to sue.

CTG
Cardiotocography (CTG), also known as Electronic Fetal Monitoring (EFM), is one aspect of perinatal care which has been highlighted from the legal standpoint: Vincent et al (1991) claim that deficiencies in staff interpretation of CTGs have at times resulted in poor outcomes and subsequent litigation. However the supposed benefits of EFM are not universally acknowledged. A study among high risk patients by Haverkamp et al (1976) found that "The presumptive benefits of EFM for improving fetal outcome were not found."

A study of premature infants by Luthy et al (1987) concluded "...compared with periodic auscultation, the additional data from continuous electronic FHR monitoring do not improve clinical management of premature labour enough to reduce intrapartum acidosis, perinatal morbidity, or perinatal mortality." Another study (Shy et al 1990) with premature infants found essentially the same, but its mention of a significantly higher incidence of cerebral palsy among the
electronically monitored group led one commentator to conclude that the EFM "was responsible for three times as many cases of cerebral palsy in premature babies when compared with premature babies who were not subjected to EFM" (Beech 1992: 4). The original authors do not make this assumption about a causal relationship; such commentaries highlight the sometimes charged atmosphere surrounding this debate.

The large scale Dublin randomised controlled trial of intrapartum fetal heart rate (FHR) monitoring (MacDonald et al 1985) concluded that continuous monitoring was beneficial in reducing the incidence of neonatal seizures, but suggested this was due to shorter labours in the continuously monitored group. Murphy et al (1990: 38) note that continuous CTG monitoring has become integral to obstetric practice, "despite the fact that no clear evidence exists for its efficacy, especially in low risk pregnancy." Their study found a low degree of specificity (false positives) - i.e. staff diagnosing fetal compromise when it did not exist, and conclude that this is one of the main reasons for current dissatisfaction with this method of monitoring. They stressed the need to view the CTG in conjunction with other assessments (such as fetal blood sampling [FBS]), and not as the sole indicator of the fetal condition. Despite this, the use of FBS varies enormously. Keegan et al (1985) also found a high degree of false positives and false negatives in CTG interpretation. Ennis (1990) points to a high degree of over-confidence in the ability to interpret CTGs among practitioners.

Interpretation of CTGs has been shown to vary not only between individual practitioners, but also when the same practitioner examines the same trace twice (Nielsen et al 1987). With such a low level of agreement about interpretation, it is perhaps surprising that the CTG still forms such an integral part of legal wranglings when the issue is a brain damaged baby. Grant et al looked at babies born with cerebral palsy in the Dublin trial, and concluded that "intrapartum FHR patterns do not seem to correlate with later cerebral palsy...suboptimal intrapartum care, in particular failure to respond appropriately during labour to an abnormal FHR pattern, has been shown to be associated with about a 6-fold increase in the risk of very early (<48 hour) seizures but not with an increased risk of cerebral palsy; and...less than 10% of cases of cerebral palsy are likely to be related to intrapartum care" (Grant et al 1989: 1235).

The whole topic of CTG is one which divides many practitioners and patients. Its importance in legal terms is hard to underestimate, since it often provides a continuous record of one aspect of intrapartum fetal well being, despite its poor
predictive value for cerebral palsy. Staff attitudes towards their ability to interpret CTGs, and its level of use and safety are explored in Part IV.

Cerebral palsy

Cerebral palsy has been such a feature of recent litigation that a short discussion is required to explain why it has attracted so much attention; an outline of the condition is given in Appendix B. Acheson (1991), a former Chief Medical Officer, saw cerebral palsy as a serious threat to obstetrics and midwifery; this reflected the belief in an apparently inexorable rise in legal cases concerning cerebral palsy throughout the 1980s. However, it must be understood that there is no simple linear equation between obstetric mismanagement, brain damage, and large amounts of compensation.

Paneth (1993: 96) observes that "A heterogeneous group of disorders are clustered together under the term cerebral palsy," and stresses the importance of not assuming that all major disorders of development are closely linked aetiologically. He notes that mental retardation, epilepsy, autism and cerebral palsy are distinct aetiologically, clinically, and in terms of prognosis. Despite these distinctions, it is the term cerebral palsy which has come to encompass most forms of cerebral dysfunction in the child; while this may be unsound, it would appear to be commonly used, and even used synonymously with the lay term 'brain damage'. Of this term one writer remarks that "the word damage implies that some injury has been caused by obstetric management" (Anon 1989: 1251).

Towbin (1986) touches on the condition's legal considerations, commenting that (in the USA) most obstetric malpractice suits involve an infant with cerebral palsy: "If the case goes to trial, early on the jury is presented with physical evidence, an infant with cerebral palsy, a crippled, pitiful infant..." Towbin claims that many obstetricians concentrate solely on the clinical basis of the law suit, and ignore the aspect of pathogenesis, often failing even to obtain an accurate assessment of the neurological disability which forms the basis of the suit. Although a pursuer can ask for a jury to be called for a reparation case in the Court of Session, in practice this is extremely rare, and cases are heard (in the first instance) before a single judge.

Freeman and Nelson (1988: 241) state: "Intrapartum events do account for a minority of cases of neurologic injury," but that "to attribute cerebral palsy to peripartum asphyxia, one must have both an absence of other demonstrable causes and the presence of a sequence of signs during labour, delivery and the neonatal
period.” The case is put most strongly by Ann Thomson (cited by Black [1990b]), a paediatrician with the National Perinatal Epidemiology Unit at Oxford, who describes British studies and concludes that neither measures of birth asphyxia nor quality of intrapartum care are related to cerebral palsy. However the assumed link between cerebral palsy and birth asphyxia persists, and this is blamed for a rapid increase in cases alleging negligence in the late 1980s (Acheson 1991). Without an understanding of the relationship between birth asphyxia and cerebral palsy it may seem evident that a failure to diagnose hypoxia in labour, and act upon it, causes cerebral palsy and therefore constitutes negligence on the part of staff; how clinicians have responded to these suggestions is explored in Chapter 10.

Taylor (1992: 7) believes that the years since 1985 have seen more cases brought under this head of claim, but that, paradoxically, a greater proportion fail: "I think this must represent a greater awareness in parents of the possibility of obstetric factors being associated with suboptimal medical care." While understanding the possibility of obstetric causation, there is apparently not a corresponding understanding of alternative (more likely) causes. At the same conference Watt (1992) stresses the need for lawyers to accept contemporary scientific opinion on the causes of cerebral palsy. Thomison (1991: 944) believes that in the USA lawyers really do understand this, but are not going to admit it "as to do so might preclude their turning a dishonest dollar or so here and there."

Press reports tend to highlight cerebral palsy rather than other obstetric cases, partly because they involve a child, and partly because the sums of money which may be won are so large compared with other personal injury litigation. Doherty and James (1994: 92) claim that this concentration on brain damage cases diverts attention away from other areas of obstetric practice in which claims are more easily foreseen and prevented. It will be remembered that the MPS subscription levels have risen sharply since 1990, and that the three levels of insurance risk were low, high, and (highest of all) obstetric. This logic is driven by the large amounts in damages which are paid when negligence in such cases is established.

McKain (1991), in commenting on one unsuccessful action, mentions that the parents would have been awarded £1m had they won. The bandying about of such figures may make a story more emotionally appealing, but may also distort the story. From a copy of the judgement in this case I discovered that although the amount claimed was just over £1m, even if the case had been successful the judge would have awarded £770,000. Robertson (1992) notes that in another case £800,000 is
agreed in an out of court settlement (strangely after the court hearing but before the judge could produce his decision). Again, the large sums involved apparently make the case newsworthy.

Cerebral palsy is a complex condition, but one which some find it preferable to simplify. It has great emotional appeal in terms of news-worthiness, and represents a significant threat to the financial stability of Trust hospitals (the section on quantum in Chapter 5 will make this point very clearly).

Litigation in the USA

So far I have deliberately confined the discussion on litigation almost exclusively to the situation in Britain. Much has been written about the North American experience, and there have been claims that Britain is moving towards an American-style litigation crisis, but there are a number of reasons why the US literature and experience should be viewed with a degree of caution when attempting comparisons. For such topics as cerebral palsy, I have cited US studies, because the theories which have been mooted and the research which has been carried out can apply equally to Britain and the USA. However the direct experience of perinatal litigation is different. In this section for consistency I use the terms 'plaintiff', 'defendant', and 'tort' rather than pursuer, defender and delict.

The USA has a fault-based civil law system similar to that operating in Britain; however, the award of damages in the USA is higher: juries routinely sit in US courts for negligence cases, which provides a plaintiff's lawyer with the opportunity of playing on the jury's sympathy, a ploy criticised by Relman (1990), and above in the section on cerebral palsy by Towbin (1986). There are contingency fees for lawyers - these mean that the lawyers will take up to a third of the award if their clients win the case, and nothing if they lose. Some argue that this gives an incentive to lawyers to make extravagant claims for damages. In part the awards need to be higher, since the cost of looking after someone with a disability (such as a brain damaged child) must be borne principally by the family, whereas here there is (for the time being at least) the NHS which can take some of the strain through providing respite care, and the Benefits Agency, which administers incapacity benefit (formerly invalidity benefit) for those who are chronically sick and unable to work.

Lawyers are allowed to advertise in the USA in a way which many would find unacceptable in Britain. Manuel (1991: 95), referring to a television advertisement in which a classroom scene sees just one child in the class being inattentive and staring
out of the window, paraphrases the advertisement (perhaps caricaturing it), saying "If your child has a learning disability, it could have been caused by malpractice during the birthing process, call your friendly attorney."

An extreme case is noted by Illingworth (1987: 14): in Chicago in December 1986 a plaintiff was awarded $32m for a child's 'brain damage', ascribed to "failure to monitor the heart adequately." A possible side effect of such high awards is that insurance companies may be encouraged to settle 'frivolous' claims out of court rather than risk losing much more after a court hearing.

Juries
The question of whether juries are the appropriate mechanism for deciding court cases (both criminal and civil) has been debated at length and for many years in the literature. Over fifty years ago Jerome Frank asserted that "the jury applies law it doesn't understand to facts it can't get straight" (Frank 1945), and Vidmar (1989) notes that Chief Justice Warren Burger complained in 1971 that "juries are not competent to deal with the complex issues that come to trial in the federal courts" (Burger 1971). In appraising Kalven and Zeisal's seminal work 'The American Jury' (which only reported on criminal cases), Hans and Vidmar (1991) note that many of the criticisms levelled against juries, for example that they are unable to understand complex cases, have not been borne out by any empirical data. Kalven and Zeisal's (1966) analysis is based on work carried out in the 1950s, and Hans and Vidmar (1991: 349) concede that "Their important conclusions that juries understand the evidence and wage only a modest and polite war with the law could be time-dependent." This acknowledgement reflects the developments in jury selection since the 1950s, since when the composition of juries has been changed to reflect more accurately the local community, although the process of jury selection remains controversial. Vidmar (1996: 97-8) notes that "Jurors today are often selected on the basis of their lack of knowledge of the crime, rather than their stated ability to be impartial; or selected on the assumption that they will be inclined to view themselves as representing the perceived interests of their own racial, ethnic, or gender group, rather than deciding the case on the basis of the trial evidence."

In general there are three specific criticisms which have been levelled against the jury system: they are thought to be unable to understand complex evidence; they are believed to be biased against defendants, particularly 'deep pocket' defendants; and they are said routinely to award large amounts in compensation. With regard to the first criticism, Hans and Vidmar (1991: 348) concede that "Juries of the 1990s...
much more scientific, technical, and expert evidence than they did three or four decades ago. It is appreciated that not everyone will be able to absorb complicated evidence, for example about degrees of neonatal asphyxia or encephalopathy and their likely neurological sequelae. Vidmar and Schuller (1989: 142) note that Rosenthal (1983) claimed that in complex cases jurors may "ignore the evidence and instead rely on the credentials and demeanor of the expert and what they perceive to be her or his conclusions." However, Rosenthal's conclusions were based on interviews with only eight jurors, and on reviewing other literature Vidmar and Schuller disagree with this finding: "Jurors do not appear to suspend their own judgment in deference to the expert. The expert's testimony is evaluated in the light of the juror's own experience, common sense, and recognition of the adversarial nature of the trial process" (Vidmar and Schuller 1989: 173).

With regard to the questions of pro-plaintiff jury bias and exorbitant damages awards, Daniels (1989) claims that the attacks on juries are part of an agenda constructed by (among others) the insurance industry. 'Horror stories' are used in insurance industry advertisements to depict juries as biased against defendants: "This imagery clearly intends to instil fears and anxieties which can be eliminated only through civil justice reform" (ibid: 285). Such 'agenda-building' is intended to deflect attention away from the real cause of recurrent malpractice crises which, says Daniels, is the insurance industry's boom and bust business cycle: "The sheer outrageousness of the stories summarises the crisis and the causal role of juries and the civil justice system. The horror stories evoke a widespread feeling among citizens that a system permitting such anomalies to take place must need immediate and fundamental reform" (ibid: 294). Vidmar et al (1994) found in an experiment which compared attitudes towards iatrogenic and motor accident injuries that juries did not penalise physicians unduly when assessing damages for pain and suffering. Greene (1989) points out that in fact little is known about how juries calculate awards. While acknowledging that juries may sometimes be biased against corporate defendants, and "may fuse their sentiments about liability with decisions about damages," she goes on to assert that jurors' reasoning is frequently involved and sophisticated, and is not the simplistic 'single sum' approach advocated by some critics (ibid: 246).

While Daniel's claim that the debate about a 'crisis' is led largely by the insurance industry has some merit (in his article he includes ten advertisements by insurance providers which make this point), the absence of obstetric provision in certain areas of the USA, due to a lack of insurance cover (see below), is difficult to describe as
other than critical for those who need such a service. Calling for a large scale jury study along the lines of Kalven and Zeisal, Hans and Vidmar (1991) conclude that there is no empirical data to confirm many of the attacks made on juries.

**Incidence of litigation**

The perceived (or constructed) litigation / malpractice crisis must be examined in context, with the vital question being how often people sue. A study in California in the mid-1970s showed that only 10% of hospital patients suffering negligence due to medical staff filed claims, and only 40% of these (i.e. 4% of the total injured) received any compensation (Danzon 1986: 2002). This comparatively low incidence of litigating was reflected in the large-scale Harvard Medical Practice Study, which examined over 30,000 case records to determine the incidence of medical negligence. It concluded that accidents were far more likely (by a factor of ten) to occur in hospitals than in other workplaces: there was one disabling injury for every 100 admissions to hospital, and one in four injuries was caused by negligence, but only one in eight victims of negligence actually filed a claim.

Reporting the study, Brennan et al (1991) concluded that adverse events occurred in 3.7% of New York hospitalisations in 1984 (a total of 98,609 adverse events). 27.6% of these (n=27,179) were thought to be due to negligence, which, the authors point out, all could have led to successful litigation. However, they acknowledge that this assessment could only identify the incidence of injuries caused by negligence, and not the incidence of negligence itself: "Our figures reflect not the amount of negligence, but only its consequences" (ibid: 373). With regard to the views of medical staff, they note that "in the records with evidence of negligence, physicians disagreed frequently about the extent of substandard care...(they) find it difficult to judge whether a standard of care has been met" (ibid: 374). These results, which indicate a significant lack of awareness among doctors about what constitutes an acceptable level of care (and, implicitly, what might constitute grounds for civil legal action) are reflected in the studies by Hupert et al and Shapiro et al (considered below).

Leape et al (1991), reporting the same study, concluded that a majority of the adverse events (58%) were attributable to management error. Acknowledging that not all adverse events are preventable, such as an unpredicted reaction to a drug, or bone marrow suppression following chemotherapy, they conclude that reducing the risk of adverse events requires several different approaches. Among these are on-going research into illness and its causes and treatments; the effective dissemination
of guidelines and standards for practice, in part through in-service education; and "the development of better mechanisms of identifying negligent behavior and instituting appropriate corrective or disciplinary action" (ibid: 383)

Leape et al (1991: 383) also acknowledged that error prevention requires "attention to the systemic causes and consequences of errors, an effort that goes well beyond identifying culpable persons." The analysis of error in the hospital setting has been examined by Bosk (1979) and Daniels (1992). Daniels notes that "The dynamics surrounding the organisation of medical work are themselves another source of uncertainty in the work environment as well as often being an impediment to the management of error" (ibid: 123). He goes on to point out that an error is only so labelled in retrospect, and that there are a variety of methods of dealing with an error which depend on its perceived severity. These range from a 'private talk' with the person responsible ('reading the riot act') to public admonition (e.g. on a ward round), formal reprimand and invoking of the disciplinary procedure, and even dismissal (ibid: 133). He asserts that the complexity of the organisation, with different units and subspecialties failing to appreciate each other's needs while jealously guarding their own autonomy, creates uncertainty and makes errors more likely. The interaction of personnel from different disciplines also creates a situation where disagreements over the organisation of care (and nursing staffing levels are a particularly acute example of this) can lead to error.

Bosk (1979) examined the role of 'superordinate' surgeons in controlling the mistakes of junior colleagues, and in reviewing the performance of their peers. He found that there was a significant distinction between errors deemed to be technical, and those thought to be 'moral': "Technical errors are the occasion for restitutive sanctions, while moral errors are an occasion for repressive ones" (ibid: 169). This aspect of morality is picked up by Hupert et al (1996: 4) who found in their survey that "A larger number of respondents equate competence not with expertise but with character - namely, the moral character of the practitioner" (original emphasis), and that consequently doctors who were sued viewed the legal action as an attack on their integrity. Bosk's study examined how errors were labelled and dealt with 'in-house': how the surgical superiors in the hospital approached the matter of their junior's performance. It is important to stress that this study did not look at cases of negligence only: negligence is in fact a small sub-set of the category of errors. What patients think about such errors is not reported, although one conclusion of the Harvard study was that "Contrary to doctors' impressions, injured patients do not sue at the drop of a hat, encouraged by juries who bend over backwards to dip into the
deep pockets of malpractice insurers in order to do something for needy victims" (Weiler, cited by Gray [1993: 478]).

However, despite such apparently reassuring evidence of an apparent reluctance among patients to sue, other data appears to confirm an upward trend in litigation: Whelan' (1988: 71) notes that between 1970 and 1986 the number of claims per insured physician in the USA went up by more than four times. A reason for the higher rate of claims is suggested by Quam et al (1987: 1597): "Patients who have paid directly for their care, through a mixture of insurance premiums and contributions out of pocket, seem more likely to feel aggrieved when treatment fails." However, this does not account for the recent increase. Sloan et al (1989: 3291) found that "physicians with relatively prestigious credentials had no better, and on some indicators, worse claims experience", and they conclude that those who were sued were less likely to make subsequent changes to their practice, so contradicting one of the supposed educative roles of a fault based system. However it is not in doubt that increasing litigation is a matter of serious concern (Freeman 1992).

A survey carried out by the American College of Obstetricians and Gynecologists (ACOG) in 1987 showed that 71% of their members had been sued for negligence at least once, and 26% had experienced three or more claims (Acheson 1991: 160). These figures accord with those of Danzon (1986), who reported that 73% of obstetricians had been sued at least once. Dworkin (1989) believes that the increased tendency to litigate resulted from a growing awareness of the power of the law as a force for good, which stemmed largely from the civil rights movement of the 1950s and 1960s. Baldwin et al (1991: 1050), who found that the overall rate of obstetric malpractice claims for 1982-88 was one claim per 3125 deliveries, claim that insurers should "consider basing obstetric malpractice premiums on numbers of deliveries rather than specialty." Ward's analysis of 500 obstetric and gynaecological malpractice claims found much the same reasons for suing as the reasons identified in the English surveys noted above (Ward 1991).

Midwives in the USA have also been implicated, although Robinson claims that this is unfair. She describes how an ‘insurance crunch’ has hit midwives, despite the fact that only 6% of midwives have been named in malpractice suits, compared with the much higher figures for obstetricians noted above (Robinson 1986: 1015). Midwives
tend to work with women who are deemed 'low risk', and, it is claimed, they develop closer links with those in their care: they (midwives) cite a breakdown in the doctor-patient relationship as contributing to malpractice suits. There is increasing specialisation and subspecialisation within medicine, and this has greatly altered the doctor-patient relationship: doctors are now strangers, no longer family friends. In addition, some commentators claim that the greater role of technology has meant a greater potential for mistakes. “Consumerism and somewhat unrealistic expectations about the capacities of modern medicine,” she notes, “have combined to make patients less trusting and more willing to blame the doctor for an adverse outcome” (ibid: 1017-8).

That the name of American midwives should be tainted by malpractice because the obstetricians are having difficulties may be unfair, but it appears that the problem lies in the availability and cost of insurance. Danzon (1986: 2001) reveals that by 1986 on Long Island neurosurgeons were paying premiums of more than $100,000; and that in protest at rising malpractice liability 234 Massachusetts physicians withheld their care for two weeks. This 'strike' strategy was not the first of its kind: Browning (1986: 39) reports that in 1976 thousands of southern California doctors had walked off their jobs in protest at a 327% increase in premiums. One option is for the midwives to self-insure under the aegis of the American College of Nurse-Midwives (ACNM) which, since it is not a profit-making body, can keep the premiums low. The relatively infrequent number of malpractice claims against midwives should lend a certain stability to the scheme, since it has been the suits against doctors which made the insurance field unstable.

Effects of litigation

More worrying from the point of view of doctor-patient relationships is the report that a senior member of the American Medical Association claimed that "Physicians are increasingly seeing every patient as an adversary" (Browning 1986: 39), and the claim by Casselberry (1985: 630) that family physicians are being squeezed out of maternity care by the threat of litigation. The study by Hupert et al (1996) concluded that physicians were often unaware of the true legal test for negligence, and (for this reason and others) frequently viewed legal actions as an attack on their moral character. As a result of this they resented the legal intrusion into their working lives, and perversely refused to accept the supposed 'deterrent effect' of the tort process: "Torts may anger honest physicians who feel unjustly accused. This may lead to physicians to reject negative tort verdicts and actually subvert constructive deterrent teachings of the tort trials" (ibid: 8).
The large Wisconsin study by Shapiro et al found some significantly divergent attitudes about litigation when comparing the responses of sued physicians, non-sued physicians, and patients who had sued. While 96% of suing patients believed physician error was a reason for malpractice action, only 20% of sued physicians agreed with this; the divergence was even more marked with regard to physician negligence (as opposed to error) - 97% and 10% respectively. Responses towards questions of the openness and honesty of the pre-claim relationship between doctor and patient, and to the question of respect for one another, also showed large differences in outlook. Non-sued physicians seemed to believe that personal conflicts between patient and doctor were a much more likely cause of malpractice action than either physicians who had been sued or litigant patients (Shapiro et al 1989: 2192). With such differences in outlook, there is clearly room for an improved mutual understanding of the issues at stake in patient dissatisfaction and subsequent litigation.

Other effects of the litigation 'crisis' have been referred to, for instance the increased use of tests; this may be encouraged in a fee-for-service system where the costs of the tests are passed on to the patient, or more accurately the insurance company. Acheson (1991: 160), citing the ACOG study referred to above, notes that defensive medicine appears to be prevalent: 69% of those obstetricians surveyed said the fear of litigation was affecting the way they conducted their clinical practice; 27% had reduced the number of high risk cases they would take on, 13% had reduced the number of deliveries they conducted, and 12% had given up practising obstetrics altogether. In Georgia in 1987 there were 70 counties without a practising obstetrician; two-thirds of the obstetricians in Michigan said that the fear of litigation was their most serious professional problem, and the same proportion in California said that as a result they were now performing more caesarean sections.

Concern about a rising caesarean section rate (now at 20-25% in much of the USA) is not new; Keifer (1993: 1787) cites a distinguished obstetrician addressing an ACOG meeting in the 1950s, at a time when the rate was up to 10%: "Gentlemen, I hope some day this group may rediscover the birth tract."

DeMott and Sandmire (1990) examined the varying incidence of performing caesarean sections between obstetricians, and concluded that these reflected the individual's response to the threat of litigation. Goyert et al (1989), while noting the different rates of performing caesarean sections, concluded from their study that this did not reflect the obstetrician's recent medico-legal experience. Another study
(Localio et al. 1993), however, concluded that after controlling for other variables, caesarean delivery was positively associated with physician malpractice premiums. Rosenblatt et al. (1990) found that older physicians, and particularly those in urban and solo practice, were most likely to give up obstetrics; recent involvement in litigation was also held to play a part. A deliberate economic move to avoid the increasing overheads of obstetric practice was held to account for some physicians giving up obstetrics (Rosenblatt and Hurst 1989).

Gould et al. (1989) found a distinct socio-economic influence in the chances of a woman having a caesarean section; ironically, since caesarean section has a minimal effect on the rate of cerebral palsy, but is significantly associated with increased maternal morbidity, it could be argued that the richest are receiving the poorest care.

The US Institute of Medicine concludes from the ACOG's findings that the poorest sections of society are being deprived of the service of obstetricians, since the areas the obstetricians are least prepared to work in are those where the risks of an adverse outcome are greatest (Acheson 1991). This view is echoed by Dingwall (1986) who claims that a US obstetrician can expect to be sued eight times in a 35 year career. With regard to income levels, Rostow et al. (1989: 1058) note that there is a widespread belief that the poor are more likely to sue, but conclude from their study that there is no evidence for this.

Black (1990a: 36) also describes this aspect of risk avoidance, highlighting the perceived need to avoid specialities, procedures and patients which allegedly carry a high risk of leading to a malpractice claim, and he cites a study which said that up to 49% of doctors who had been sued reported that they now refused litigious patients. Hengstler (1986) cites one obstetrician who refused to accept either a lawyer or the legal firm's clerk after that firm had initiated suits against him: "We're not refusing to treat anyone connected with a law firm. Previous reports about that just aren't true. We are refusing to treat lawyers who sue us. We can't have a decent doctor-patient relationship with a lawyer who is suing us. What if she goes into labor a week before the malpractice trial is set and there are complications in the delivery room? What if she were to die on the operating table? It's rare, but it could happen. How would that look?"

Other studies have indicated that the fear of litigation has discouraged doctors from collecting clinical information for audit: one in Ontario claimed that clinical audit had stopped completely when it became clear that the findings were not exempt from
subsequent litigation. Symonds (1992: 9) also reports that in West Virginia and
Florida a system of no-fault compensation had to be introduced for claims
concerning birth-related injuries as a result of the virtual breakdown of the obstetric
services, which seems to confirm the frightening view that many women are at risk
of having obstetric services denied them, and Taylor et al (1992) report North
Carolina's introduction of an 'obstetrical care incentive program' which encouraged
certified nurse-midwives to practice, so providing the service which had been the
responsibility of (no longer practising) obstetricians.

The Virginia Birth-Related Neurological Injury Compensation Act came about in
part due to the work carried out by O'Connell on no-fault insurance. In the 1970s he
had examined automobile insurance, and concluded that a no-fault mechanism was
preferable to a tort-based system. The existing system, he argued, served plaintiffs
poorly but lawyers well; in particular he criticised the contingency-fee method
whereby a lawyer's fees could "take a savage cut out of the victim's payment -
keeping in mind that all of the payment is designed, in theory at least, to reimburse
the victim for his loss, with no extra amount being tacked on for attorney's fees.
Thus the contingent fee almost literally comes out of the plaintiff's hide" (O'Connell
1971: 42).

With regard to the calculation of damages for pain and suffering, a concept he called
"truly...protean...- almost unlimited in the manner in which it can be expanded,"
(ibid: 39), O'Connell also criticised the techniques which attorneys sometimes used,
in particular "the so-called 'blackboard technique' whereby counsel uses in argument
to the jury a mathematical formula stating that specific sums per day, hour, minute or
even second should be allowed as damages for pain and suffering....Some idea of the
astronomical values that such techniques can impart to personal injury cases can be
seen from the remarks of the appellate court in (one) case, 'If one cent were used for
each second of pain, this would amount to [$36] per hour, to...[$864] per 24-hour
day, and to...[$315,360] per year...Yet a penny a second for pain and suffering might
not sound unreasonable" (ibid: 40-41). Concluding the following year that to
calculate damages for pain and suffering by multiplying medical bills was a disaster
because it gave the injured plaintiff an incentive to "pad his medical bills, confident
that his 'investment' in medical bills will be returned manyfold, at no real risk to
himself" (O'Connell and Simon, 1972: 6), no-fault insurance for car drivers was
successfully introduced.
Maintaining the principle which had been introduced for car drivers and in workers' compensation, O'Connell continued to argue for a no-fault system in certain forms of medicine: "as long as the system requires that claimants prove fault on the part of health care providers (with or without caps) and entails payment to claimants for pain and suffering, the system would be unworkable as an insurance mechanism for both claimants and defendants" (O'Connell 1988: 1476). In the proposed Act "no-fault payments (would) be traded for economic loss in a defined set of serious obstetrical cases" (ibid: 1478). In liaising with the Medical Society of Virginia he stressed the need to make proposed changes palatable to avoid being watered down or rejected outright; however it was an insurance crisis rather than reasoned argument in favour of a more equitable system which proved to be the catalyst for the Act, as Fisher (1990: 640) notes: "In 1986 one of the major insurers in Virginia, the Pennsylvania Hospital Insurance Company, withdrew from the market after a judgement of $8.3 million dollars was made in favour of an infant...As a result 23% of the State's obstetricians were left without cover." Of the two other insurance companies which provided cover for Virginia obstetricians one stopped offering cover to new practitioners and the other confined its cover to groups of ten or more. Acknowledging that it was an insurance crisis which had brought about the political will to accept a no-fault proposal in Virginia, and despite the fact that his preferred 'early offers' approach (which had also been considered in Massachusetts) was turned down by the Virginia legislature, O'Connell accepted the amended (and less flexible) no-fault provision claiming that he was persuaded to back it "as an alternative to be tried and from which to learn" (O'Connell 1988: 1482).

Under the scheme babies damaged during delivery by hypoxia or mechanical injury who subsequently became either permanently disabled, aphasic, incontinent or non-ambulatory, or who were predicted to require close supervision for the rest of their lives, would be compensated. The scheme was to be financed by the state's obstetricians (about 600 in number) who would each pay $5,000 annually; additional income would come from physicians not practising obstetrics ($250 p.a.) and from Virginia's hospitals and insurance companies. However, according to a former president of the Virginia Trial Lawyers Association, the scheme, despite circumventing the requirement to prove fault, still requires that the plaintiff "prove the doctor caused the injuries. And causation has always been the battle ground in tort cases" (cited by Blodgett 1988: 35). Further criticism comes from Epstein (1988: 1469), who points out that there is now evidence that a baby may be neurologically damaged if its mother has one 'hit' of cocaine in the first trimester of pregnancy,
"even though it might be very difficult to trace the results thereafter...It seems most unlikely that the Virginia no-fault plan was intended to be a compensation program for victims of maternal drug abuse. Yet that is the risk it creates."

Claiming that the no-fault scheme cannot be shown to be any better than the system it replaced, Epstein (1988: 1474) argues that the correct response to "the blunders of the present malpractice system" is a market system in which patients and doctors will contract out of the tort process. Another argument levelled against no-fault schemes is that they will inevitably become too expensive to run; but as Lamb (1992: 28) notes about the Virginia scheme: "Forty infants a year were supposed to be compensated. Three years into the scheme none had been compensated as all claims had foundered on the tight definitions of causation..."

Reviewing the need for no-fault compensation, Manuel (1990: 627) claims that Americans are "suing themselves into second-class medicine," but the response is fragmented and dependent on local conditions; only a handful of areas have introduced such schemes to date. A modified version of 'no-fault', based on what they term Accelerated Compensation Events, is examined by Bovbjerg et al (1991).

Danzon (1986: 2004) claims that the tort system in the USA does in fact work quite well, although she believes that patients do not sue often enough to deter negligence; she does however advocate capping claims since she believes juries award too much in the way of damages.

International comparisons have been described by several authors, and not just in relation to the USA and Britain: Kritzer et al (1991) found several differences between the attitudes of Canadians and Americans (having compared Ontario with five federal judicial districts in the US), and also noted that Fitzgerald found that Americans "were more likely to seek legal counsel than Australians" (ibid: 507). Quam et al (1987: 209) do not accept that Britain is in danger of sliding towards a US-style crisis, since access to health care remains throughout life here, and there is no direct cost to the patient for future medical care. The USA has twice the proportion of practising lawyers, who in addition operate under a contingency fee system; and juries sit in negligence cases in the USA, which many believe increases damages awards. For these reasons, the litigation crisis which has hit the USA is not inevitable here, and so comparisons should only be made with caution.
Postscript
There are a number of gaps in the literature concerning this whole topic. The limited data available have highlighted obstetrics as the clinical area with the most significant claims and payments record, but the scale of the problem remains shrouded in secrecy. That practitioners are concerned about the possibility of litigation is clear from the many articles published in the medical and (to a much lesser extent) midwifery press, but the effects of the fear of litigation have not been quantified. Anecdotal evidence abounds, but this is a flimsy foundation on which to construct risk and claims management policies. The financial impact of litigation has produced new schemes by which Trusts may spread the cost of damages payments, but the fundamental structure of the law of medical negligence remains unchanged; calls for no-fault compensation from the medical profession have not impressed the government.

Although individual Trusts may know their own record on litigation, the lack of comprehensive information diminishes the debate, and denies the possibility of open comparison with others: the context of the broader picture is lost. Filling these gaps should also help practitioners and health service managers to understand better the nature of perinatal litigation; this can only benefit risk and particularly claims management strategies, and should also provide information to patient support groups about the best chance of success for those who seek their advice about alleged clinical negligence.

The possibly deleterious effects of defensive practice remain a matter for speculation; establishing whether staff have changed their practice as a result of the fear of litigation, and if so in what ways, would seem to be an urgent matter, both from the professions' point of view, and the managers'.
Chapter 3

Methodology

This thesis adopts a socio-legal perspective. The eclecticism of socio-legal enquiry has been noted (Lacey 1993; ESRC 1994), and while this does create a difficulty in establishing a narrow definition of socio-legal research, the interdisciplinary nature of the process is held to be one of its main strengths (Genn and Partington 1993). The empirical character of much socio-legal work has been contrasted with the more theoretical sociology of law, but a more mutually beneficial relationship between these two approaches has now been claimed (ibid).

Hillyard (1993) notes that socio-legal scholarship has a desire to see the development and implementation of policy, and it is hoped that this research will contribute to an improvement in the understanding and experience of this aspect of medical negligence law. As such it is neither intended to be read as an adjunct to a legal text book, nor as a purely sociological exercise. In methodological terms it was not constrained by any particular discipline, but was free to secure the best available means of answering the central research question. In fact there are three central questions: how much litigation is there, what are its principal features, and what are its perceived effects?

The research was conducted along two distinct albeit connected lines of enquiry: having gained access to the relevant files, establishing the incidence of litigation meant adopting a quantitative approach. Describing the nature of litigation involved a mixed approach: separate heads of claim could be counted, and as such this too was essentially a quantitative exercise, but the documentary analysis of the cases indicated that a purely quantitative approach could not do justice to any meaningful attempt to describe what perinatal litigation involves. The qualitative nature of describing the various features which appeared to predominate in such legal actions involved, as Morton-Williams (1985: 42) puts it, "a blend of imagination, flexibility, receptivity, discipline and hard work that enables the researcher to process the information as objectively as possible while making his or her own contribution to the analysis and synthesis of the data."

The survey of clinicians, which allowed for a certain amount of 'head-counting' (eg concerning how many obstetricians and midwives had been involved in litigation), was primarily concerned with assessing attitudes and perceptions, and so was also
qualitative in nature. Further qualitative research, involving in-depth interviews with a selection of respondents, comprises part of the overall theme of this research, and is planned. However the wealth of qualitative data obtained from the questionnaires provides a significant input to the debate about the perceived effects of litigation.

Given the lack of detailed information in the literature about this subject, there existed considerable scope to mould the research approach to preferred lines of enquiry. Burgess (1984) points out that researchers must approach substantive and theoretical problems with a range of research methods in mind, and happily there was scope to do this. As stated, content analysis of the cases involved a combination of quantitative and qualitative approaches, as did the analysis of the questionnaires.

A lack of restrictions posed by funding agencies or other outside bodies (cf. McDermott 1987), and the surprising ease with which access to confidential legal information was secured, meant that fewer constraints were encountered in the data collection and analysis than was anticipated. While undoubtedly pleasing, the facility with which the data collection on the legal files proceeded meant that particular care had to be taken to remain aware of the values and possible preconceptions which might have been brought to the research.

Majchrzak (1984) points out that values are necessarily included in both research design and implementation. In this research some were my own, firstly through working part time as a midwife throughout the duration of the research, and secondly through having graduated in a particular pair of academic disciplines (Social Policy and Law). Awareness of the values of potential study users had also to be considered: confidential data had to be presented in such a way that disclosure of the identities of the personnel or locations involved should not be possible.

The normative values of society-at-large, in part represented by the stance taken by certain consumer groups, were also included, since this topic is one which has generated some heat (though little light) in recent years. Avoiding a single track assault on a problem which is multidimensional reflects Glaser and Strauss' 'grounded theory' approach (1967), in which information gathering and model building are constantly interchanged. Given that so little information concerning the intricacies of this topic was available before the start of the research, determining a particular line of approach in advance was not possible: much of the analysis was performed sequentially, the picture being built up gradually as more data was collected.
Research perspectives

A number of authors have looked at the question of medical negligence litigation, and these have been discussed in Chapter 2. Those articles which give actual statistics relied heavily on the MDOs which traditionally defended medical staff in cases involving allegations of negligence. These organisations were reluctant to publish details of their cases, citing commercial confidentiality, but they have allowed certain authors limited access, from which tentative conclusions about the incidence and nature of medical negligence litigation can be drawn. However, changes in the role of the defence organisations resulting from the granting of Crown indemnity to hospital doctors mean that the limited data which they have released is both piecemeal and fast becoming out of date. This research aimed to fill this considerable gap.

To date there has been little attempt to chart the attitudes towards litigation among those clinical staff working at the 'sharp end'. Some of the literature discussed in Chapter 2, notably Acheson (1991) and Saunders (1992) refers to the perceived effects of litigation, but does not cite empirical findings and appears to be purely anecdotal in origin. This research examined on a large scale the attitudes of clinical staff to litigation, both from the point of view of their personal involvement, and their perceptions of its effects.

The research approached perinatal litigation from a number of perspectives. This was important, because merely to look at it from the point of view of how many cases there are a year, or how much money it costs the health service each year, or what litigants feel about either the care they have received or the legal system which processes their claim, is to miss the complex interplay between these and many other factors, and may inadvertently introduce an element of bias into the research. A more holistic approach was intended to gain a better perspective, by seeing each of these factors in relation to others.

There is a distinct possibility that this research could be used in a policy context. Given the sensitivity of the data, I did anticipate the possibility of certain restrictions being imposed on me by the gatekeepers (i.e. health managers). However, apart from being required to apply formally to two research ethics committees, and having to sign a confidentiality clause for one of the areas concerned, no restrictions or demands were placed upon me, except the requirement that I guarantee anonymity. While details of legal cases are included here, including at times the grade of the
relevant clinicians, the location and identity of those involved are not divulged and ought not to be discernible.

The avenues offered by this wider scope have had to be balanced by the desire to make the study conclusions palatable to the gatekeepers, it being hoped that this research may help to push the policy process along by contributing to risk and claims management strategies. In practice this has meant trying to identify lessons which may be learnt from particular situations so that repetition of error is less likely.

As Majchrzak (1984) notes, any research which attempts to be of use to policy makers must take into account the policy making process; this requires an understanding of the political, financial, and bureaucratic arrangements (to name just three) which affect policy making. In this I anticipated being at a disadvantage: the managerial set up within the health service has been in a state of flux, and budgetary constraints are widely thought to rule decision making. These may make practical recommendations problematic. It may be that the research is seen more as helping to define the problem rather than concentrating on developing specific solutions, what Weiss (1977) calls the "enlightenment approach". In shaping the policy makers' understanding of the problem, this approach can make causes and solutions easier to identify, and so aid policy making in the longer term.

I was constantly aware of the constraints of my research, in particular those of time and finance. To a limited degree these restricted the amount of data I was able to collect and analyse, although I did manage to secure comprehensive access throughout Scotland. I am conscious that however convincing my conclusions, no one piece of research is ever likely to generate a fundamental shift in policy. Majchrzak (1984) notes that research findings "are only one of many inputs to a policy decision...Policy is not made, it accumulates...policies are continually suggested, implemented, evaluated and revised."

Certain academics and other interested parties around Britain advised me that access would be all but impossible to arrange, but in fact the responses to requests for access were universally favourable. Much of the credit for the ease of gaining access in this way must go to a particular official of the Central Legal Office (CLO) in Edinburgh who sent out a covering letter to all of the Scottish health managers with my request for access, and who it seems also spoke with a number of these managers giving them personal assurances.
Given the sensitivity of the files in question, and the pessimistic outlook of some senior researchers, I had been prepared to be rebuffed at least in part, perhaps being allowed access only to edited versions of case files, and not for example being able to explore the full circumstances underlying each case. This turned out to be unnecessarily pessimistic.

An anticipated problem was terminology, and in particular distinguishing between complaints and legal claims: what is seen by one solicitor as a request for disclosure of medical records could be seen by another as intimation of a potential claim, and by still another as intimation of an actual claim. In practice this was not problematic: allegations of negligence were easy to identify, and whenever this or a claim for compensation was made, the legal file was opened, and became part of the research.

Many writers have emphasised the need to take on board the political environment of the study (Bachrach, 1972; Majchrzak, 1984; Patton, 1986), and the design of the research depended in part on how the health managers were thought to view the issue. I acknowledged the possibility of patchy access to data, which would have made comparisons difficult and obtaining a comprehensive view impossible; however I did gain full access to the legal files, and so can speak with confidence about the situation in Scotland. Requests for access to English files were only made in two areas; in both access was granted, but there is no way of knowing how representative of the situation in England as a whole these two areas may be, and so conclusions about English perinatal litigation are necessarily more tentative.

The research questions became more focused following a considerable time spent conducting a literature search; from this I constructed the data collection sheet for legal files, and the questionnaires which were sent to midwives and obstetricians (Appendices C and D).

Because the research aimed to analyse legal files and clinicians’ perceptions in a comprehensive manner, the matter of sampling was not a serious issue: having secured comprehensive access, all legal files for Scotland and the two English areas were identified. At that stage it was impossible to predict what might be a representative geographical sample, and this was not attempted. The diversity of heads of claim was quickly apparent, and so the possibility of examining a numerical sample of files posed a significant potential for introducing bias; since this would have reduced the generalisability of the results, this was not done.
Regarding clinicians, all known practising obstetricians in the areas in which legal file analysis were approached. Most of the midwives were contacted through the RCM: an estimated 85% of midwives in Scotland belong to the RCM, and for bureaucratic reasons the easiest way of contacting this large body of midwives was by using their membership details. RCM membership also provided the means of contacting midwives in one of the English areas; in the other, the hospital concerned sent me a coded list of staff members (see below). Since an overwhelming proportion of midwives belong to the RCM, it may be assumed that RCM members are broadly representative of midwives as a whole.

Access and other practical / ethical problems
Because this subject is very sensitive, when requesting access to legal files and approaching clinicians for their views I had to guarantee that under no circumstances would individuals or specific hospitals be identified in any subsequent report. I could not guarantee anonymity to the extent that I would not know or be able to find out the identity of the people involved (pursuers, defenders and staff); however, hospital managers and clinicians were assured that individuals (and hospitals) would be 'anonymised' so that identification would not be possible.

A potential problem is that in a smallish organisation like the Scottish Health Service, once particular situations are described the personnel or locations can become very apparent, even when using quite general terms such as 'A teaching hospital in the east of Scotland'. This was avoided by giving each case a unique identifier, and referring only to a hospital's status (teaching, district general, or cottage). Pursuers of course could not be named either; unless the legal action had been reported in the media (in which case it was already in the public arena) they should not be identifiable.

The issue of confidentiality is closely linked with the question of secrecy, that is to say, secrecy on the part of the agencies responsible for protecting the legal files. Bok (1984) notes that

"conflicts over secrecy...are conflicts over power: the power that comes through controlling the flow of information....Secrecy can harm those who make use of it in several ways. It can debilitate judgement, first of all, whenever it shuts out criticism and feedback, leading people to become mired down in stereotyped, unexamined, often erroneous beliefs and ways of thinking".

I prepared this as an argument, anticipating refusals to requests for access to legal files: nominally at least, health providers are advocating the rights of individuals to
make informed choices. Without adequate information in the public arena (such as incidence rates for particular occurrences), informed decision making is impossible. Despite the logic of this argument, researchers have sometimes found it extremely difficult to obtain even routine data from hospitals (Waterson, 1993); however, as stated, I secured unrestricted access to the files.

Bok is clear that there is no universal approach to dealing with secrecy: no general presumptions can be made either for or against it. Instead it must be dealt with in a particularist way. Secrecy, she claims, "refers to...concealment. It also denotes the methods used to conceal, such as codes, disguises or camouflage, and the practices of concealment, as in trade secrecy or professional confidentiality" (Ibid). In my own case, secrecy may be justified by the gatekeepers on either of these two grounds: 'trade' secrecy is a concern in the modern health service, and professional confidentiality is very much a concern when legal and patient files are the subject of research.

Hospital managers could have argued that there are possible injuries to innocent persons from certain kinds of publicity: for example clinicians may have their reputations destroyed by unfounded allegations of negligence or incompetence. At the heart of their concerns may be the suspicion that I would, deliberately or otherwise, make unwarranted disclosures. Dalenius, of the US Office of Federal Statistical Policy and Standards, notes that "If the release of certain statistics makes it possible to determine a particular value relating to a known individual more accurately than is possible without access to those statistics, then a disclosure has taken place" (cited by Steinberg, 1983). Accepting this definition, I strove to ensure that no such identification was possible. Steinberg (1983) suggests using 'alias identifiers', but even these may not be sufficient to conceal the identity of individuals in the research "if the data are also coded to small geographical areas" (Ibid). This has been avoided by not referring to the location of health boards or hospitals, but only relying on the unique identifier mentioned above.

A further problem is political: highlighting the incidence of litigation in Scotland by drawing an incidence 'map' could be construed as very bad publicity for emerging Trust hospitals. The current political set up in the health service has brought about a situation where there is a quasi-market system and hospitals are being encouraged to compete with each other for 'custom'. Given this, the new Trusts and the existing health boards are very conscious of their image. With providers competing amongst themselves to win contracts from purchasers, image becomes important; looking
forward at the start of the research, the danger of possibly very damaging publicity resulting from the revelation that a particular hospital has (say) twice the national average rate of litigation was seen as a possible reason for health managers to refuse access. When the initial responses were more positive than everyone had expected, I thought such examples could be used to persuade less willing managers to comply; in the event, this was not necessary, although the reasons for their agreement are not known.

It was possible that some questionnaire respondents could see me as a means of 'blowing the whistle', or at least of making some situation or event more public. Whistleblowers who are found out may find themselves in trouble with their employers. Bok (1984) notes that whistleblowing is seen by employers as a breach of loyalty, a form of betrayal; for the person blowing the whistle there are also strong tensions: "They must confront questions of loyalty, conscience and truthfulness, and personal concerns about careers and peace of mind" (Ibid).

Whether, and how, this information should be made more public would depend to a large extent on what it is, and who is likely to want to know. Bok criticises the concept of a public 'right to know': "Taken by itself, the notion that the public has a 'right to know' is as quixotic from an epistemological as from a moral point of view, and the idea of the public's 'right to know the truth' even more so...How can one lay claims to a right to know the truth when even partial knowledge is out of reach concerning most human affairs...?" (Ibid. 254; original emphasis). Despite this, clearly there are matters which may be of interest, for example to consumer groups. The ethical point is to present the data without allowing for personal identification to take place. This comes back to the methodological problem of presenting data in an aggregated way so as to preclude personal identification.

Riecken (1983) also claims that outside parties may be interested in the results of research. He notes that sponsoring agencies may "wish to look over the researcher's shoulder...and this motive may threaten confidentiality" (ibid. 6). Fortunately this was not the case with my research: none of the three sponsoring bodies (ESRC, NBS and Iolanthe Trust) are demanding copyright or exclusive access.

The methodology selected for this research, then, is a combined quantitative-qualitative approach. Because of the paucity of detailed information in the public domain, some of the research - particularly that concerning the legal files - followed a partly deductive line of enquiry: as more information became available, so the
awareness of the issues at stake became clearer. This will be apparent from reading Part III, which describes the factors affecting the origins, conduct and outcome of cases. The notion of theory emerging from empirical research reflects the approach described by Glaser and Strauss (1967).

Legal data collection
The data collection took place mostly in Edinburgh at the CLO, but also required a certain amount of travel to the two English areas. The legal files satisfied Scott's requirement of authenticity - that they are what they purport to be, and are by a specified author (Scott, 1990). They also contained documentary evidence from both pursuer and defender; however, since the Health Board is the defender, the weight of evidence reflected this partisanship. Regarding their credibility, then, they are likely to be sincere, but what Scott calls "methodological distrust" suggests that their accuracy (for instance as to the exact circumstances of an incident) may be questionable (Ibid). In the same vein, Platt (1981), citing Naroll (1962), notes that there are several features which may conspire to cast doubt on the veracity of an account, including the time between an event and its reporting, and the degree to which the author has a professional stake in the content of the report. Both of these characteristics are of particular importance in retrospective accounts in medical negligence cases.

While it was not the purpose of this research to judge on the merits of individual cases, content analysis of the case files nevertheless involved examining such retrospective reports and, where available, any contemporaneous (clinical) records, and recording the circumstances of each case. Neither retrospective accounts nor contemporaneous records are written with the purpose of research in mind (Robson 1993), and while the former may reflect a degree of interpretation by the relevant author, the latter, being contemporary, ought to be straightforward descriptive accounts. However, clinicians are aware of the legal nature of case records, and with an alleged increase in awareness of litigation on their part, it is entirely possible that such clinical records are indeed being written with a considerable degree of 'defensiveness' in mind.

Since I was only examining fairly recent files their survival as records was not anticipated as an issue: the question of some but not all papers surviving, so making them possibly unrepresentative, was not thought to apply. It is acknowledged that partial access would have made representativeness an issue, and file storage in the CLO was rather haphazard: at the start of the research all closed files were stored in
a basement, but there was no central register, and no procedure for indicating when a file had been removed. It is possible that the initial stage of 'tagging' the files was not comprehensive, but as no other research was ongoing at the time, it is unlikely that more than a very few were missed. However, in the midst of the research, the procedure for storing the closed files changed, and they were moved to a different site under the control of a private firm. Before consigning the closed files to the separate site, the CLO retained certain essential information about the nature of the cases, and stored this on computer; this was retrieved and analysed later, and made comparison with the files already studied possible. This meant that detailed data (in excess of the basic CLO computer-held information) was obtained for closed files in six of the twelve HBs in which a perinatal legal file had been 'tagged', amounting to 45% of the closed Scottish cases. While this did not diminish the amount and quality of the essential information (how often people sue and for what reasons) the supplementary information (such as the exact circumstances of each case, and the profile of people involved) was lost. Detailed data on open cases was possible for all HBs and all open and closed English files were personally examined.

Interpretation of the clinical aspects of these documents was not problematic, since I am familiar with the clinical situation to which they relate. This gave me what Scott (1990) calls "an appreciation of the social and cultural context"; in addition my academic training should have enabled me to maintain a certain distance between the data and its analysis.

Postal surveys
The aim of the second part of the research was to discover whether there is a perception that litigation and the threat of litigation are problematic, and whether clinical practice was felt or known to be changing in response to this. Regarding the postal questionnaires, I was fortunate in being able to pilot the questionnaires on clinical staff in my own work area; their content reflected some of the points raised in my undergraduate dissertation (Symon 1992), as well as issues raised in the literature.

The postal questionnaires broached the question of perceptions of litigation partly on a 'multiple/fixed choice' basis, and partly by inviting 'open answers'. The advantage of conducting this part of the research on a large scale is that it allowed for comprehensive analysis. I was given enormous assistance by the RCM in Scotland in contacting almost all registered midwives in Scotland; and similar help from the Royal College of Obstetricians and Gynaecologists regarding obstetricians. These
helped to secure a respectable response rate, and, in Scotland at least, allowed for fairly conclusive analysis of the perceptions of staff working in this area to be drawn with a high level of confidence. The English sample - comprising those working in the two areas in which legal files were examined - was much smaller and, as with the legal files, conclusions are necessarily much more tentative.

The midwifery survey
An estimated 85-90% of midwives belong to the RCM, so this seemed the most effective way of identifying them, particularly in Scotland, which has a scattered population with a significant number of midwives not living close to the urban centres where most maternity units are sited.

The Scottish board of the RCM has membership lists which can be broken down by branch; all full members were contacted. The midwife's membership number (placed on the back of the return envelope) was used to identify non-respondents, and also allowed return rates by branch to be calculated. RCM membership was also used to contact the midwives in one of the two English areas (from a list supplied by the London office of the RCM those with a particular post code were identified); the midwives in the second English area were those with a base within a particular city hospital which organises community-based teams as well as hospital care. The midwifery management in this hospital sent me coded numbers for each of their midwives.

For the main survey 3616 midwives were contacted: 372 in England, and 3244 in Scotland. This followed a pilot survey of 48 midwives in one Scottish area which elicited an overall 71% return rate. All the questionnaires in Scotland were sent out by the RCM office in Edinburgh, and RCM membership numbers were used to identify non-respondents. Questionnaires for the two English areas were distributed locally having been sent in bulk; in the case of the first English area the RCM membership list provided names and addresses, but the majority, who were hospital based, received their questionnaire in the internal mail; in the second English area the coded list provided by the midwifery management was used and the forms were again distributed in the internal mail. Each form came with a covering letter by the author, and a second covering letter from the Director of the Scottish Board of the RCM encouraging midwives to participate; a Freepost envelope using the Edinburgh RCM office as a mailbox was included for the return of the questionnaires.
The covering letter assured respondents that their replies (and particularly comments) would be anonymised in any report, and this I have done. A small proportion of respondents interpreted this as meaning that the entire survey was anonymous, and they removed their unique identifier from the return envelope. This complicated the sending of reminders.

Reminders were sent out to the majority (80%) of non-respondents; the process of identifying and targeting them was complicated by the postal strike of May 1995. An initial response rate of 50% was used in calculating the costs of the survey (the pilot survey of 48 midwives in one part of Scotland produced an initial return rate of 42%, rising to 71% following reminders). For the main part of the survey, the initial return rate was 35%. Reminder letters included a copy of the questionnaire with a new covering letter, and a further Freepost envelope. Research costs from the NBS (Margaret Callum Rodger Award), once obtained, did not quite allow for every non-respondent to be sent a reminder.

Although a total of 3616 questionnaires were sent out, the final sample population was slightly smaller than this, due to several members of the RCM having either retired or gone abroad, written saying they felt themselves ineligible, or who were otherwise uncontactable. When these numbers were removed from the study population, a total of 3513 was left. A total of 1803 completed questionnaires were returned, but the last thirteen were rather slow in coming in, so analysis was of 1790 replies, giving a response rate of 51%.

Incidentally the response rates in the midwifery survey from Scotland and England were significantly different: 50% from the Scottish target population, compared to 63% from the English. This is partly explained by more effective targeting of reminders, but even the initial return rates, at 34% and 51% respectively, showed a significant difference.

Certain information about the respondent's clinical grade, size of unit, area of work, and length of experience allowed for comparisons to be made according to these variables. The full characteristics of the midwifery respondents are shown in Appendix E; briefly, units were divided into seven different sizes (measured by the number of deliveries annually): less than 100; 100-999; 1000-1999; 2000-2999; 3000-3999; 4000-4999; and 5000 or more. Area of work was defined as Wards/Clinics; Community; Labour Ward; Neonatal; or Team Rotation (a mixture of most or all of the preceding). Length of experience categories used were less than
three years; 3-5.9 years; 6-8.9 years; 9-11.9 years; 12-14.9 years; 15-19.9 years; and 20 years or more. For ease of reading in the text the '.9' figures are rounded up.

It is acknowledged that the English-based sample is much smaller than the Scottish sample and that it may not be representative; however there is no particular reason to believe that the English respondents are atypical of English midwives generally.

In an attempt to find out whether there were any significant cross border differences in the responses, a comparison between the views expressed by midwives in Scotland and those in the two English areas was carried out. To do this midwives were 'matched' in pairs to exclude possibly confounding variables (grade, length of experience, size of unit and area of work). The English sample, being much smaller, was taken as a base, and matching pairs for each respondent sought from within the Scottish sample. Of the 231 English respondents, pairing was possible in 172 cases; details of how this was done, and explanations for some of the differences between the two samples, are shown in Appendix F. In this exercise, where applicable, reference is made to any significant differences between the Scottish-English matched pairs.

The obstetric survey
Obstetricians were approached using the published list of Fellows and Members of the RCOG, and through names supplied by the RCOG and by the hospitals concerned. Practitioners were targeted at their last known place of work; because of job mobility a number of junior grade practitioners were uncontactable, and so this survey contains a large proportion of senior obstetricians.

As with the midwifery questionnaire, the English sub-sample is much smaller than the Scottish sub-sample; nevertheless, a number of statistically significant differences were found. The caveat about the size of the English-based midwifery sub-sample applies to these English-based obstetricians too.

Those targeted for this survey were all the obstetricians in Scottish hospitals and in the three hospitals within the two English areas; also targeted were a number of GPs in Scotland who practise obstetrics outwith the consultant unit setting in rural / island areas. The covering letter which accompanied the questionnaire specified that the research concerned obstetrics and not gynaecology, since this reflected the data collection from legal files; since many early pregnancy conditions are treated in gynaecology wards and not on maternity wards in some hospitals, for the purposes of this survey 'obstetrics' is deemed to cover cases from the 20th week of pregnancy
onwards. Each questionnaire came with a covering letter from the author guaranteeing absolute anonymity in any report, and indicating supervision from a senior Scottish obstetrician; also included was a stamped addressed envelope for responses to be sent to the offices of the RCOG in London, which had kindly allowed me to use their address as a post box.

A total of 338 questionnaires were sent out, and the initial response rate was 52% (n=174); reminders, including a covering letter and a further stamped address envelope, were sent to all non-respondents, and this produced a total response rate of 63% (n=211). Seven were returned indicating that the respondent was in some way unable to take part. 21 respondents came from the three English hospitals, 190 from Scotland (including 19 GPs). More information on the characteristics of the obstetric respondents is given in Appendix E.

The questionnaire had been piloted using obstetricians from one hospital in Scotland; following this, and discussions with the supervising obstetrician, the format was revised for the main survey.

The questionnaire format
The questionnaires were essentially the same, and can be found in Appendices C and D. However, some questions were directed specifically at obstetricians, others at midwives, and so they were not identical. Both were divided into four sections: the first concerned litigation in a general sense; the second looked at pregnancy and the notion of 'at risk'; the third concerned the labour period; and the fourth looked at communication, counselling, and the role of consumer groups. The back page of the midwifery survey was left free for respondents to add whatever they wished, either adding comments to answers given, discussing litigation (or the threat of litigation) and its effects on practice, or relating personal experiences in this field. In all 435 midwives (24%) added comments on the back page, some spilling over onto extra sheets. The 'prize' for this was one midwife who included more than three typed sheets entitled 'The Ramblings of a Geriatric Midwife'.

In an attempt to maximise the response rate, the obstetric survey form was slightly shorter than the midwifery survey form, and no free space was left on which extra comments could be added. It is acknowledged that the discussion of the various points raised in the questionnaires leans more to the views of midwives, since far fewer additional comments by obstetricians were received.
Part II

Perinatal Litigation:
How much, when and why
Part II contains two chapters which examine and describe the incidence and nature of perinatal litigation. Chapter 4 answers the first and - for some - the most important research question, namely 'How much litigation is there?' It also demonstrates how this varies between different areas and different hospitals; for reasons of confidentiality the names of the Health Boards, English areas, and of the hospitals concerned, cannot be given. A distinction ought to be made here between the incidence of litigation (the actual number of legal cases) and the rate of litigation (the ratio of deliveries to legal files); although these are not exactly the same, because of an almost constant birth rate the incidence and rate are practically identical when viewed graphically. Comparisons between different areas are according to rate and not incidence.

A true Scottish-English comparison would only be possible if certain information about the small English sample were made known; in order to preclude identification of the English areas studied (so avoiding inadvertent identification of specific cases), only a very brief mention is given of the situation in England. Despite this, the data presented here show the incidence (as well as the rate) of litigation for Scotland and the two English areas since 1980. It then examines the length of time it takes to initiate and conclude a legal action, and discusses some of the possible influences brought to bear in this area.

Chapter 5 turns its attention to the reasons for litigation; it describes why people sue obstetricians and midwives (and occasionally others involved in perinatal care), and discusses the success rates for pursuers, looking at these different heads of claim. It was possible to construct a limited profile of perinatal litigants from the demographic data available in some of the legal files. Access to legal aid and the matter of damages is also discussed. It will become apparent that the Central Nervous System (CNS) head of claim is markedly different, and a separate profile of CNS pursuers is given, as well as further information on CNS cases.

In discussing the reasons for suing, this chapter does little more than summarise the salient features of each head of claim; a fuller description of typical cases is given in Appendix J, and in Part III these and other aspects of perinatal litigation are opened up for a much more detailed scrutiny.

The data reported here were obtained through information held in legal files in the Central Legal Office of the NHS in Scotland, and in the legal departments of the two relevant English areas. Data from a total of 622 cases was obtained: 514 from
Scotland, and 108 from England. All of the English files were personally read, as were 302 of the Scottish files, with the data on the remaining 212 being obtained from the CLO computer database (this holds essential information including the reasons for suing, and the dates of incident, legal notification and closing of the file). In seventeen cases there was more than one head of claim: thus it sometimes appears from the data in the charts and figures that there are more claims than the total number of files.
Chapter 4

The incidence of litigation

Chapter 4 demonstrates how much perinatal litigation there has been since 1980, and shows how this has varied between different hospitals and areas in that time. A distinction between CNS cases and non-CNS cases is made, and the time it takes to initiate and conclude a legal action is discussed.

Incidence over time

The initial step in charting the incidence of perinatal litigation was to record how many files were opened regarding events occurring since January 1980. Given the varying lengths of time taken by some pursuers to bring their action, it can be argued that the year of birth is not the most accurate way of assessing trends, but it serves to open the debate. The time gap between event and initiating legal action is discussed later.

Figure 4.1 shows how many legal files were opened concerning events in the years shown (1980-1995); this refers to all the areas under consideration - all of Scotland, and the two English areas - and the figures for both CNS and non-CNS cases are given.

Figure 4.1

Legal files: relevant year of birth

It can be seen that there was a fairly steady increase in incidence throughout the 1980s, but that the peak reached in 1990 has tailed off dramatically. Because pursuers can still initiate actions for up to three years following most events, and effectively without time limit concerning a brain damaged baby, the figures for the last few years shown in the chart will almost certainly be an under-representation.
However the 'non-CNS' cases for up to 1992 should be more or less complete, since data collection ended in May 1996, and the Statute of Limitations will effectively bar most non-CNS actions concerning events before May 1993. Even allowing for more cases to be brought concerning the later years in the chart, the apparent drop off is striking, and to illustrate that the drop off is not wholly to be explained by a large number of latent files, the following chart shows the year in which a perinatal legal action was raised.

Figure 4.2

Legal files: year action raised

There is a dramatic drop off in actions raised in the last two years in the chart which is not easily explained. The first few years in the chart will be an under-representation since this research is only concerned with events occurring since January 1980: actions will have been raised in the early 1980s concerning events in the 1970s.

The apparent surge in legal actions throughout the 1980s can also be depicted by charting how many legal actions are brought relative to the number of deliveries in an area. The next three charts show how the incidence of litigation (measured in 'deliveries per legal case') has changed over the last 16 years. There are four time periods: 1980-1983, 1984-1987, 1988-1991, and 1992-1995. Each of the twelve Scottish health boards (HBs) and two English areas which attracted legal cases during this time are shown, and their respective incidences plotted. It will be seen that in 1980-1983 there were considerable differences in the incidences of different HBs, but these appear to even out.

It should be borne in mind that these claims relate to the year in which the relevant incident occurred. All the figures may be a slight under-representation, since legal
actions concerning brain damaged children can be made effectively without time limit, and it is quite possible that further actions will be initiated which concern children born throughout the 1980s. In particular the figures for 1992-95 may be lower than their true eventual level.

Figure 4.3

Deliveries per legal case: Scottish HBs and two English areas
1980-95

However, despite this apparent 'evening-out' of incidence between HBs, there are still large differences in rate. To explore this further, the next chart highlights the period from 1984-1995.

Figure 4.4

Deliveries per legal case: Scottish HBs and two English areas
1984-95

While the trend between 1984-87 is one of increasing litigation, it can be seen from the above chart that in some HBs the incidence of litigation diminishes (i.e. there are more deliveries per legal case) in the last period. This is highlighted further in the following chart, which looks at the last two four-year periods only.
By this stage there is no consistent trend: in many areas the picture is now one of diminishing litigation. The figures are the same as in the first two charts, but the differences between the various areas are more clearly seen using a different line graph (the figures for each individual HB and English area are compared vertically rather than horizontally). However, as noted above, the figures for the time period 1992-95 in particular may be incomplete. Compared with the 1988-91 period, of the fourteen geographical areas under investigation, in nine the incidence appears to be falling, in one it is the same, and in four it is increasing. Nevertheless there does appear overall to be a drop in the rate of litigation, for this speciality at least. If this trend continues, it may be concluded that the 'litigation crisis' has passed.

Incidence by hospital
It was possible to chart the occurrence for each hospital, and to subdivide this into 'CNS' and 'non-CNS', and give the numbers of decisions in favour of both defenders and pursuers. The Tables for this data are seen in Appendix G; the hospitals (40 in Scotland and 3 in England) are each given a number in order to preclude identification.

However, stark figures on the absolute occurrence tell us little about the influencing factors. The hospitals noted in Appendix G have varying annual delivery rates; a more enlightening approach is to categorise the hospitals by size, and then chart (as in a league table) the rate of litigation as measured by 'deliveries per legal file' at
each hospital. Simply comparing each hospital with the others could discriminate against the smallest units. It will be remembered from Chapter 1 that one of the English hospitals, due to boundary and other organisational changes, only held comprehensive data for 1988 onwards; this hospital only appears in Tables 4.1 c and d below.

The four sizes are determined by annual delivery rates for the time period shown and are 'Very small' (less than 250); Small (250-1,000); Medium (1,001-3,000); and Large (over 3,000). Figures for delivery rates were obtained from the Information and Statistics Division of the National Health Service in Scotland (ISD) for all the Scottish units, and by direct approach to the English hospitals concerned. It will be seen that not every hospital is represented in each Table: in some cases this was because no legal files were identified for that unit for the four years in question; in other cases it was because the hospital concerned had closed or had transferred its maternity services elsewhere. The English hospitals are identified with an (E).

Tables 4.1a-d: Deliveries per legal file by hospital

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The wide variation in the rate of litigation is a feature which makes easy conclusions impossible. One hypothesis is that the larger units, partly because they attract more of the high risk cases, may be more prone to litigation, but this is not borne out by the figures: there appears to be no particular association between the size of a unit and its likelihood of attracting legal claims (as measured by this index). The figures in Appendix II demonstrate this lack of correlation. For the smaller hospitals, just one or two legal files in four years can give a dramatically high 'rating'. However, certain hospitals do tend to be at or near the top of their section of these tables: of the largest units, for instance, Hospital 33 features prominently in Tables a-c; similarly

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<th>Size of Unit</th>
<th>Deliveries per file</th>
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Table 4.1c: 1988-91
Table 4.1d: 1991-95
of the medium-sized units Hospital 21 is fairly prominent. As stated before, this does not necessarily reflect on the standard of care at these hospitals, merely on the apparent inclination of patients attending that hospital to consult a solicitor. The English hospitals had varied rates: Hospital 33, a large teaching hospital, featured prominently in its league up until 1991.

An interesting comparison with the USA can be made here: Baldwin et al (1991), looking at individual obstetricians with malpractice experience between 1982 and 1988 (the very years when litigation was supposedly hitting 'crisis' levels), estimated an average of one claim per 3125 deliveries. It can be seen that many of these British (mainly Scottish) hospitals had a far higher rate of legal claims than the allegedly litigious North Americans. However, this again only tells us how often people sue, not why or how likely they are to succeed in their actions, and this is a crucial distinction. As can be seen in Appendix G, Hospital 33 (noted above to be attracting a high level of claims) has successfully defended all six closed CNS claims made against it for births occurring between 1988-91 (seven CNS cases are still open); pursuers there have had more success in non-CNS cases, winning 7 out of 15 for 1988-91.

There is no simple equation based on incidence which will help hospitals predict how often or when they will be sued, or for what reason. This reflects the view of Dingwall and Fenn (1991: 95) who noted the difficulties in predicting when significant claims would arise. More information is required in order to help build up the picture, and a 'profile' of litigants is discussed in Chapter 5. Other contributing factors to the unpredictability of litigation are the lengths of time it takes to initiate and conclude an action.

**Time to raise legal action**

A common complaint by health service legal staff is the time it takes a pursuer to initiate a legal action. Understandably, the longer the delay, the more difficult it will be to carry out a thorough investigation; some of the reasons for delay in raising an action are discussed in Chapter 8, but the figures for these legal cases are shown here.

Not everyone is slow off the mark: for non-CNS cases, the minimum length of time was 7 days. However, the maximum was 12 years and 44 days: this case concerned a child whose scalp was allegedly damaged at forceps delivery; corrective surgery was attempted at six years of age, so the problem was known about years before the legal
action was raised. The case is still open. It is intriguing that there are several non-CNS cases which take many years to arise, despite the theoretical impediment of the Statute of Limitations. One which took over eight years concerned a child with blindness in one eye; this turned out to be a congenital cataract which was diagnosed at eight months of age. Why it took another seven and a half years to consult a solicitor is unknown; since the condition was congenital, the action failed, as do most of these 'late openers'. The average time to raise legal action for non-CNS cases was 17.6 months.

For CNS cases, the minimum was 16 days, the maximum 14 years 5 months, the average being 3 years. It should be remembered that this research only looked at files concerning events from 1980 onwards; legal files were identified concerning babies born before 1980 which took much longer to arise - one took 16 years, another over 20. Halle (1997) notes one which took 27 years.

Figure 4.6

Comparison by Anova single factor showed an extremely high degree of significance when comparing CNS and non-CNS (p<.0112). Clearly the two types of legal action must be treated differently. However, despite this difference, the bulk - over two thirds - of CNS cases are brought within three years:
Occasionally the serving of a writ is a means of keeping the case live, and occurs just short of the expiry of the triennium: in 6 cases the writ arrived with the first solicitor’s letter - in all six cases the triennium was less than a week away (in another 37 cases the writ was served within two months of the expiry of the triennium).

Another way to analyse readiness to sue is to compare the average length of time it took to initiate a legal action for the four time periods already described. From the following figure it can be seen that for both CNS and non-CNS litigation, there has been a steady drop in the average length of time it takes people to begin a legal action; while the average for the CNS cases may each lengthen (it being possible to bring an action effectively without time limit) the fact that over two thirds of these CNS cases were brought within a relatively short time may indicate that there is a genuine trend towards suing more quickly. The downwards trend for non-CNS cases would appear to confirm this, although it is acknowledged that there may be more cases brought for babies born especially between 1993 and 1995 which do not figure in this research. The overall trend, however, is unmistakable.
It appears that legal actions are raised more quickly (median length of time reflected the average time almost exactly). An explanation for this (one voiced by some clinicians in Chapter 9) is that society - or at least certain elements within it - is becoming more litigious. This is difficult to verify, but anecdotally it would seem that a recourse to legal action is more common in many aspects of contemporary life. If public bodies (among others) are now more likely to be sued, are they reacting by dealing more swiftly or efficiently?

**Time to close cases**

In 436 closed cases (345 non-CNS and 91 CNS) there was sufficient information to allow analysis of the time it took to conclude the legal action; this relates to the gap between legal notification of the claim, and the date on which the case is formally closed.

Non-CNS cases took an average of 27.2 months to close; CNS cases on average 38.6 months. This was not statistically significant (p=.08; calculation by Anova). For the non-CNS cases, unsurprisingly, the unsuccessful cases were concluded much more quickly than the successful ones: 22 months compared with 41.8 (p<.01). Likewise for the CNS cases, unsuccessful actions were concluded more quickly - on average 33.4 months, compared with 64.9 months for successful actions (p<.014). Some of the reasons for the delays in legal actions are discussed in Chapter 8.

For the non-CNS cases, analysis was performed in how long the successful ones took to conclude:
It can be seen that there is no consistent trend, but that cases seem to have been concluded more swiftly in recent years (median times reflected the average times closely). There are only 15 successful CNS cases which have been concluded and which have all the data necessary to do this analysis; almost all of these relate to actions raised in the period 1985-1988.

The time it took to close unsuccessful actions (both CNS and non-CNS) is seen in the following chart. Again, there is no consistent trend, but since 1984 actions appear to have been closed more quickly.

This may reflect a more organised or streamlined approach to dealing with litigation; alternatively, the relatively quick time it takes to conclude some unsuccessful cases
may simply reflect the fact that many more cases with little or no chance of success are raised, and these are dropped relatively quickly when it is appreciated that they will not succeed. Median length of time, while mirroring the average time shown for CNS cases, showed a peak in 1988-91 for the non-CNS cases, falling in the years 1992-95.

Success rates by year have fluctuated for both CNS and non-CNS cases (these can be seen in Appendix I). It cannot be concluded that speedier resolution of cases indicates that a higher number of 'less meritorious' cases have been brought recently. It is perfectly feasible that health service legal staff have developed a more efficient or streamlined approach to dealing with legal claims.

Summary

This data shows how often people sue concerning perinatal events in Scotland and in the two English areas. It became difficult to describe the differences between the Scottish and English data without revealing the identity of the English hospitals, and for this reason a Scottish-English comparison was very limited. Despite this, it was noticeable that in the period 1988-91, when the surge in incidence was at its height, that two of the English hospitals were at or near the top of their 'size of unit league'. However little can be concluded from incidence alone: success rates for pursuers varied, and when broken down by hospital the numbers become too small for conclusive analysis. Reasons for settling cases also vary, as is explained in Chapter 7.

The incidence of litigation undoubtedly increased sharply in the 1980s throughout Scotland; it is not known how representative the English areas may be of England as a whole, but the picture here too was one of a rapid increase in perinatal litigation, reaching a peak in 1990. There has, however, been a considerable drop in incidence since that time; this concerns both CNS and non-CNS cases. It is difficult to know why this should be: changes in eligibility to Legal Aid may account for a surge in incidence in 1990, and this change may have speeded up some cases which may otherwise have been brought a year or two later, or even longer. The diminishing length of time it takes to initiate a legal action may lend weight to this theory, but this may be no more than an association: the gap between event and legal notification was already diminishing steadily. Whether or not the apparent drop in incidence since 1990, and particularly since 1993, indicates that the supposed 'litigation crisis' has passed will only be known when accurate data for later years are available.
It is interesting to note the diminishing time it takes to initiate a legal action, and it is difficult to explain this without concluding that society is becoming more litigious. The time it takes to conclude legal cases also appears to have diminished since 1984-87, but there is still a strong requirement for litigants to be patient: successful CNS cases took on average well over five years to conclude, and even non-CNS cases took well over three years. Forbearance and determination would appear to be essential when considering litigation of this sort. The low rate of success for pursuers in this specialty (see Chapter 5) indicates a difficulty with establishing negligence, even when the clinical outcome is poor; in part this may reflect the inexperience of some solicitors, who take on clients whose cases have little legal merit. The poor performance of some solicitors in this field has been noted elsewhere (Genn 1989), and is discussed further in Chapter 7.

The data offered here may satisfy some people's interest in knowing how much litigation there is in this field. However it is not as straightforward as this: quite apart from the unexpected fall in the incidence of litigation since 1990, raw numbers tell us nothing about why people sue, and little about the context and origins of cases. Chapter 5 now takes up this story.
Chapter 5

The nature of litigation

Chapter 4 could only show how often pursuers have brought a legal action concerning perinatal care. The reason for legal action, and the rate of success enjoyed by pursuers is now considered. The discussion in Chapter 4 made a distinction between 'CNS' and 'non-CNS' cases: the conduct of such cases is markedly different, both in the time it takes to initiate and conclude an action, and in the possible damages which may be awarded (see below); they are, consequently, approached differently by legal staff. However, a wide range of allegations concerning perinatal care were included in these files; the incidence and success for each of these is detailed below.

Types of case

The following figure illustrates the wide variety of head of claim in perinatal litigation:

Figure 5.1 Perinatal litigation - allegations' and outcomes:

* Key to abbreviations in Figure 5.1: IUD - Intra-Uterine Death; CNS - Central Nervous System; NND - Neonatal Death; ROP - Retinopathy of Prematurity; RLF - Retrolental Fibroplasia; FTD - failure to diagnose; anaes - anaesthesia
While the allegations concerning CNS damage in the baby are by far the most common reason for suing on behalf of a baby, they only constitute 51% of the 'baby cases', and only 26% of all the cases. There were also many reasons why litigation was initiated concerning the treatment of the mother, of which perineal trauma (19% of maternal cases, or 9% of all cases) is the most common. The plethora of reasons for suing indicates that the problem is a complex one, and cannot be easily described; this makes risk management more problematic, since the issue is not one which can be targeted by one particular approach.

One way of helping to focus the risk and claims management approach is to look at the success rates of each head of claim. Many of these claims have not yet been decided, but still it is possible to discern some areas which are less likely to be successfully defended (such as retained swabs: this is one area which can be targeted). At an overall success rate for pursuers of one in four, this aspect of personal injury litigation is clearly problematic for pursuers; the rate for medical negligence litigation generally is known to be lower than that for most personal injury litigation (30-40% compared with 86% [Fenn and Dingwall 1989: 40]), but this specialty appears to have an even lower rate. The success rate under the CNS damage head of claim, at 18%, is even lower than average for all perinatal cases.
### Table 5.1 Perinatal Litigation: Decision in favour of:

<table>
<thead>
<tr>
<th>Decision in favour of</th>
<th>Defender</th>
<th>Pursuer</th>
<th>Success rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stillbirth / IUD</td>
<td>27</td>
<td>13</td>
<td>33%</td>
</tr>
<tr>
<td>Birth injury (non CNS)</td>
<td>28</td>
<td>4</td>
<td>13%</td>
</tr>
<tr>
<td>CNS damage</td>
<td>80</td>
<td>18</td>
<td>18%</td>
</tr>
<tr>
<td>NND</td>
<td>19</td>
<td>10</td>
<td>34%</td>
</tr>
<tr>
<td>Failure to diagnose/treat (baby)</td>
<td>10</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Neonatal injury</td>
<td>4</td>
<td>2</td>
<td>33%</td>
</tr>
<tr>
<td>Baby infection</td>
<td>3</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>ROP / RLF*</td>
<td>2</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other (baby)</td>
<td>1</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Failure to diagnose/treat (mother)</td>
<td>15</td>
<td>4</td>
<td>21%</td>
</tr>
<tr>
<td>Trauma (non perineal)</td>
<td>18</td>
<td>9</td>
<td>33%</td>
</tr>
<tr>
<td>Perineal trauma</td>
<td>35</td>
<td>10</td>
<td>22%</td>
</tr>
<tr>
<td>Epidural / Spinal</td>
<td>23</td>
<td>5</td>
<td>18%</td>
</tr>
<tr>
<td>Analgesia/Anaesthesia (other)</td>
<td>4</td>
<td>1</td>
<td>20%</td>
</tr>
<tr>
<td>Infection</td>
<td>9</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Retained products</td>
<td>21</td>
<td>4</td>
<td>16%</td>
</tr>
<tr>
<td>Retained swab</td>
<td>1</td>
<td>23</td>
<td>96%</td>
</tr>
<tr>
<td>Retained placenta</td>
<td>2</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Retained (other)</td>
<td>2</td>
<td>1</td>
<td>33%</td>
</tr>
<tr>
<td>Caesarean section</td>
<td>27</td>
<td>4</td>
<td>13%</td>
</tr>
<tr>
<td>Other (mother)</td>
<td>16</td>
<td>7</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>347</strong></td>
<td><strong>115</strong></td>
<td><strong>25%</strong></td>
</tr>
</tbody>
</table>

Figure 5.1 shows that there are many reasons for suing, and clearly perinatal litigation cannot be fully understood from a brief summary. The heads of claim are discussed further in Appendix J, with examples of successful and unsuccessful actions given, and the circumstances surrounding the origins of these claims are discussed more fully in Part III.

### A profile of litigants?

It is not intended (or feasible) to paint a picture of a typical pursuer; however the data available may help with defining and targeting risk and claims management. Dingwall and Fenn (1991: 97) note that in their study of 470 files they "were not permitted to link claim records with patient histories so...(their) data on plaintiffs is very limited." They go on to note that in a study of that size meaningful data are unlikely in helping to construct a profile of litigants, since sub-division would quickly make cell sizes too small for detailed conclusions.

* ROP - Retinopathy of prematurity; RLF - Retrolental Fibroplasia
In this research it was possible to link claim records with patient histories in 250 cases. In these files certain demographic data were available, such as the patient's (or her partner's) age and occupation; marital status was also noted. However, information was rarely comprehensive. Further details of those suing under the CNS head of claim are given in the 'Further data on CNS pursuers' section below; such cases are more critical from a risk or claims management point of view: the tragedy of the outcome (and the potential for damages) is much greater.

**Age of pursuers**

Age range for the pursuers (at the time of the relevant birth) is shown here:

**Figure 5.2**

The bulk of pursuers - not surprisingly - were in their twenties or early thirties: 84% of non-CNS pursuers and 82% of CNS pursuers were aged 20-34. In this respect the CNS and non-CNS pursuers are fairly similar. By parity, as might be expected, there was some difference in average age, with significant differences between primigravid women and those with two (p<.00001) and three (p<.05; calculation by Anova) children. However, given the entirely normal age range for both CNS and non-CNS pursuers, the theory that litigants are more likely to be 'elderly primigravidae' disgruntled at a less than optimal outcome, would seem to be dispelled.

**Parity**

From the following pie charts it can be seen that almost half (42% each) of both CNS and non-CNS litigants sued concerning events in their first pregnancy, and that more than half had not previously carried a pregnancy to viability (56% and 50.5% respectively). The category '0+' refers to those women who have had a spontaneous
or induced abortion, but have not carried a pregnancy beyond the age of viability (currently 24 weeks).

Figure 5.3

Parity of non-CNS pursuers

Figure 5.4

Parity of CNS pursuers

On its own, of course, parity tells us little; however, given that approximately 36% of births are to first time mothers, the high proportion of nulliparous litigants (i.e. those who had not previously delivered a viable baby) may reflect high expectations in society concerning pregnancy, or at least a reluctance to accept any outcome which is less than ideal.

It was also intriguing that these nulliparous litigants had a significantly higher success rate (p<.05) than the parous litigants. Their reasons for suing were broadly similar, the only marked differences being a much higher prevalence of suing for
perineal trauma and retained swabs. Both of these, but particularly the latter, explain the higher success rate.

**Social class: all litigants**
The following chart shows the proportion of litigants in each social class group; the Registrar General's standard classification was used (OPCS 1981). This data should be interpreted with great caution, since these figures were produced from the minority of litigants' files from which the social class group of either the woman or her partner could be ascertained; many descriptions were unclassifiable, such as 'army' or 'housewife'. The 'unemployed' category was not classifiable, but the figures are shown here for interest. The whole notion of classifying people by social class group is controversial, not least because many occupational groups are difficult to classify, and so these figures do little more than hint at the social class profile of perinatal litigants.

**Figure 5.5** Social Class of litigants

There has been a convention that where a woman's partner's occupational group is known, that should decide in which occupational group the woman is classified. Numerous anomalies to this approach may be cited, and indeed from these figures it can be seen that a much higher proportion of the partners came from social class one (p=.013). Analysis of the woman's occupation does show a 'bell-shaped distribution', although this is not quite so when analysing the partner's occupation.

Identification of occupation was only possible where the pursuer's midwifery case notes were available. A comparison of the reason for suing was made between those
pursuers whose occupation (or whose partner's occupation) was known, and those whose occupation was not known: analysis showed broadly similar reasons for going to litigation - 30% of the first group and 26% of the second group sued because of CNS problems in the child. The only statistical difference was found under the perineal trauma head of claim: 13% of the first group (n=24) compared with 8% of the second group (n=35), p<.05 (analysis by Chi-square).

Given the spread of social class groups, litigation clearly cannot be seen as the preserve of any one group; perceptions among clinicians of who is likely to sue are discussed in Chapter 9.

Access to Legal Aid
In only 87 cases was information on Legal Aid identifiable. In 21 it was refused: in three of these cases the baby had cerebral palsy, but these cases all occurred in the 1980s (before the rule changes concerning eligibility for Legal Aid). In 62 Legal Aid was allowed (eight of these on appeal). In a further five it was treated as abandoned, and in one case it was rejected by the pursuer. The outcomes of the legally aided cases (by head of claim) is shown in the following chart (in three cases there was more than one head of claim):

Figure 5.6*

Types of case in which Legal Aid was obtained.

In the 62 cases in which Legal Aid was known to have been granted, the pursuer was successful in 24 cases, unsuccessful in 22; the remaining 16 are still on-going. In one

* Figure 5.6: FTD - failure to diagnose; NND - neonatal death; SB - stillbirth; IUD - intrauterine death
of the 21 cases in which Legal Aid was refused, the pursuer was successful, but this case concerned a retained swab; such cases are usually conceded quickly by the defenders, and since the outcome is almost certainly a decision in favour of the pursuer, the Legal Aid Board may have felt that such a case did not require assistance of this sort.

Data on Legal Aid was sketchy, so conclusions are problematic; 23 cases concerned cerebral palsy, there were six concerning stillbirths, and eight concerning perineal trauma. However, of the closed cases in which legal aid was granted, the success rate is above 50%. Over the period 1980-95 the success rate is reasonably constant, with some fluctuation noted.

Figure 5.7

Cases in which Legal Aid was obtained

It is difficult to draw conclusions from these figures: obtaining Legal Aid certainly appears to improve a pursuer's chances of success, but this may simply reflect the Legal Aid Board's own screening process which aims to ensure that only cases with a reasonable chance of success are assisted in this way. Raising the 'success rate' to above 50% still does not come near to the figure for most personal injury litigation cited by Fenn and Dingwall (1989). In the last few years the rules concerning eligibility to Legal Aid have been tightened (this does not affect the cerebral palsy cases); it may be that this restricted eligibility accounts in part for the drop in incidence of litigation since 1993.
**Damages**

One aspect of the CNS cases which sets them well apart from the non-CNS cases is the matter of damages. While the average for non-CNS cases was £8,514.9, the CNS cases had a much higher average: £380,852 which was extremely significant statistically (p<.01; calculation by Anova).

For the CNS cases, three cases were settled for £50,000 or under. While at first glance this seems a comparatively small sum for a brain damage case, it should be remembered that the sum will be reduced if the child dies. The large costs are incurred for on-going expenses and loss of future earnings which of course will not apply if the child has died. At the other end of the scale, one of the cases was settled for £2.2m, and there have apparently been awards of £2.5m and £3.5m in 1996 (personal communication). The question of damages is discussed more fully in Chapter 7.

<table>
<thead>
<tr>
<th>Table 5.2</th>
<th>Damages awarded</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-CNS cases</strong></td>
<td><strong>CNS cases</strong></td>
</tr>
<tr>
<td>Under £1,000</td>
<td>Under £50,000</td>
</tr>
<tr>
<td>£1-5,000</td>
<td>£50-100,000</td>
</tr>
<tr>
<td>£5,001-£10,000</td>
<td>£100,000-£250,000</td>
</tr>
<tr>
<td>£10,000-£50,000</td>
<td>£250,000-£1m</td>
</tr>
<tr>
<td>Over £50,000</td>
<td>Over £1m</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>Average</strong></td>
</tr>
<tr>
<td>£8,515</td>
<td>£380,852</td>
</tr>
<tr>
<td><strong>Median</strong></td>
<td><strong>Median</strong></td>
</tr>
<tr>
<td>£2,800</td>
<td>£310,000</td>
</tr>
<tr>
<td><strong>Minimum</strong></td>
<td><strong>Minimum</strong></td>
</tr>
<tr>
<td>£200</td>
<td>£14,500</td>
</tr>
<tr>
<td><strong>Maximum</strong></td>
<td><strong>Maximum</strong></td>
</tr>
<tr>
<td>£140,000</td>
<td>£2.2m</td>
</tr>
</tbody>
</table>

Non-CNS cases, by comparison, tend to be much less expensive to settle: over a quarter of the 91 closed cases about which quantum is known were settled for less than £1,000. The most expensive to settle (at £140,000) concerned a woman who suffered a third degree tear at delivery and who required a temporary colostomy; the other more expensive non-CNS cases concerned poor episiotomy repair, damage to a cervix, and a neonatal death.

**Further data on CNS pursuers and cases**

As mentioned above, it is not intended to construct a picture of a typical pursuer. Nevertheless, if risk management can identify features or prevent occurrences or events which lead to such tragic outcomes, then few would argue that any
information which helps this process should not be used. The following data illustrate further the spectrum of individual backgrounds of legal cases concerning CNS events, and highlight the difficulty in constructing a comprehensive risk management approach.

From the overall identified incidence of litigation in this field (n=166), data concerning at least some of the demographic background and clinical events was available in 88 cases. Usually this was because a copy of the mother's or child's case notes were included in the legal file; occasionally it was from reading a comprehensive summary of the case in an expert report.

Although at least some data was available in 88 cases, the amount and quality of data varied, and many of the features discussed here relate to a much smaller sub-sample; where this is the case, the size of the sub-sample is given (n=). However, valuable information is presented which may help clinicians and health service managers to identify particular at risk situations, and hopefully to deal with them both competently and sensitively so that the misunderstandings which characterise so many legal cases are minimised.

One inescapable conclusion, however, is that cerebral palsy is often an unexpected outcome, and that the predictive abilities of the markers of fetal or neonatal compromise described in the literature review and Appendix B are often poor. The implication this has for clinicians is rather perturbing, since their actions may be held up to intense scrutiny even when all the available information at birth and in the early days indicates a healthy baby.

**Social class: CNS pursuers**

As stated before, the analysis of social class is particularly problematic, and again, it is not known whether the parents of whom personal data was available are typical of all the litigants in this study. The following charts show the social class composition of (respectively) the mothers and fathers of children with CNS damage compared with all other litigants.
As can be seen, the CNS pursuers are slightly more likely to be in the higher social class groups, although in neither figure does this reach statistical significance. It is possible that this reflects an even greater unwillingness among the better off in society to accept without complaint the fact of a brain damaged child. It is commonly accepted that the middle classes are better able to take advantage of facilities and benefits, and it may be that their assertiveness is reflected in the area under study.

One aspect of these cases which may support this contention is the examination of the rates of success of CNS pursuers when analysed by social class: a possible explanation is that a typically middle class assertiveness is required in order to deal with protracted legal proceedings, and indeed to push them along when things
become sluggish. It will be remembered that successful CNS actions took on average 64.9 months to conclude.

<table>
<thead>
<tr>
<th>Table 5.3 Social class of CNS pursuers... and of their partners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Success</strong></td>
</tr>
<tr>
<td>SC1 or 2</td>
</tr>
<tr>
<td>SC3 (N and M)</td>
</tr>
<tr>
<td>SC4 or 5</td>
</tr>
</tbody>
</table>

Success does appear to be concentrated in the better off pursuers - in fact none of the Social Class 4 or 5 pursuers were successful. However this observation is just that, and is not intended to indicate a causal relationship between social class group and chance of legal success. Unfortunately the number of closed cases where the pursuer's social class is known is relatively low, but it is interesting to be reminded that the overall success rate under this head of claim is 17.6%.

Marital status was identifiable in only 60 cases.

<table>
<thead>
<tr>
<th>Table 5.4 Success rate of CNS pursuers analysed by marital status</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marital status</strong></td>
</tr>
<tr>
<td>Married</td>
</tr>
<tr>
<td>Widowed</td>
</tr>
<tr>
<td>Divorced</td>
</tr>
<tr>
<td>Separated</td>
</tr>
<tr>
<td>Single</td>
</tr>
</tbody>
</table>

Little can be concluded from such limited figures. When success rates by marital status are examined, the numbers become too small for conclusive analysis, but it is interesting that of the 36 closed cases the eight successful pursuers were all married. It is possible that, together with a typical middle class assertiveness, a degree of family support is also required in order to pursue a case successfully. However, too much ought not to be read into this: marriage as an institution is far less popular, and many of those noted to be 'Single' may in fact have had long term partners who could provide the support theoretically provided by a husband.
Obstetric and medical history

Of the parous mothers, data on previous obstetric history was available in just 25 cases. In 14 of these, no poor obstetric history was noted; for the remaining 11, the relevant obstetric events are as noted here:

<table>
<thead>
<tr>
<th>Table 5.5 Parous mothers with poor obstetric history</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caesarean section</td>
</tr>
<tr>
<td>Premature delivery</td>
</tr>
<tr>
<td>Premature twin stillbirths</td>
</tr>
<tr>
<td>Neonatal death, and ≥ 2 spontaneous abortions</td>
</tr>
<tr>
<td>≥ 2 spontaneous abortions</td>
</tr>
<tr>
<td>Third degree tear</td>
</tr>
</tbody>
</table>

By and large clinicians are already alert to the significance of a poor obstetric history. These figures reinforce the need to identify such information where it exists but, given that a poor obstetric history was found in a minority of parous women with data available, also illustrate how the absence of a poor obstetric history is no guarantor of what would be considered a good obstetric outcome in a subsequent pregnancy.

Of all the pursuers under this head of claim, 13 (out of 41 with evidence of background data) had an existing medical condition; this included three who also had a poor obstetric history. These conditions are shown here (some had more than one condition):

<table>
<thead>
<tr>
<th>Table 5.6 CNS pursuers with existing medical condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic hypertension</td>
</tr>
<tr>
<td>Respiratory disease</td>
</tr>
<tr>
<td>Cardiovascular disease</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Psychosis</td>
</tr>
<tr>
<td>Diabetes</td>
</tr>
<tr>
<td>Epilepsy</td>
</tr>
<tr>
<td>'Tremor since childhood'</td>
</tr>
<tr>
<td>Genito Urinary infection</td>
</tr>
<tr>
<td>Tuberculosis</td>
</tr>
</tbody>
</table>

It is not suggested that these conditions necessarily have any causal connection with either the outcome of the pregnancy in question, or the decision to sue; their
existence is merely noted. It is quite routine for such information to be collected when a pregnant woman books for antenatal care and delivery at a hospital; the aim is to identify possible 'at risk' situations which may be amenable to intervention.

**CNS: Antenatal care**

Antenatal care is aimed at establishing that a pregnancy is ongoing and that the mother and baby are both healthy. Identification of pregnancy complications is a key feature, and for this reason the obstetric ideal is that women should register with a maternity unit early in the pregnancy, and have regular check-ups. The time of the first clinic appointment (measured in number of weeks pregnant) is an indicator of how well this ideal is met; similarly, the total number of clinic appointments is an indicator (admittedly a rather crude one) of the level of obstetric input.

For these mothers who eventually have a child with a CNS problem, the average first hospital clinic appointment was at 15.5 weeks (range 6 to 32). This is slightly higher than the first booking of all other pursuers (13.7 weeks; p<.05, calculation by Anova). Whether this is relevant in terms of outcome would seem unlikely, but it is curious that a poor pregnancy outcome is associated with what many obstetricians might see as a less than optimal start to antenatal care. In fact over time this finding is not consistent: although the first visit time is later in the years 1988-91 (15.3 compared with 13.3 weeks), and markedly later between 1984-87 (17.3 compared with 13.4 weeks), between 1980-83 and 1992-95 the first visit time is slightly earlier in the CNS cases. It would appear that this is a chance finding.

The pattern of antenatal care has changed significantly over the last decade or so, with moves to reduce the number of routine hospital clinic appointments for the healthy pregnant woman. For this reason merely counting the number of clinic visits is a very crude tool by which to assess the level of obstetric input; in fact the total number of hospital clinic visits for the CNS pursuers was lower than the number for all other litigants (4.5 compared with 5.7); this also reached statistical significance (p=.02), and is not explained by the women in the first group delivering more prematurely. Again, this finding is noted for interest, and is not intended to help explain obstetric outcome; many other variables have influenced the number of clinic visits; a more accurate measure might be counting the total number of antenatal visits (whether in a consultant's, midwife's or GP's clinic), but this information was only available in a small number of case files.
Given that the cause of cerebral palsy is poorly understood, but that a large majority of cases are believed to be due to early pregnancy events which are not amenable to intervention, instigating additional antenatal surveillance (in the form of more clinic visits) may only be trying to close the stable door once the horse has bolted. These findings, then, are anomalous, and difficult to explain. It should also be borne in mind that the data relate only to those parents who have a brain damaged child and who have decided to take legal action; in this respect they may not be typical of all parents with brain damaged children.

Factors possibly associated with cerebral palsy have been described in Chapter 2 (and are more fully detailed in Appendix B); their prevalence in this study is now discussed. Multiple pregnancy occurred in only six out of the 166 legal cases concerning CNS problems; in two out of these six cases, delivery was premature. Confirmed antepartum haemorrhage occurred in 17 cases; 8 of these ended in premature delivery. A minority of all cases (25%) concerned premature delivery, which may reflect a greater acceptance by parents of a baby born prematurely who has developed cerebral palsy that negligence had nothing to do with their child's condition. The gestational palsy that negligence had nothing to do with their child's condition. The gestational ages for the brain damaged children the subject of litigation is shown here:

Figure 5.10

Gestational age of CNS babies

![Gestational Age Graph]

Confirmed intrauterine growth retardation (IUGR [measured by birth weight being less than the tenth centile]) was a factor in 24% of all these cases, but was much
higher among boys than among girls (35% and 12% respectively; p<.05 by Chi-square analysis).

Figure 5.11

Birth weight centiles of CNS babies

Although IUGR was present in only a quarter of cases, this is theoretically a factor which could be diagnosed antenatally. Whether or not this would lead to elective operative delivery which would (in theory) prevent both birth asphyxia and subsequent cerebral palsy is a moot point: current theory holds that IUGR is probably a manifestation of an existing susceptibility in that fetus, and that the cerebral changes which manifest later as cerebral palsy have already taken place. Nevertheless, it is one of the roles of antenatal care to identify the at risk fetus, and to instigate careful monitoring, particularly in labour.

Identification of the gender of the baby in question was possible in 79 cases; 46 of these were boys, compared with 33 girls. It is acknowledged that there are more boys born with cerebral palsy than girls, the ratio being about 1.3:1, which is reflected in this study.

CNS: The labour period

Induction of labour was noted to have been carried out in 25 cases. In twelve of these a specific reason was mentioned: Post dates (6); PET (2); IUGR (1); APH (1); reduced liquor and poor CTG (1); reduced fetal movements and poor CTG (1). The first of these examples does not denote any particular concern about fetal well-being; the others all indicate that either the known maternal or presumed fetal condition warrants intervention by induction. However, little can be deduced from this, since induction rates between different hospitals and between different consultants within the same hospital vary greatly, as do definitions for induction criteria. Half of the
induced group (n=13) went on to have their labour augmented: 3 by rupture of the membranes, 4 by syntocinon, and 6 by both of these methods.

Inadequate fetal monitoring has been identified as a feature of litigation (James 1991; Capstick and Edwards 1991). Details about the level of fetal monitoring in labour were, unfortunately, unavailable except in a few cases. In four it was evident that no monitoring had taken place, in 18 there had been intermittent monitoring, and in a further 9 monitoring had been continuous. Of the 12 who had stated reasons for induction, six were monitored intermittently, and two (both induced for post dates) continuously. For the remaining four, no information concerning monitoring was found.

Of the 27 in which either intermittent or continuous monitoring was known to have been carried out, and a further eight in which at least intermittent monitoring was carried out, the following were found (information on the presence or absence of abnormalities was only available in 29 cases):

| Table 5.7 |
|-----------------|-----------------|-----------------|
| CTG monitoring of babies who develop CNS problems... | and outcome of case | Pursuer | Defender | On-going |
| No abnormalities | 8 | 0 | 3 | 5 |
| Prolonged bradycardia | 5 | 2 | 3 | 0 |
| Severe variable decelerations | 5 | 2 | 2 | 1 |
| Reduced variability | 3 | 2 | 1 | 0 |
| Late decelerations | 2 | 0 | 1 | 1 |
| Combination of abnormalities | 6 | 2 | 1 | 3 |

In four of the eight cases in which no abnormality was found, the pregnancy had gone to term without apparent mishap; in two of the others the baby was premature (one at 36 weeks, the other at 31 weeks). Little data was recorded concerning interventions in labour - in only six cases was fetal blood sampling known to have been attempted (two of these were unsuccessful). While the absence of a FHR abnormality seems to weigh in favour of the defender, the converse is not necessarily true: it can be seen that the mere presence of a FHR abnormality is no guarantee of success for the pursuer.

Similarly the presence (or absence) of meconium during the labour does not necessarily indicate the outcome of the case; it is facile to assume that one possible
marker of fetal compromise will do so, despite an apparent assumption on some people's part that the presence of meconium confirms fetal compromise:

| Table 5.8 : Relationship of meconium staining to outcome of case |
|---------------------------------|-----------------|---------------|---------------|
| CNS babies:                     | Pursuer | Defender | On-going |
| Meconium present                | ..      | 5        | 7           | 9           |
| Meconium not present            | ..      | 2        | 9           | 5           |

The numbers involved here are very small; any study which hoped to show possible associations would need to have much more information about the details of the labour.

The mode of delivery for the babies whose CNS problems became the subject of litigation (n=77) is shown here:

<table>
<thead>
<tr>
<th>Table 5.9 Mode of delivery CNS babies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spontaneous vertex</td>
</tr>
<tr>
<td>Breech</td>
</tr>
<tr>
<td>Vacuum</td>
</tr>
<tr>
<td>Straight forceps</td>
</tr>
<tr>
<td>Rotational forceps</td>
</tr>
<tr>
<td>Elective caesarean</td>
</tr>
<tr>
<td>Emergency caesarean</td>
</tr>
</tbody>
</table>

Table 5.10 shows the clinical reason for the 27 emergency caesarean sections:

<table>
<thead>
<tr>
<th>Table 5.10 Reasons for emergency section, CNS babies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fetal distress</td>
</tr>
<tr>
<td>Premature labour</td>
</tr>
<tr>
<td>APH / IPH</td>
</tr>
<tr>
<td>Abruption</td>
</tr>
<tr>
<td>Previous section and breech</td>
</tr>
<tr>
<td>Breech in labour</td>
</tr>
<tr>
<td>Transverse lie second twin</td>
</tr>
<tr>
<td>CPD</td>
</tr>
<tr>
<td>PET</td>
</tr>
<tr>
<td>Failed ventouse</td>
</tr>
<tr>
<td>Compound presentation</td>
</tr>
<tr>
<td>Not stated</td>
</tr>
</tbody>
</table>
The 'fetal distress' category is one which is difficult to define, since it is a notoriously subjective assessment. The discussion in Chapter 2 noted how various definitions compete, yet none secure real confidence concerning predictability of outcome. Clinicians' views about this are explored in Chapter 10.

It is also interesting to note the two cases in which babies were delivered electively by caesarean section; in theory they have avoided the pitfalls of labour altogether. Both were born at term, the reason for operation being identified cephalo-pelvic disproportion; both were born in good condition, although one was noted to appear dysmorphic. The reason for the cerebral palsy is unclear; one action was unsuccessful, the other is on-going.

Mode of delivery itself gives only an indication of how staff view the fetal condition during labour; any instrumental or operative delivery in labour would indicate a degree of concern about fetal well being. Another angle is to examine length of labour.

Figure 5.12

Length of labour CNS babies born vaginally

For those born by SVD*, average length of first stage of labour was 7.42 hours (range 1.75 - 16); second stage average 50 minutes (range 3-180). For the forceps deliveries, average first stage was 7.9 hours (range 2 - 13), second stage average 60 minutes (range 25-240). In few of these cases is there - at first glance - any

* SVD - Spontaneous Vertex Delivery (a 'normal' delivery)
indication that the first stage of labour is particularly long; indeed, some are quite short. More contentious is the length which a second stage of labour ought to last (or be allowed to last). In the absence of any signs indicating fetal compromise, many clinicians will be prepared to allow it to last for up to three hours; Saunders et al (1992) claim that a prolonged second stage has no consistent relation with low Apgar scores or admission to a special care baby unit, although it is positively associated with early maternal morbidity. Other clinicians, mindful of the potential for poor outcomes, will intervene much sooner. Again, the matter of how the process of labour is viewed is discussed in Chapter 10. Given the knowledge about the outcome of these cases, it may appear obvious that some of the labours ought to have been brought to a swifter conclusion. However this is contentious, for the desire to have a normal delivery without interference is a significant factor for many pregnant women, as is the desire by many clinicians to ensure as much as possible that this happens. Nevertheless, patient autonomy and choice are not as paramount as some may believe or wish; again, this is explored in the staff surveys.

Inadequate supervision, whether of patients or junior staff, has been identified as a factor in poor outcomes (James, 1991). The circumstances surrounding this topic are explored further in Chapter 6, since supervision may relate to the entire period of labour. However, it has been possible to identify the grade of the person delivering the baby in some of the CNS cases in which mode of delivery was clearly noted (see Table above). A whole range of staff positions is involved, confirming the frequently unpredictable nature of such poor outcomes.

| Table 5.11 Grade of accoucheur delivering baby with CNS problems |
|------------------|------------------|------------------|
| Mode of delivery | Accoucheur        | Supervised by    |
| SVD (n=14)       | Student midwife (4) | Staff midwife (2) |
|                  | Medical student (2) | Sister (2)       |
|                  | Staff midwife (4) | Staff midwife (1) |
|                  | Sister (4)        | Sister (1)       |
| Breech / Vacuum (n=5) | Registrar (3) | Not known |
|                    | 'Doctor' (2)       |                  |
| Forceps (n=13)    | SHO (2)            | Not known        |
|                    | Registrar (10)     |                  |
|                    | Consultant (1)     |                  |
| Emergency caesarean (n=17) | SHO (1) | Not known |
|                   | Registrar (15)     |                  |
|                   | Consultant (1)     |                  |
In the cases where the senior supervising staff member has not been identified, this is because the information was not available in the legal file; it cannot be taken to mean that there was no such supervision. What this table does indicate is that no matter a staff member's seniority or length of experience, they may find themselves involved in an investigation of events which have culminated in a tragic outcome. What the table cannot do is explain the circumstances behind each individual case; some of these circumstances are explored in Chapter 6, which looks at some legal claims in the context of the clinical setting.

**CNS: initial condition of the newborn**

While mode of delivery will give some indication of the perceived condition of the baby at birth, a far better assessment is the Apgar score at one and five minutes. As stated in Chapter 2, this measurement has been criticised, particularly for its poor predictive value, but it still remains the almost universal method of charting the condition of the newborn baby. It also gives an indication - crucial in terms of litigation - of how well the baby appears to have coped with the stress of labour. In 77 cases the Apgar score was stated (this did not include two babies born in 'Good condition').

The 1-minute score gives only an initial assessment of the degree of asphyxia (if any), and indicates the level of resuscitation required. While it is poorly predictive in terms of outcome, a low score should be accompanied by careful but vigorous resuscitation; the atmosphere in the delivery room is likely to be tense, and the mother (and her partner if he is present) will almost certainly be aware of this; how this affects their recollection of events will vary. Some of the issues surrounding perceptions and recollections are discussed in Chapter 8.

As can be seen, a large proportion (53%; n=41) of these 77 babies were born with a serious degree of asphyxia (an Apgar score of 3 or less); a further 13% (n=10) had moderate asphyxia, and 14% (n=11) had mild asphyxia. Only 19% (n=15) were not thought to be asphyxiated at one minute.
The poor predictive value of the one-minute score has been mentioned; less inaccurate is the five-minute score, which is held to have a better correlation with eventual outcome (Levene et al 1986). It can be seen from the following figure that the five minute scores indicate a significant improvement for many of the babies.

By this stage, far fewer of the babies are severely asphyxiated: 13% (n=10). A further 19% (n=15) are moderately asphyxiated, with 17% (n=13) mildly asphyxiated. 41% (n=32) are not thought to be asphyxiated. The improvement in score is illustrated in the next figure, which shows the average 5-minute score for babies with a particular one-minute score.
This shows the correlation between one and five minute scores: although those babies born severely asphyxiated do improve, this improvement still takes them to the level of moderate asphyxia at best by five minutes. Those born moderately asphyxiated are much more likely to do well; and those with mild asphyxia at one minute are seen not to have any degree of asphyxia at five minutes. Of course these figures represent an amalgam of individual cases: even some babies born with severe asphyxia manage to improve to the extent that they are not considered asphyxiated at all by five minutes; equally, other babies barely improve at all.

However, despite the clear overall improvement seen here, all of these babies subsequently develop cerebral palsy; it should be borne in mind that the Apgar score is only one factor, and that despite a good initial condition, a premature baby may still encounter many problems which could affect its cerebral functioning. However, Figure 5.9 above shows how a large majority (75%) of these babies were born at term, so prematurity cannot be claimed as a complicating factor for most. Given the immense importance attached to the labour period in litigation of this sort, it is critical to note the apparently good initial assessment of so many babies who later manifest cerebral problems. Clinicians delivering a term baby with no noted asphyxia at five minutes, and no obvious congenital abnormality, will be inclined to feel that the outcome from the baby's point of view has been good, and are unlikely to expect the outcome to become the subject of litigation; yet these legal cases are proof that this can occur.
Data on cord blood gas analysis was unfortunately unavailable in these cases. It has been mentioned that fetal blood sampling was attempted in six cases, but routine cord blood analysis is a relatively recent innovation, and given that many of these examples of cerebral palsy concern term babies with no apparent asphyxia, in the absence of a clear clinical indication to carry out cord blood analysis this would not be done. In recent years maternity units have acquired the facility to perform this test on site, rather than having to rely on portering and laboratory staff to transport specimens and carry out tests; until this has been common practice for some time it will not be possible to secure comprehensive data on the blood gas analysis of the newborn baby.

A complicating factor is the existence of a congenital abnormality; in many cases this will make the pursuer's case difficult to prove, since the causal element required by law will not be proven if the baby's condition is due (at least in part) to its congenital condition. In four of the cases under review a congenital abnormality was mentioned; in one case it was not specified, which makes causal connections difficult to establish. The other three were a child with hydrocephalus, one with an XYY chromosomal complement, and one described simply as 'dysmorphic'. None of these four cases succeeded.

**CNS: The neonatal period**

Admission to a special care or intensive care nursery is another indicator of the newborn's condition. Of the 77 cases examined this occurred in 46 cases; in a further 8 it was specifically stated that admission had not taken place (these eight all concerned term babies with an Apgar score of 8 or more at five minutes).

An infant's progress in the neonatal period may also help to explain a subsequent condition. Neonatal seizures certainly indicate a degree of cerebral dysfunction, and, as noted in Appendix B their presence has been claimed to represent a hugely increased risk of developing cerebral palsy (Johnson 1991). Information on this topic was available in 41 cases: in 7 of these, the baby definitely did not have a seizure; in a further 3 there was a possibility of seizures having occurred; in 2 cases they occurred only after discharge home, and in 29 cases they were clearly documented while in hospital.

Data available on these showed that gestation ranged from 34 to 42 weeks (average 39.2; n=25); only three of these babies were premature. Apgar scores at five minutes
ranged from 0 to 10 (average 5.2; n=24), with eight babies not apparently considered asphyxiated at that stage:

Figure 5.16

5-minute Apgar score of babies who had seizures

Seizures are problematic in terms of truly objective diagnosis, not least because babies thought to be starting to fit will often have strong anti-convulsant drugs administered; these prevent the outward signs of seizures but also diminish consciousness to the extent that it is difficult to verify either cerebral irritation or cerebral well-being. The mere presence of one or more seizures does not necessarily indicate permanent cerebral damage, but the longer a baby continues to fit the greater the evidence of cerebral dysfunction, and the poorer the outcome. Given the routine masking of the most obvious evidence for such seizures, it may be difficult to know how many fits a baby has had, and so predicting permanent cerebral damage becomes complicated. As these legal cases indicate, very often the diagnosis is made only after some time.

Another diagnosis which indicates concern about a baby's cerebral function is Hypoxic Ischaemic Encephalopathy (HIE). This is discussed further in Appendix B in relation to neonatal seizures. Data on encephalopathy was given in only a few of the cases studied here: in 2 cases, it was noted to be mild; in 9 it was believed to be moderate; and in a further 9 it was recognised as being severe. In two other cases the grade was not mentioned. All those with a diagnosis of HIE were known to have had seizures; however, three babies with known seizures were believed to be normal on discharge home, so the presence of seizures alone does not necessarily indicate immediately that a child has HIE. Nevertheless, these three babies were later found to have cerebral palsy, so the optimism at the time of discharge home proved to be unfounded.
Of all the babies for whom information was available concerning their supposed condition at the time of discharge home (n=48), a third (n=16) were believed to be normal. Of these 16, the day of discharge ranged from 2 - 36 (average 11); all except two were term babies (these two were both born at 31 weeks). Four had moderate or severe asphyxia at five minutes (their Apgar scores were 3,4,6,6), but all the others were not thought to be asphyxiated; and three were known to have had seizures in hospital. What these cases show is that confidence in a diagnosis of normality may be misplaced on occasion. Given the lack of any hint of intrapartum or neonatal problems in some of these babies, further weight is leant to the argument that many cases of cerebral palsy do not concern the labour period, and that the apparent belief in much of society that labour should be the target for intervention (and for criticism when this is not done) is often erroneous.

Summary
There is a wide variation in reasons for suing, which makes descriptions of the phenomenon complicated. It cannot be put down to concerns about brain damaged children alone: while this was by far the most common of all reasons for suing, it accounted for only 26% of all cases. The unpredictability of cerebral palsy as an outcome was also a notable feature: in several cases the child was apparently normal at discharge home, and many babies who subsequently had cerebral palsy diagnosed were not thought to be asphyxiated at birth. Implications for the education of clinicians are developed further in Part III, but it is important not to focus exclusively on the CNS cases, despite their distinction from other cases, notably in terms of potential damages. Any risk management which aims to reduce the likelihood of future litigation must take account of the wide spectrum of heads of claim.

A profile of litigants was attempted, and while it was interesting to note the apparently greater rate of higher social class litigants in the CNS cases, and the higher rates of success enjoyed by those who were of a higher social class, the numbers involved were small, and the whole notion of classifying people by social class problematic. The age range of pursuers showed no surprises, although the high incidence of primiparous litigants may reflect high expectations and consequent dissatisfaction when an outcome is less than desirable. For a more accurate profile, many more cases would need to be examined, but this data serves at least to open the debate, given the difficulty which other researchers have had even in linking claims and personal data.
Data concerning access to Legal Aid was sketchy. Given that cases are screened by the Scottish Legal Aid Board before financial assistance is given, it may be thought that a success rate of just 50% is rather low; however this is twice the overall success rate for perinatal litigation as a whole, and better than the figures quoted by Fenn and Dingwall (1989) for medical negligence litigation generally.

The discussion of the clinical background to legal cases involving cerebral palsy provides a valuable understanding of some of the complexities of this issue; the poor predictability of the condition has been demonstrated, although data was unfortunately sketchy in many instances, and conclusive analysis impossible. Nevertheless the information provided here illustrates the potential for litigation which exists in the clinical situation.
Part II: Conclusion

Chapters 4 and 5 have described the incidence and nature of perinatal litigation. While the incidence rose sharply throughout the 1980s, it appears to have fallen dramatically since 1990, and especially since 1993. Whether or not this trend will continue will only be known when data for current years are made available. Nevertheless it may be that the supposed 'litigation crisis' has passed, which, if true, will have far-reaching implications for health service finances.

However, merely listing how often and why people sue is unlikely to be much use in terms of identifying ways of reducing the incidence of litigation, the apparent drop in incidence notwithstanding. The huge variations seen between different hospitals means that little can be taken for granted in terms of trying to predict when cases will arise. Equally uncertain is the outcome of the different heads of claim, the only exception being that of the retained swab, whose outcome is almost certain. For the other cases an understanding of the circumstances surrounding the events in question is required, and this is given in Chapters 6 and 7. Obstetricians were involved in most of the cases under review; occasionally anaesthetists or neonatologists bore the brunt of the legal action. In all cases midwives were involved, either directly (e.g. through their actions at delivery) or indirectly (because they were present when the actions of other clinicians formed the basis of the law suit). The multi-professional nature of this aspect of medical negligence litigation makes co-operation between the different groups essential if risk management is to work. However a consultant obstetrician's vicarious liability for staff working under his/her aegis, together with the concern many midwives have to assert their autonomy and the consequent struggle for control between midwives and obstetricians, often makes this difficult; these features are explored further in Parts III and IV.

A heavy emphasis on CNS cases, quite apart from their 'news-worthiness', reflects the concern which such cases generate in health service circles. Despite being only one of many types of claim, the difficulties with investigating the claim (because of the longer time it takes to initiate) and the potential for heavy damages, means that such cases must be considered separately. As with all the other cases, there is much more to them than the mere fact that they have been brought. Risk and claims management can only begin to target particular situations when they have much more information about the circumstances of the claim available. Part III develops this theme, starting with a discussion in Chapter 6 of the clinical situation which forms the basis of these law suits.
Part III

Delving further: the origins, conduct, and outcome of perinatal litigation
In Part II the incidence of perinatal litigation and the reasons for suing were described; however this gives little more than a superficial view of the situation. In order to augment and clarify the picture, and to provide the detail necessary for risk and claims management, some cases are described here in a way which goes beyond merely describing the primary reason for suing. Part III is divided into three chapters, looking at clinical, legal and other influencing factors in turn; this will identify and highlight certain features of litigation which may be amenable to change.

Chapter 6 looks at events in the context of their clinical setting, and describes how these may be influenced by such exigencies as unit protocols and policies, levels of supervision, and the notion of a pregnant woman's capacity for choice and consent. The legal importance of CTGs is stressed, and the question of failing to make a diagnosis is discussed in the light of certain cases. These are features which may be amenable to targeted improvement through continuing education of staff; as such, a reduction in the occurrence of events which lead to litigation may be hoped for.

Chapter 7 describes legal features such as the involvement of pursuers' solicitors and the question of causation; it also examines some of the financial aspects of litigation, and explains how these may affect the conduct of the case. Such characteristics often do little to induce confidence in the legal system, and it is hoped that the discussion in this chapter will contribute to the debate about legal reform.

Having examined legal cases from clinical and legal perspectives, Chapter 8 scrutinises some of the factors which influence the origins and course of litigation. 'Talking to patients' considers the importance of communication, and looks in particular at how patients are warned of possible complications or poor outcomes, and how apologies and explanations are handled when such outcomes occur. 'Recollections' explores some of the problems which arise when patients and staff alike encounter difficulties with remembering events accurately; and 'Motives for litigation' investigates some of the possible reasons which propel patients to become litigants. Lastly, 'Delays' reviews one of the least attractive aspects of litigation, namely how even relatively straightforward cases can become bogged down in a legal or bureaucratic morass.

However disheartening at first, most of these influencing factors are amenable to some form of targeted educational or administrative improvement; this will be of interest to lawyers, as well as health managers and hospital Trusts, whose budgets and reputations are directly affected by prolonged litigation. In theory, improved
communication between patients and staff at particular times will contribute to a reduced perception on the part of patients that litigation is necessary.

It is not possible to include a full summary of each case, but notable features are identified from selected cases which help to illustrate particular points. It is not intended that the success (or otherwise) of a legal action can be deduced from these brief summaries. In order to preclude identification of the people involved, in all relevant cases I have substituted initials for names, the initial in question not being the first letter of that person's name. Where relevant, times have also been altered, although the length of time between specific events is accurate. Each case has a unique identifier: a number with a description of the type of hospital concerned (TH - teaching hospital; DGH - district general hospital; CH - cottage hospital).

These legal cases come from both Scotland and England; also to help preclude identification of particular cases the term 'legal department' is used in each case to describe the actions or reports of the defence solicitors. In Scotland this is the Central Legal Office of the Scottish Health Service, which is based in Edinburgh; in England it is the relevant local health service legal office.

There are many different points which can be made from these legal cases, and indeed one case may be viewed in a number of different lights. In this discussion certain legal procedures will be referred to; to clarify these and to help explain the usual conduct of legal cases, the following flow chart and explanation should be borne in mind. This is only a very approximate summary of the course of events in perinatal litigation, from the onset of the claim to settlement. Most cases will broadly follow this pattern; at any stage either side may concede; if the pursuer is successful, the matter of damages is then negotiated.

The following shows only a very brief outline of a typical case. The timing of the writ varies - it can be the first intimation of a claim, or may appear after months or years of argument between the legal department and pursuer's solicitors. Either side may concede the case at almost any stage.
Usual course of events

**Pursuer consults solicitor**

**Intimation of claim received by legal department (LD); this may come in the form of a writ.**

**LD informs hospital, and repudiates allegation in the first instance. If case notes requested, these are copied to solicitor or nominated expert**

**Investigation by hospital:**
- locating and examining case notes
- statements by staff involved
- opinion of senior staff (whether or not directly involved)

**Formal repudiation by hospital if it appears that no negligence has occurred**

**Expert report by senior obstetrician or midwife from another hospital or university department if there is doubt about causation or staff involvement**

**If experts agree, case may be dropped by pursuers or conceded by defenders; if pursuers successful, quantum negotiated**

**If experts disagree, writ may be served, or further reports requested on the areas of disagreement**

**If sides still disagree, case may proceed to court**

**Explanation**

The pursuer (or plaintiff) may be the patient herself, her partner, or in the case of a child, a parent or guardian

Initial repudiation gives the hospital time to investigate

This determines whether the case will be defended or not

Pursuer may accept this repudiation, especially if accompanied by a full explanation

The expert report gives an impartial view of the case, and if critical of staff will often lead to an offer to settle the action

The pursuer's expert does not usually disclose his/her findings to the defenders; however the pursuer's solicitor may allude to certain findings or opinions.

Quantum is the amount of damages

Depending on these findings, either side may concede at this stage

Settlement may be reached just before the court stage in order to avoid high court costs if one side fears it may not win
Chapter 6

Clinical aspects

The clinical aspects of legal cases cover many areas; a large majority, although by no means all, relate to care given in the intrapartum period. These aspects include staff actions, the quality of communication with patients (particularly where explanations are sought), supervision, notions of choice and consent, the consequences of alleged delay in treatment or care, and the place of protocols and policies in maternity units.

The following discussion takes certain legal cases and examines them in the light of such headings; placing legal cases under this spotlight will broaden the understanding of the reasons for litigation, and so help to focus the debate on how to reduce its incidence.

Failing to diagnose

Staff may be criticised for failing to make a diagnosis. This in itself is not evidence of negligence, but the failure to take steps to diagnose in certain circumstances may be. However, there does appear to be a perception among some members of the public that failing to diagnose something is itself negligent.

Case 8 (DGH) At 24 weeks a woman goes into premature labour; staff diagnose a urinary tract infection, which can be very similar in its symptoms.

Pursuers do not accept that the symptoms may be so similar that they can be confused - i.e. do not accept that the staff could have honestly not diagnosed premature labour. The baby is born alive, but subsequently dies.

Although this case is apparently dropped, the pursuer is clearly disgusted with the standard of care she believes she has received, and in her next pregnancy she refuses to book with any hospital within the same health board. In another quite extraordinary case, legal action is brought because of a failure to diagnose two pregnancies in the same woman.

Case 573 (DGH) Woman took contraceptive pill right up until the 34th week of pregnancy; had gone to her GP complaining of swollen ankles at 32 weeks and been referred to a consultant. Her GP had diagnosed a stomach growth which would have to be removed. Consultant then diagnosed pregnancy.

Four years later she went to her GP complaining of abdominal pains; he diagnosed "stomach problems" and referred her to a consultant who diagnosed fibroids - she said she was still having monthly periods.

It turns out that she was 18-20 weeks pregnant at this stage.
Presumably the fact that the woman said she was still menstruating (apparently ruling out the possibility that she might be pregnant) explains why this case was unsuccessful.

Taking reasonable steps to diagnose something will be a defence; failing to do so, or failing to recognise the significance of findings, may count heavily against a clinician. In the following case a failure to carry out monitoring formed the basis of the complaint:

*Case 418 (DGH)* Stillbirth at 32 weeks. The pursuer claims that the midwives who attended her at home (because of her raised blood pressure) did not predict the intrauterine death. The Community Midwife refers her to hospital with a history of no fetal movements. Although there is only mild hypertension, extensive placental infarction occurs. Claim is that although on three occasions she was seen by midwives and complained of lack of fetal movement, no extra monitoring was carried out. The report notes that little was done to identify the problem, which was particularly severe as it developed between 28 and 31 weeks. Had this been done, fetal compromise would have been noted, and steps taken to deliver the baby.

In another case a baby is stillborn when the presence of meconium is apparently detected, but not acted upon:

*Case 542 (TH)* The admitting midwife records "no SRM", but also "black substance in the vagina" - now presumed to be meconium. Expert report: "The finding of meconium can only be made once the membranes have ruptured; every midwife must know this basic information. However this particular midwife seems to have been happy to record two mutually exclusive statements in her admission note."

This claim appears indefensible, and is to be settled. The failure to detect an incomplete placenta and abnormally high blood loss postnatally led to critical illness in another case:

*Case 416 (DGH)* Recurrent postnatal vaginal bleeding; patient collapses. Haemoglobin found to be 2.7g/dL. In Theatre, "substantial piece of placental tissue" removed. Placenta had been thought initially to be doubtful, then said to be complete (Pathology received a piece of placenta 10 x 6 x 4 cm). Hypovolaemia leads to severe adult respiratory distress. Admitted to Intensive Care.

Expert report states that the midwives should really have brought to the attention of the doctors more strenuously the question of persistent postnatal blood loss. It seems the amount was seriously underestimated. Haemoglobin fell by over 10g/dL, indicating a massive blood loss. Expert midwifery report: "I think all concerned (both midwifery and medical) showed a lack of initiative in how blood loss may be measured..."
This case was conceded, and settled out of court. In another postnatal case, the failure on the part of both hospital and community staff to recognise urinary retention proved catastrophic for one patient:

Case 288 (DGH) After delivery more than 24 hours were allowed to elapse before the patient was catheterised, 1800 mls drained. Catheter left in situ for 48 hours; thereafter managed to urinate once (100 mls). Wanted to go home, allowed. Readmitted 2 days later.

Patient had been seen by Community Midwife and GP at home, but neither diagnosed a full bladder (found to have 1.5-2 litres of urine). It's likely that she has now suffered permanent denervation, and is only able to void urine spontaneously by straining; this could cause problems later on with stress incontinence and prolapse.

The lack of basic care in this instance appears indefensible, and it seems likely that a negotiated settlement will result. In all such circumstances staff will be judged with reference to what a 'reasonably competent practitioner' would be expected to do in similar circumstances. Clinical negligence can only be established if the standard of care falls below that level, and damage results. Failing to diagnose something may seem obviously negligent to the lay person, but when the more critical legal definition is applied the connection is often less obvious.

The importance of CTGs
The whole topic of CTG is one which divides many practitioners and patients. Its importance in legal terms is hard to overstate, since it often provides a continuous record of one aspect of intrapartum fetal well being, despite its poor predictive value for cerebral palsy. The following cases illustrate how midwives may become involved in legal arguments.

In one case, the midwives are criticised when a fetal scalp electrode (FSE) - used to monitor the fetal heart rate - becomes disconnected some 5-10 minutes before delivery.

Case 332 (TH) There is meconium staining. The woman is transferred from the Midwives' Unit to the consultant unit. The FSE falls off, but auscultation is carried out between then and delivery, this is recorded as satisfactory throughout. The parents seize on the few minutes when the FSE is unattached to explain the child's subsequent condition (cerebral palsy).

The Writ states: "The hint of meconium staining...ought to have alerted the midwifery staff and registrar to the risk of fetal distress occurring. Accordingly continuous FHR recording ought to have commenced at that time."

While this action is ongoing, it would appear from the various reports that the midwives did all they could have been expected to do; continuous fetal heart rate
recording using an abdominal transducer may be very difficult immediately before delivery, and in this case the scalp electrode is unattached. As the midwives continue to monitor the fetal heart rate using intermittent auscultation and record that this is satisfactory, their actions appear to be defensible.

At times it may be difficult to use the CTG to record the fetal heart rate; in such instances good documentation is essential:

Case 472 (DGH) Baby born very asphyxiated. Pursuers claim that the monitor should not have been taken off. Staff document that it was very difficult to listen to the fetal heart as the patient moved and rocked a lot.

Midwife looking after her notes frequent loss of contact with the FHR on the CTG trace, and states: "I made the decision to stop the print out from the monitor but kept the transducer and belt in situ, and I was continually listening to the fetal heart." Midwives' reports indicate that the fetal heart was satisfactory at all times.

In this (ongoing) case the expert report backs up the midwives' actions. In other cases reports have criticised midwifery actions:

Case 358 (TH) Pursuer's solicitors claim that instead of diagnosing fetal distress in labour, staff assumed the "heart rate coming and going" was due to a defective CTG machine. Only when the third machine (they claim) was showing the same sort of trace was the woman sent for caesarean section. A placental abruption is discovered then.

There is nothing documented to say the CTG machine was replaced at all. Eventually the CTG traces are found, and they reveal one change of machine, from an old to a new model. There is a gap of 2½ hours when the CTG is not on. There are six written recordings of a fetal heart rate in this time, at half-hourly intervals. Medical expert feels the midwives can be criticised for not having a more detailed record.

In fact despite the implicit criticism of the staff, the pursuer's solicitors do not pursue this case vigorously, and it would appear that the case is dropped. In another case the presence of apparent abnormalities is not acted upon:

Case 391 (DGH) Persistent early FHR decelerations. The staff appeared to think these were benign, despite there being reduced variability and meconium staining.

Expert report: "There is a period of 90 minutes... when there was no CTG recording. This is an unacceptable situation where the patient has had a previous section, at 42 weeks with meconium staining, and with CTG abnormalities which are persistent and who was on Oxytocin."

This catalogue of at risk factors does not appear to have alerted midwives to the need for extra vigilance; an interesting point is noted in a separate case where the question of whether the midwife can insist on carrying out such monitoring is raised. When put to midwives and obstetricians this question produced considerable differences of opinion (see Chapter 10).
In other cases the lack of action by midwives has been criticised:

*Case 165 (DGH)* Pursuer's solicitors claim: "It would appear that a foetal monitor was incorrectly adjusted and, accordingly, the readings which it gave were not properly interpreted and significant abnormalities were disregarded."
The CTG trace has 'wrong speed' written on it. It seems that different speeds were used at different times in labour, and no times are logged, so it's harder to interpret.

Expert opinion: "I do not recall having ever seen a trace with such a smooth line and almost complete lack of beat to beat variation...The nursing (sic) staff faithfully recorded the events but apparently failed to appreciate the significance of the flat trace and therefore did not report it to the medical staff."

This action is conceded by the defenders shortly before the court hearing is due. There are other cases in which the CTG has showed abnormalities which were ignored by staff. In one instance (Case 561 [TH]) the expert reported:

"It is difficult to see the point of fetal monitoring if no action is to be taken when there are obvious abnormalities in the recording."

In another case there is a similar damning lack of awareness on the midwife's part about the CTG:

*Case 572 (TH)* Defence solicitor states: "(The midwife) admitted quite freely that she spent many hours in watching a fetal heart monitor which she was insufficiently trained to interpret or understand at the time. She has since been better trained and, looking back at the fetal heart traces during the period she was on duty, she sees them as being abnormal. In my opinion, quite a bit of liability must therefore attach to a system which asked midwives to watch a monitor which they are insufficiently trained to understand."

CTGs will remain a critical part of intrapartum care in many units. The need to ensure that staff are properly trained in CTG interpretation is one step which employers can address, but it should be remembered that the UKCC Code of Professional Conduct "encourages (practitioners) to declare their incompetence in certain procedures rather than to try to undertake them." Individual midwives also have a responsibility to ensure that they are adequately prepared for the duties entrusted to them.

As with every other sphere of midwifery practice, good documentation in this area is essential, and may well provide the midwife with her best defence. What these cases show is how a legal case may be decided by the actions of staff concerning the CTG. While its widespread application remains controversial, the CTG is not going to disappear, and midwives who work in units where it is employed must be competent in its use. Not all such cases relate solely to midwifery inaction or ignorance concerning CTGs: junior doctors too have been criticised for their inability to
recognise FHR abnormalities. The lessons for staff education are obvious from this, and are discussed in Chapter 10.

Storage of CTG traces so that they survive and are readable is also a matter of concern to hospitals. The possibility for electronic storage has been mooted, since paper and ink quality can deteriorate over the years. In one case the CTG trace from the delivery survived, but was presented at a medical meeting: a registrar used a thick black felt tip pen to illustrate points he was making, effectively obscuring the trace. In another teaching hospital case the CTG trace cannot be found at all. Many people are doing research, and it appears that the trace has been borrowed for this reason; it is felt that maybe some central hospital register of research studies is required so that records can be more easily found.

It is hard to over-emphasise the importance of CTGs in this area of the law, despite the many misgivings about its use. Adequate training of all staff members in its interpretation, together with efficient storage (and retrieval when required) are the minimum which hospitals must guarantee. Education of the public - as well as staff - as to the limitations of this technology will help to establish a more realistic understanding of its applicability.

Supervision
Inadequate supervision, both of patients and of junior staff, has been cited as a feature of perinatal legal actions. The unpredictability of each day's workload in maternity care means that it can be difficult to guarantee that adequate staff are always available; busier units with high stress levels are more susceptible to high staff sickness rates, and so ensuring that sufficient staff are on duty can be problematic. Even with a full complement of staff, supervision of juniors may not always be possible. This can lead to tragic outcomes:

Case 554 (TH) Without consulting a more senior colleague, an SHO decides to use oxytocic drugs to speed up a labour, when there is already evidence of fetal distress. The woman has had a caesarean section and cervical cryosurgery in the past, and has an epidural in situ. The uterus ruptures vertically through the cervix. The baby dies six days later.

Unsurprisingly this case is settled by the defence. A similarly tragic case concerns a junior midwife (qualified for four months at the relevant time), who looks after a woman in the second stage of labour. To understand this case it should be pointed out that the 'normal' range for the fetal heart rate (FHR) is 120 - 160 beats per minute, and that a persistent low heart rate indicates almost certain fetal compromise:
Case 581 (TH) The midwife documents a series of fetal heart rates, nearly all of which would be considered suggestive of fetal compromise, but does not inform a more senior midwife or doctor for about an hour. Her records show the following:

<table>
<thead>
<tr>
<th>Time</th>
<th>FHR</th>
<th>Time</th>
<th>FHR</th>
<th>Time</th>
<th>FHR</th>
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<tr>
<td>13.30</td>
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<td>14.00</td>
<td>102</td>
<td>14.22</td>
<td>105</td>
</tr>
<tr>
<td>13.33</td>
<td>145</td>
<td>14.05</td>
<td>105</td>
<td>14.24</td>
<td>108</td>
</tr>
<tr>
<td>13.35</td>
<td>100</td>
<td>14.09</td>
<td>100</td>
<td>14.30</td>
<td>90</td>
</tr>
<tr>
<td>13.45</td>
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<td>14.12</td>
<td>110</td>
<td>14.33</td>
<td>96</td>
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<tr>
<td>13.52</td>
<td>100</td>
<td>14.15</td>
<td>110</td>
<td>14.42</td>
<td>115</td>
</tr>
<tr>
<td>13.56</td>
<td>100</td>
<td></td>
<td></td>
<td>14.20</td>
<td>98</td>
</tr>
</tbody>
</table>

The midwife claims she asked for help at 13.55, saying she thought the woman needed a forceps delivery. She was told by the Sister that all the doctors were busy. She does not record this conversation, and seems to have waited until 14.35, assuming that someone would come when they were free.

The fact that the midwife has entered an alteration in the woman's position (to the left lateral) indicates that she suspects that some intervention is needed to address apparent problems, but her evident failure to take any further steps, or at any rate to document that she has done so, leaves her wide open to criticism. It is a far more tragic result for the baby and the family, since the baby develops cerebral palsy.

An example of inadequate supervision in the postnatal period concerns a woman who has had a forceps delivery, having had a caesarean section in a previous pregnancy:

Case 579 (TH) Expert report is critical of the SHOs who are called to examine the pursuer when she has severe abdominal pain on the second postnatal day. The expert felt that being so called was unusual, and so the two SHOs should have called a senior colleague.

Instead one prescribes intramuscular narcotics, which only mask the pain. The uterus ruptures, and a hysterectomy is required.

Claims which concern levels of supervision may criticise junior staff for not requesting additional supervision or support from their senior colleagues, or the senior staff themselves for failing to ensure that junior members of staff are sufficiently capable of carrying out their duties. Most frequently, however, the question of inadequate supervision seems to occur when the unit in question is busy.

That this is so is of little comfort to those parents who suffer a tragic outcome, as shown by this husband's statement (Case 532 [TH]):

"There was only one midwife who was looking after (my wife) and she was also looking after someone else in the room next door. She was not with us all the time but kept popping in and out of the room... I would say that 90% of the time we were on our own."

In this case, tragically the child develops cerebral palsy, allegedly due to the failure to monitor adequately the second stage of labour.
Just how staff are deployed when a unit, particularly a Labour Ward, becomes busy is a matter which must be decided by the senior staff member present. Decisions are made in the light of the best available knowledge about patients and their state of progress in labour; despite the best intentions, however, errors may be made or conditions deteriorate suddenly only when the necessary staff are elsewhere.

In investigating the circumstances which give rise to legal claims, the hospital may examine the ward or unit report books to see how busy the unit was, and to help account for the whereabouts of the staff on duty at the time. It can be argued that optimum staffing levels are never likely to be met, given cuts in budgets and the need to reduce 'over staffing'. Just how this can affect the treatment given to patients is shown in the following case (in which the relevant times have been altered).

Case 425 (DGH) There is a delay in going to caesarean section (for fetal distress) overnight. Duty anaesthetist busy with another emergency. Second on call anaesthetist has to come in from home.
Operation note: "N.B. Patient in Theatre 20 minutes before arrival of anaesthetic registrar."
2nd on call registrar anaesthetist called at home 04.38. Arrived at 04.53 at the hospital, and in Theatre by 04.58. Delivery of infant at 05.06

Once the second anaesthetist arrives there is no delay, but the damage (it is claimed) has already been done. Whether a second on call anaesthetist should be on site rather than allowed to go home when on call can be debated; a legal action can succeed when a unit fails negligently to provide an adequate service (Bull v Devon HA1). There have been times when specific procedures have to be postponed because the relevant unit is very busy, and on occasions this appears to lead to a poor outcome.

Case 468 (DGH) A patient is allowed to go 3½ weeks over her 'due date' because of a lack of beds; the baby is stillborn. She claims the consultant told her that if she'd delivered even a week earlier there would have been no problem.
Consultant agrees that the woman's induction was delayed because of a lack of beds, but claims it is acceptable practice to allow a patient to go to 43 weeks. Admits that once the registrar had deferred induction because of bed shortage, further monitoring (using CTGs) should have been carried out.

Such cases are certainly problematic: causation (which is discussed below) must be established before the case can succeed; what might seem self-evident to the lay person can be rather more complicated, but it is difficult not to sympathise with patients who make such claims. The whole matter is complicated by the demand from certain consumer groups to reduce the incidence of obstetric intervention. Demands made about induction of labour are discussed in Chapter 9.

1Bull v Devon HA 1993 4 Medical Law Review 117
Adequate supervision is essential to good care; anticipating the number and skill mix of staff required in an unpredictable area like the Labour ward is an inexact science, and at times the workload may overwhelm the staff available. Clearly there are management and budgetary considerations here, but supervision of patients and junior staff alike is a constant requirement, not one which occurs only when the unit is busy. There is an onus on staff to ensure that this level is maintained whenever possible, and to inform management when it is impossible to do so.

Consent and choice
These are crucial features of health care, and ones which have become particularly important in maternity care. The requirement for consent is clear in legal terms: carrying out a procedure without consent can be construed as a trespass or an actual assault; the need for the woman's decision-making to be informed is clear because in pregnancy and labour those concerned are almost always both adult and competent. There has been a growth in the need for clinicians to demonstrate that they have given adequate information to the patient, since claims have been made on the basis that patients have not fully understood the nature or possible consequences of a procedure or operation; this is the doctrine of 'informed consent'.

Consent is required before any operation can be carried out (with a few exceptions in cases of immediate emergency). During an operation it may become apparent to the surgeon that further action, beyond that which was anticipated, is needed. When the patient is unconscious consent clearly cannot be obtained; even when the patient has epidural or spinal anaesthesia, and is awake, it can be argued that informed consent is not possible, since there is no time for the patient to reflect on the situation before either agreeing or disagreeing.

*Case 87 (DGH)* Pursuer's solicitors: "Our client learnt that while she had been under general anaesthetic one of her ovaries and a piece of tube were removed."

The standard consent form said: "I hereby consent to the performance of any operation which may be considered necessary."

The consultant claims that after the operation the wife was almost hysterical, and so explained to the husband why she had removed one ovary which appeared malignant - although histology showed it was benign.

The impracticalities of trying to counsel a patient in difficult circumstances is explained by a hospital manager to the pursuer's solicitors in one instance: "(The Consultant) does not consider it normal practice in an acute obstetric emergency to counsel patients in detail on all the possible difficulties that might, very infrequently,
arise." In this case damage to the Fallopian tubes was caused at caesarean section, leading to secondary infertility. In another case the obstetrician noted, again at caesarean section, that a previous section scar has ruptured; the rupture was large, and it was felt that a further pregnancy would almost certainly lead to uterine rupture and stillbirth and possibly even maternal death. The obstetrician ligated the Fallopian tubes to prevent further pregnancy, and was sued for an unauthorised sterilisation. This is an ethical matter as well as a legal one, but in this instance the defence of necessity appears to be sufficient.

Another patient complained when a photograph of her was taken while she was in labour and without her consent (Case 188 [TH]). An anaesthetist wanted a picture of a patient using 'Entonox' (a mixture of oxygen and nitrous oxide) apparatus, but did not seek consent at an earlier time, and instead took the photograph while the woman was having a contraction. His explanation was:

"In view of the self-administration of the NO₂ and the effects of the labour I assumed implied consent."

These events took place in the early 1980s; such an assumption would hopefully not be made today. The emphasis is now very much on consent being informed rather than assumed, although there are problems attached to this (see the section 'Known complications' in Chapter 8). All this relates to the notion of the patient having a degree of choice in her care and treatment.

Choice is not as simple a matter as it might first seem: must a woman express her choice, or can she be expected to wait until someone asks her what her preferences are? Clinicians may sometimes forget that some patients are intimidated by hospitals and by professional staff, and that some view the hospital as foreign territory in which they are unlikely to assert themselves. In one case (No. 533 [TH]) the complaint is made that a medical student assisted at a woman's delivery:

Professor of obstetrics to legal department: "As a teaching hospital all the women at this hospital are aware that medical students may be present during their labour and birth, and we rely upon them to tell us if they do not wish this to occur."

Here the presumption is that the onus lies with the woman. Such a view can be easily criticised, but legal claims are sometimes made because the woman's expressed preferences have not been overridden: in one instance the pursuers allege that an elective caesarean section ought to have been carried out, but it is well documented in the notes that the woman has made it quite clear that she wanted a normal delivery.
When a woman has expressed a wish for minimal intervention but has suffered a damaged or dead baby, the argument will then usually turn on whether earlier intervention would have affected the outcome at all.

Several cases relate to a woman's desire for a normal delivery having already had at least one child by caesarean section. Given the recently vaunted scope for choice within maternity care, it is a matter of some debate whether treatment will be significantly altered in the light of such expressed wishes. In one such case (No. 399 [DGH]) a consultant obstetrician notes:

"It may be that this enthusiasm for a vaginal delivery as opposed to caesarean section in some way influenced her obstetric management."

When the outcome is poor it is very easy for clinicians to claim that their advice was ignored or given insufficient weight by the patient. It would appear to be tempting for some to pursue the 'I told you so' line, and use such outcomes to justify higher levels of surveillance in routine care in the future. While this may be so, these cases inevitably reflect a rather distorted picture, in that all the cases relate to an outcome which is suboptimal; those instances where a patient has successfully had a normal delivery after having had an earlier caesarean section receive less attention.

It is not always the case that the woman's expressed choice is for minimal technology and intervention; a number of cases have concerned the woman's dissatisfaction that she was in fact persuaded to try for a normal labour and delivery when she wanted an elective caesarean. While such instances may be fairly rare, it is a common perception among staff that demands by patients for either elective induction of labour or caesarean section are growing. It is difficult to justify conceding to a demand for such procedures when there are no clinical factors which would warrant this; it could be argued that in a fee-for-service situation a patient could justifiably claim this, but we are not yet in that situation in this country.

With much safer anaesthesia today than has been the case in the past there does appear to be a popular perception that operations are more or less risk-free. It is possible that patients may claim that they are only exercising the choice which various government and local charters say is now theirs when they make such demands; if so these ignore the fact that a caesarean section is still a major abdominal operation not without its risks. Obstetricians may be caught on the horns of a dilemma when such requests are made, for current policy is to reduce the number of caesarean sections (which coincides with the demand for less intervention).
Consent is well enough understood by clinical staff for it to be only rarely the basis of a successful negligence action; choice, however, much vaunted in government charters, provides more of a potential dilemma. Whether or not a patient is deemed to be capable of understanding every item of information relating to a condition, or whether indeed the standard of consent ought to be 'informed' or 'rational', is a matter of debate. Staff must be aware of what current practice is in order to know how much information to give to patients (see 'Talking to patients' in Chapter 8).

The standard of case records
This section develops the question of the standard of case notes, since this has been highlighted as a crucial area in defending allegations of negligence (Cetrulo and Cetrulo 1989), and is one area which is certainly amenable to targeted improvements (James 1991). In 'Delays' in Chapter 8 it will be seen how records are essential to the investigation of a case, and how, in many instances, they have left much to be desired with regard to tracing the relevant clinical staff. This section is included with other clinical aspects because documentation is such a vital part of everyday clinical practice.

The first matter is that detailed entries ought to be made in the notes, especially when a decision has been taken with regard to management. In one case (No. 592 [TH]) a registrar is unable to recollect any of the events in question, and admits:

"I would not necessarily make any comments in the notes if correct management was being followed."

A lack of documentation in 'wait and see' decisions can make it appear as if no decision has been taken. The second matter is that what is written in the notes ought to be clear and accurate. One midwife, already cited, noted what are thought to be two mutually exclusive statements in her admission note ("no SRM... black substance in the vagina") from which the expert report concluded that the midwife's actions were not those of a competent professional, the black substance being supposed to be meconium. In the same case there was a discrepancy of twenty minutes between the recorded timings of the midwife and the doctor, which may have been crucial.

In another case (No. 127 [TH]), a student midwife admits that her entries were poor:

"As I was anxious to get a better quality CTG, I didn't take my hands off the transducer and was aware that I wasn't recording this in the case notes."

In a similar situation (Case 612 [TH]) the midwife notes:
"FH listened with sonicaid - satisfactory - I did not record it as the notes were in the other corner of the room and Mrs. K needed me next to her all the time."

These situations are readily imaginable: in cases where fetal compromise is suspected, the need to ensure that the fetal heart rate is heard as clearly as possible may mean that the attending staff member has no hand free with which to write entries in the notes. In the first of these cases there is further confusion over the entry 'SR informed': there is doubt as to whether this refers to the sister (abbreviation 'Sr') in charge of the labour ward, or the senior registrar (abbreviation 'SR'). Abbreviations are commonly used as a time saving measure, but can cause confusion.

The need to be able to trace staff from their entries in the notes requires that they sign their name legibly against each entry; in one case concerning a child with cerebral palsy (Case 126 [TH]), there is the following unsigned entry in the Labour Ward notes:

"Tonic uterine contractions. Syntocinon reduced."

Without identification it is extremely difficult to clarify who did what and when. Even with apparent identification, some signatures are little more than squiggles on the page (one legal staff member describing such as an 'Arabic hieroglyphic'). James (1991) advises staff to print their name as well as giving a signature, a matter which is addressed in Chapter 10.

Poor writing can cause further problems with interpretation of records:

Case 231 (DGIF) From reading the case notes the pursuer's solicitors claim that an obstetrician cut the bladder during a caesarean section, and so ought to have called for a more senior colleague to assist in the repair. The legal department retort that the pursuers have misread the notes: what the surgeon wrote was "left angle bleeder caught", not bladder, although it later transpires that there was in fact bladder involvement.

Despite this misreading, apparently due to poor legibility, the pursuers do succeed in showing that there was negligence involved. In a neonatal case, the defenders concede the action because the midwife concerned had only a poor recollection of the events, and could not make sense of one or two of her own entries.

Entries in the case notes or other records may be relied upon heavily, but will not necessarily be taken as proof of what happened. Entries may be quite erroneous: in more than one case the Theatre records have shown a complete swab count, but a retained swab has subsequently been found, making a case indefensible.
Contradictory entries do little to convey a sense of competence:

Case 611 (TH). The baby transfer form states 'Cord round neck x 1'; the infant summary form has 'cord around neck' by one staff member, and someone else has added 'x 3, tight'.

Which if these was correct could be crucial in determining whether staff actions were appropriate. In another case (No. 364 [TH]) there are three different versions of the baby's Apgar scores at one and five minutes: one entry records them as 1 and 5, another as 3 and 4, while the third claims 2 and 4. The objectivity and reliability of the Apgar score is discussed in Chapter 10 and in Appendix B.

In one case concerning alleged retained products a midwife wrote in the labour ward summary that the placenta was complete but the membranes were ragged. This caused disagreement as to whether negligence had occurred in not ensuring that all the products of conception were expelled. In another case an attempt to get round this conundrum caused more problems:

Case 435 (DGH). The midwife in question had written, following her usual practice, that the placenta "Appears complete" in the delivery notes. Legal department to MDO: "This is simply because she could never guarantee that it was complete, just that it appeared to be the case." Had she had any real doubt she would have contacted the doctor.

Expert report: "(1) checked a random sample of casesheets within (my) unit to check on practice; one member of staff uses the term 'appears complete' and in her interpretation she has no doubt that the placenta, to all appearances, is complete and personally I would agree that unless the placenta or membranes are recorded as incomplete, I would conclude that they are complete."

It is clear how such entries could give the impression to pursuers that they may have a case; given this, it may be wiser for staff to be more assertive and record the placenta and membranes as complete if they appear to be so, rather than try to cover oneself in case a small piece of either placental tissue or membrane has been retained and subsequently causes problems such as haemorrhage or infection.

Other cases have been lost partly because staff have failed to make appropriate entries, and sometimes any entries at all. In one case the failure to note any difficulty with a delivery led to the inference that excessive force had been used when Erb's palsy was diagnosed. Another case highlights the failure of Community midwives to record what they said or did despite making several home visits; the lack of any description of further monitoring, given a history of reduced fetal movements, weighed very heavily against them.
In another case an obstetrician fails to make any entries recording an episiotomy and forceps delivery. The case centres on the material used for the repair of the episiotomy; the labour ward summary written by the midwife says catgut was used, and the section relating to the repair has the entry "pp Dr. Y". The doctor thought he had used Vicryl sutures, which self-absorb; in fact it transpires from laboratory examination that the sutures were made of silk, and so should have been removed by staff. The failure to do this caused problems: the Writ claims for loss of her sex life and an inability to enjoy her daughter for nine months. The pursuer is successful in this case, and obtains £12,000.

Case records will be relied upon heavily in a legal investigation; given the unexpected nature of many legal claims, staff who fail to keep clear contemporaneous records, particularly in the Labour ward, may be putting their heads in a noose. It may be difficult to maintain a good standard of record keeping when the unit is extremely busy or when emergencies occur, but there is a clear duty to make adequate entries in the casenotes as soon as is practicable.

Protocols and policies

Very often the decision on which course of action is taken will be determined largely by the diktat of local protocols and policies. These are designed to ensure consistent standards of care, and to avoid confusion as to best practice when particular eventualities arise. A downside of this argument is that individual autonomous practice is inherently reduced; choice for the clinician in these circumstances is diminished. Nevertheless consultants still retain the option to develop personal policies which those staff under their aegis must follow. In one case (which relates to the arguments about when to offer caesarean section) a consultant claimed it was his policy to offer elective sections to older pregnant women with no living children.

Protocols may be introduced after adverse outcomes or complaints; several units now apparently have a requirement that gauze swabs are specifically accounted for after perineal repair in the labour ward (as is routine in the operating theatre) because of the legal claims about retained swabs.

Protocols will also reduce the scope for the patient's choice; midwife-run units (MRUs) will have certain criteria for transfer of patients to the nearest consultant unit. For those women who elect to deliver in the MRU, these may contradict their expressed wishes, which places the notion of choice in context: choices will only be accorded respect if the labour proves to be problem-free. Just what constitutes a
problem requiring transfer might be debated. A similar situation within a consultant unit might be the presence of meconium staining of the liquor; in such circumstances electronic fetal monitoring may be strongly advised. This question is addressed in Chapter 10.

By and large, following a local protocol will be a good defence to an allegation of negligence, since the presence of the policy indicates in theory what a reasonably competent practitioner would do (or, in the English law context, what a competent body of co-professionals would do). It is highly unlikely that a protocol which has been deliberated upon would be held to represent such a poor standard of care that a conclusion of negligence could be drawn.

In one case the pursuers allege that in order to speed up her labour a midwife administered too much syntocinon to a labouring woman; the hospital were able to point out that the rate of infusion had followed the protocol, and so was not negligent. When protocols are not followed, it is indeed possible that negligence may be inferred, as in this case concerning a perineal repair:

Case 152 (TH) "Neither Staff Nurse (sic) X nor Sister Y, whom Staff Nurse X erroneously supposed was supervising the repair, possessed a certificate of competence...disciplinary action has resulted from it."

Although the pursuers do in fact have a very good case here, because of difficulties in obtaining Legal Aid in order to pay for an independent medical expert, they are unable to pursue the action.

In the next case the pursuers claim that in not following unit protocols, the midwives were negligent:

Case 532 (TH) Cerebral palsy: alleged failure to monitor second stage of labour adequately; patient allowed to push for 90 minutes.
Pursuer's solicitors claim the policy was not to allow pushing for longer than 30 minutes.
In fact the unit protocol states that midwives must inform the doctor after an hour if there is no advance in second stage (two hours if an effective epidural is in situ).

In fact this case turns on the fact that CTG abnormalities in the second stage were ignored by midwives, and it appears likely that the case will be settled. Calling for medical assistance in the presence of certain at risk situations may not be formally covered by a unit policy or protocol, but is certainly understood to be a required part of good practice.
A protocol may stipulate the level of experience which certain staff must have in order to carry out particular procedures. In one particularly tragic case (No. 489 [DGH]) a baby died after an unsupervised locum junior paediatrician attempted to carry out neonatal resuscitation; it transpired that he was untrained to do this. The consultant obstetricians at that hospital had requested further staff from the health board, but this was not forthcoming, and neither was increased supervision for inexperienced staff. The expert report stated:

"(This doctor) was not competent to resuscitate...it is absurd to suggest that all paediatric SHOs on starting a job are expected to be trained and competent in the procedure... (He) asked for help and could not get it. It is totally wrong to put all the blame on (him); the blame falls on those who put him into such a position."

This legal action was initiated only after a Fatal Accident Inquiry had found evidence of serious shortcomings in the role of management.

One problem with determining what a particular hospital's protocols were at a particular time are that formal and comprehensive sets of policies and protocols are a relatively recent introduction; until a few years ago protocols in many units appeared on a fairly ad hoc basis. In one case pursuers allege that the failure to give Vitamin K to a baby led to haemorrhagic disease which culminated in intraventricular haemorrhage and subsequent cerebral palsy. Difficulties were encountered in determining what the hospital's policy regarding Vitamin K was at the time (eight years before the action is raised); the matter had been discussed, and was known to have been given routinely soon after this event, but it is unsure whether the policy was in force at the time.

There may be some difficulty in distinguishing protocols, policies and guidelines, and determining the relative weight accorded to each. By and large a protocol carries the most weight, and guidelines the least, with policies somewhere in between. Something which becomes 'usual practice' may be thought of as a policy, but may not be formally constituted as such. One such 'usual practice' is the examination after perineal repair of the vagina and rectum to ensure that the repair has been adequate, and that no swabs have been retained.

In one case in which a vaginal tampon is not removed following the repair, the senior obstetrician notes that it is his usual practice to offer a vaginal examination two days following delivery in order to assess involution of the uterus; an incidental advantage is that it should also identify any retained swabs. This rather misses the point that to fail to check immediately after the repair is very poor practice, and that for such a
swab to be retained will mean that a case is indefensible in all but the most exceptional instances.

Unit protocols are designed to ensure consistent and competent standards of care; as such they may weigh heavily in legal considerations, and clinicians must be aware that they provide a bulwark against allegations of negligence.

**Differences of opinion**

In most of the cases mentioned above the pursuers claim that staff negligence caused a specific harm; the position is more complicated when the staff concerned disagree about a particular situation, or otherwise do not act as a team.

Clinical differences of opinion are part of the very nature of health care; protocols and policies are intended to minimise the potential for profound disagreement, but there is frequently scope for clinicians to disagree. One case sees differences of opinion as to whether a patient has suffered a third degree perineal tear. In theory there is a definition for this which ought to preclude doubt about whether this very distressing complication has occurred, but in practice staff may differ as to whether the tear extends sufficiently to be classified as 'third degree'. In this particular case the patient subsequently requires a colostomy, and so there is eventually no doubt about the ano-rectal involvement, although initially members of staff did dispute this (this case is still ongoing).

Differences of opinion may relate not only to diagnosis, but also to how to treat:

*Case 229 (DGH)* Pursuer has slightly gaping episiotomy. Several staff inspect it, and none believe further treatment necessary. Subsequently she has to have excision of the scar and re-suturing of the perineum.

Her solicitor claims that their expert stated that catgut was "not the suture material that I would have chosen" for the episiotomy repair.

Expert report: just because their expert states that catgut would not have been his choice of suture material does not mean it was negligent to use catgut. "A matter of opinion only."

This point is well founded in law: it has been expressly stated that there is room for a difference of opinion within medical practice, and that a court's preference for one body of opinion over another is not the basis for a conclusion of negligence (Maynard v West Midlands RHA²).

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² Maynard v West Midlands Regional Health Authority 1984 1 WLR 634
Differences of opinion or approach between medical and midwifery staff may be profound. Before the introduction of NHS indemnity for hospital doctors in 1990 such differences of opinion could form the basis of serious disputes about their respective responsibilities, since damages, if awarded, would be divided on this basis. Now that all hospital staff are covered by the same scheme, such arguments are largely redundant, from a financial point at least (this matter is discussed further in 'The division of liability' section below).

Where different clinical practitioners have to work alongside one another, there is scope for argument about how well each carry out their respective duties. One case sees the medical staff complain that liability mostly rests with the midwives, who, they say, do not express their concerns about a haemorrhaging patient with sufficient urgency; the bleed occurs soon after amniotomy, at delivery the baby is anaemic, and there is noted to be a puncture in the umbilical cord. The defenders agree to settle this case.

A relatively common complaint by some midwives is that their expressions of concern may not be taken sufficiently seriously by medical staff (see Chapter 10). In instances such as this, tragedy can ensue if the midwife does not feel sufficiently confident to go above the head of the doctor who is apparently ignoring her contention that an abnormality is present, and call in a more senior obstetrician.

Up to now the consultant obstetrician has held a peculiar position of responsibility, being in effect accountable for the actions and failures to act of those medical and midwifery staff working within his/her team. Such a position may be about to change with the development of team midwifery and midwife-only care, but it has by and large been the norm in most units. While some obstetricians may strive to retain their position of overall seniority and accountability, this has not always been an unmixed blessing: in one case a consultant is quite indignant that he has been named in an action concerning a failure to give Anti-D immunoglobulin to a Rhesus negative woman. He says (quite reasonably) that the mistake occurred between the laboratory and midwifery staff. The woman subsequently developed high antibody levels in her next pregnancy.

This last case concerned a failure of communication between certain staff members. A very similar case also concerns a Rhesus negative patient:

Case 44 (DGH) A parous woman has been given Anti-D after her previous pregnancy; however the laboratory form asks for a repeat blood sample when they find weak Anti-D by enzyme method a day after she goes home.
The consultant writes to the GP asking for a repeat sample, but this is never done. In her subsequent pregnancy, the baby becomes iso-immunised, and is stillborn with gross ascites.

The consultant claims that as a result of the errors he identifies, changes to procedure have been made, including a reminder to all GPs that when a woman is Rhesus negative and under 'combined care', the GPs must check antibody levels monthly.

The necessity for effective communication is well illustrated by these two cases. In one of the first cases discussed in this section, in which a postnatal patient becomes critically ill after persistent heavy bleeding, it is a failure on the part of midwifery staff to alert the doctors to the abnormally high blood loss which is strongly criticised; again, communication was inadequate, and a patient suffered as a result.

Differences of opinion constitute a potential minefield for staff: in cases where there is a poor outcome they may be seized upon by the pursuers even when there is no evidence of negligence. Inconsistent advice or explanation will undermine a patient's confidence, and may even instil unfounded suspicions; as such, they present a significant threat to effective staff-patient relations.

Summary

Chapter 5 showed the diverse nature of clinical complaint which may be levelled against staff. In Chapter 6 I have shown how some of these cases arise, and indicated how some may be avoided in the future. Certain aspects - CTGs, supervision, and documentation in particular - are common enough to warrant serious consideration by those seeking to reduce the incidence of litigation. Each of these is amenable to some form of targeted improvement. A better understanding by both clinicians and members of the public about what constitutes negligence may also help to reduce solicitor involvement; a better lay understanding that a failure to diagnose is not itself evidence of negligence would be a start, but this in turn requires improved communication skills on the part of some clinicians (this is explored in Chapter 8).

An improvement in everybody's understanding of the legal processes will help to put some complaints in perspective; while the right to pursue a claim is not in question, the unrealistic basis of many suits should be a matter of concern for clinicians and lawyers alike. In Chapter 7 perinatal legal cases are examined from a number of angles which relate to legal rather than clinical aspects.
Chapter 7
Legal aspects

There are many ways in which perinatal legal cases can be viewed; this chapter examines them from angles which have to do with the actual legal operation of cases. The flow chart at the start of Part III depicts a typical course of events.

Usually the first intimation of a claim is contained in a solicitor's letter: a large majority of claims studied are initiated in this way, the remainder beginning as letters of complaint or enquiry by the patient or a relative. In Scotland these letters are forwarded to the Central Legal Office of the Scottish Health Service in Edinburgh; in England the health authority (and now Trust) legal office deals with such letters. If the letters are clearly more than just a straightforward request for information, they are classified as potential or actual claims; for the purposes of this research, any solicitor's letter alleging negligence or claiming compensation is treated as a legal claim.

The usual procedure will be for a retrospective examination of the events in question, which can take some time, given that claims may take months or even years to arrive, and given a relatively mobile workforce. Once this inquiry has identified the salient facts, a formal repudiation may be intimated, or further requests for expert reports made. While this is happening the pursuers will often be requesting the medical notes so that they can obtain an expert report as well. If a case is to be conceded, the question usually turns to quantum; before the introduction of NHS indemnity for hospital doctors in 1990, the division of liability between respective practitioners had to be made, with up to three medical defence organisations (MDOs) being involved for the medical staff, and the employer (Health Board or Authority) for the midwifery and other staff. Not infrequently these organisations argued about the respective liabilities of the staff for whom they were responsible, since financial damages would be sought from them according to these liabilities.

Solicitors' letters
In theory the first letter from a pursuer's solicitor will set out the reason for the claim, and note that this is justified as the law stands. However it is fairly common for the first letter to be less than clear; in one instance the original letter does not make it clear for a while what their head of claim is: it could be brain damage, an infected and
poorly healing perineum, or the fact that a medical student assisted at the delivery without the woman's consent. In another case (No. 110 [DGH]) the letter only states:

"We...intimate a claim on her behalf for injury and suffering sustained in the course of medical treatment following her confinement..."

Repeated letters requesting clarification of the grounds for complaint receive no reply. A similar case (No. 157 [TH]) has the following brief statement:

"My client...claims damages from you."

Again, despite several requests for further details, her solicitors make no contact, and the case drops. Such examples are surprisingly common - one such letter claimed simply "It is clear to us from our client's evidence that liability rests with the Board's employees...". It might be argued that little harm is done by such opening gambits, but the pursuer's case cannot be advanced before some specification is made, and all such letters do is delay action and increase expense; the pursuer presumably pays for all such letters, at least until the question of Legal Aid is determined.

In one action (Case 231 [DGH]) where the solicitors had simply stated that there "is a clear prima facie case of negligence in the treatment of our client", the legal department write back and enquire on what grounds a clear prima facie case is presumed to exist. The solicitors retort:

"We refer to your letter. Implicit in said letter is the failure in your part to respect our professional judgement as to whether our client has a prima facie case of negligence. We would not have intimated our client's claim if we did not consider she had such a case. God knows, we Lawyers as a profession are subject now to so many unfounded claims that this Writer would be reluctant to intimate any claim against another profession without satisfying himself that said claim had a genuine basis....Recent reports in the press of obstructiveness in the part of the staff of your office seem to us to cast an unjustifiable slur on you. We would be disappointed to have to revise that opinion..."

It may not always be clear whether the letter represents a formal legal claim or not, as shown by this legal department reply to one such letter (Case 451 [DGH]):

"It is not entirely clear whether you wish this matter dealt with as a complaint or a claim. You have used the word 'complaint' in the heading of the letter, but you have written the letter 'without prejudice'. There are separate procedures for dealing with complaints and claims."

Very occasionally the letter, while still claiming the staff have acted negligently, is so non-specific that it is seen as a hopeful trawl by the pursuer rather than a case which genuinely believes in its own merits (Case 601 [TH]):
"We...emphasise that you must give us an outline of allegations of negligence against our clients, failing which we will have no alternative but to conclude that your request to see the copy medical notes and records is simply a 'fishing expedition' for a claim."

It is difficult to decide the basis of a claim from some letters, either because no specifications are made at all, or because the details given by the solicitors do not appear to amount to more than a complaint that their client feels hard done by; however there are occasions when several heads of claim are immediately identifiable from the first letter (Case 544 [TH]):

"We anticipate that the allegations which will be made against you...may include that inadequate analgesia was applied to Mrs. D at delivery; that the hospital failed to have proper working equipment available (the Ventouse extractor), thereby necessitating forceps delivery; that the forceps delivery was performed incompetently or incorrectly, thereby injuring and damaging (the baby); and that the episiotomy was incorrectly or incompetently sutured."

In trying to be helpful, solicitors may in fact demonstrate their lack of competence and confidence (Case 415 [DGH]):

"There is always the possibility that we want instead, or as well, the case notes of (the hospital to which the child was transferred). Our present view is that that will be something that we may have to get in the end of the day, but we do not necessarily need them at the moment, but we are not sure."

The solicitors of course must rely on the pursuer or her family to furnish them with an account of the events in question. At times these are not very helpful, indicating that some pursuers have a limited understanding of what has occurred:

Case 2 (DGH) "We understand that Mrs. K's baby was living inside the womb in unusual circumstances."

In some cases it is clear that the solicitors have little grasp of medical terminology or procedure:

Case 166 (DGH) "We understand that in an attempt to speed up the dilatation of the cervix our client was attached to an epidural drip which caused her intense pain and thereafter a uterine rupture."

Case 105 (DGH) "...a considerable deficiency in the annotation relating to the peritoneal tear and repair performed."

In the first of these cases the pursuer appears to confuse an oxytocic drip (used to speed up labour) and an epidural infusion (used for analgesia). In the second case the woman suffered a tear of the perineum, not the peritoneum. Other examples are references to "the stafforious virus/bacteria" (Staph[ylococcal] aureus), and a claim that "A pyreanial Plaster was inserted" (presumably a perineoplasty). In one case
a criticism was made of staff for augmenting labour two days before the woman's due date (the dates have been altered):

"Our client was admitted on...23rd July with advanced labour pains...the houseman broke her waters despite the fact that her baby was not due until 25th July."

To go into labour two days before the due date is quite normal; what the doctor was supposed to have done given the fact that the woman had begun labour spontaneously is unclear (the amniotomy was performed to check the colour of the liquor because FHR decelerations had been heard).

In some cases it is not immediately clear just why staff are held to be responsible for every eventuality:

Case 501 (DGH) "Our client advises us that the sight of the operating marks has an adverse effect on her sex life and would actively deter any relationship with another man if she and her husband were to separate and be divorced."

What these extracts show is a low level of awareness of medical terminology and medical negligence litigation among some solicitors. There has been the suggestion made that formal lists of solicitors experienced in this area of law are made available, so that pursuers know that their legal advisers will have an understanding of how to proceed. While on the face of it a less than competent solicitor acting for the pursuer may improve the chances of a successful defence by the hospital in question, defenders are often keen to see genuine cases pursued successfully. In one case (No. 618 [TH]) the writ, when it finally arrives, is described as

"staggeringly inept...without any accompanying medical report."

The defence allow the pursuer's solicitor longer to get his statement of claim redrafted, and the legal department hint that perhaps they could prompt him to pass the case up "to a larger firm of solicitors more clued up on medical negligence claims".

A solicitor's knowledge of procedure could directly affect the pursuer's chances of success. In one case in which the baby is stillborn, it appeared initially that the solicitors were being extremely patient with a rather slow rate of progress in the case; in fact their lack of initiative in pursuing the case more vigorously is fatal to the action, because it becomes time barred.
In another case (also concerning a stillbirth; No. 396 [DGH]) formal repudiation is made by the defenders after an examination of the relevant events. The pursuer's solicitors then write and say their client

"will accept the payment of £200 in settlement of the claim."

Legal department reply: "(Your letter) came as a matter of surprise. I thought I had made it clear to you... that liability had been repudiated."

Legal department to employer: if the solicitors' expert had been "at all enthusiastic" about the claim they would be claiming much more than £200.

The solicitors now write back to say they had written in error (this letter related to another case entirely), although the relevant client's name is given on the letter.

In yet another case concerning a stillbirth (No. 254 [DGH]) a pursuer claims that she ought to have been delivered sooner than she was because of a history of two previous stillbirths. The solicitor's letter doesn't make it clear what their head of claim is, prompting the legal department to ask:

"Are the solicitors claiming for loss of society of child (incompetent)? Are (they) claiming for solatium for the husband in respect of the wife's experience (incompetent). The only possible claim here would appear to be solatium for the wife."

When the solicitors make it clear that they are claiming for loss of society for the child, the legal department reply:

"The child was stillborn and I would contend that your client can not therefore claim loss of its society since it has no legal personality for the purposes of a claim under the Damages (Scotland) Act 1976."

In more than one case the solicitors have written requesting a list of the staff involved so that they can take precognitions. Legal departments will be wary of complying with this request, and the RCM, when approached for such information, has advised midwives not to meet with the solicitors; in an adversarial system, doing so could provide additional ammunition to the other side. Any communication with the pursuers or their solicitors may be frowned upon once the case has reached the stage of formal litigation.

Another case (No. 194 [TH]) sees the solicitors write on behalf of their clients seeking an explanation; they ask repeatedly for progress reports from the employer, and eventually write:

"We understand that some form of explanation would have been given to them many weeks ago had they not asked us to write on their behalf."
This is probably true; the employer says the matter is being dealt with by the legal department. The solicitors retort:

"Our clients are looking for an explanation of matters of fact. We find it difficult to believe that the doctors concerned are opposed to providing such an explanation. Why should there be any need to consider the legal implications of telling the truth?"

This is possibly a bit disingenuous for a solicitor to claim, but the point is well made that finding an explanation can be harder with solicitor involvement, since what some would see as the legal battle lines are already drawn.

Since investigation can only proceed once the basis of the claim is clear, and only proceed with competent input from both sides, it would seem imperative that a pursuer's solicitor ought to be suitably knowledgeable about and experienced in medical litigation. From the examples quoted here it is clear that some solicitors are clearly not sufficiently experienced; drawing up and publicising lists of legal representatives capable of acting for pursuers is an essential first step. Should a less adversarial arrangement for resolving such disputes be instigated, the involvement of solicitors may be reduced, so avoiding some of the pitfalls identified in this section.

Causation
Many legal cases relate in some way to the question of causation: was the act (or failure to act) of the practitioner the cause of the pursuer's condition? In this 'the pursuer' denotes whichever member of the family is the subject of the legal action: this could be the mother, the child, or the father.

This is a wide area, covering issues as disparate as brain damage in the child, severe pain or bodily injury in the mother, and psychological trauma in the father. It should be noted that this last situation is certainly problematic in legal terms; it is much more likely that the mother will successfully sue under this head of claim than the father, but such claims do occur.

The notion of causation is crucial within a fault-based legal system. Without the causal connection, negligence cannot be established in law, and a pursuer cannot successfully claim damages. Given its legal importance, much time is spent by both pursuers and defenders arguing over the question of causation. Supportive expert opinion will be sought by each side, and negotiations made based on these reports. Since this matter is so crucial to the chances of success of a legal action, it is necessary to enquire what sort of claims regarding causation are made.
In order to establish a causal link between a clinical incident and a pathological (or psychological) condition, several requirements must be met. Before any case can proceed, the pursuer must show that such a condition does exist, and usually this must be confirmed by medical opinion. The condition may be well known - for instance an eight year old child may have been long diagnosed as suffering from cerebral palsy. Other conditions too may be obvious and well documented for that individual: an Erb's palsy in a baby, for example, or an area of alopecia on a child's head; in a mother a postpartum haemorrhage or postnatal urinary or faecal incontinence would be easily diagnosed and beyond serious dispute. The least disputable circumstances are the discovery of a gauze swab which has been accidentally left inside the patient after a procedure is completed.

In other situations, establishing that a pathological condition exists may be more problematic: nerve damage may cause relatively non-specific symptoms, including backache; spinal or pelvic injuries may be attributable to a pre-existing condition or a previous trauma; and diminished or absent eyesight in a child may not be assessable for some time. Until a condition can be established, and a causal connection made between that and a clinician's negligent conduct, damages cannot be quantified and so a case cannot be settled. In the case of cerebral palsy the diagnosis may not be made for some time after the child's birth, and parents who have had a baby who was asphyxiated at birth and who suspect that the child may be brain damaged as a result may well wait with trepidation to see whether the child shows signs of cerebral palsy in the months following delivery. Perhaps hardest of all to assess and quantify are the psychological effects of a traumatic delivery or other incident.

Some of the longest and most bitter legal battles have been fought over the question of causation regarding cerebral palsy, partly because the financial stakes are at their highest with regard to this condition. The problematic nature of establishing a link between intrapartum events and this condition, and the condition's association with premature delivery, have already been discussed; nevertheless many people seem prepared to assume such a link.

*Case 7 (DGH)* An educational psychologist apparently attributed the baby's cerebral palsy to birth asphyxia. The consultant paediatrician is quite indignant at this: "I do not think she is in a position to make this judgement."

This case was successfully defended. Causation may also be claimed when perineal refashioning ('perineoplasty' or 'perineotomy') is required: in one case the pursuer's solicitors argued that the need for this represented prima facie evidence of negligence
on the part of the midwife who stitched the woman's perineum following delivery. Usually it can be quickly established that the woman's current condition and the perineal trauma from the delivery are linked, but this is sometimes disputed:

*Case 338 (TH)* Intact perineum, but there were vaginal lacerations which required suturing. The pursuer claims a delay before suturing, and pain during the repair which had to be refashioned later.

Although this woman had long standing gynaecological problems, including dyspareunia for many years before this pregnancy and admitted loss of libido, these factors all form part of her claim.

This last case was difficult to classify: there were several criticisms by the maternal grandmother of staff action, including the timing of blood sugar estimations during labour, "Water taken off" which appears to refer to a catheterisation, and "Unable to cope with question and answer during labour". The case is settled for a very small sum (£350) which appears to be nuisance value rather than a genuine quantification of harm.

The question of causation may be affected by the time it takes to initiate a complaint. In one case it is alleged that a crush injury to pelvic nerves occurred during a forceps delivery; while the solicitors claimed that the injury was immediately apparent, it was two and a half years before the claim is made; a writ claiming £50,000 in damages is moved just before the expiry of the triennium. The obstetric staff are adamant that her delivery was not traumatic, and query how she came to make a diagnosis of displaced bladder and bowel, and fractured coccyx. While this action is technically ongoing, four letters from the defence solicitors in nine months asking for further action from the pursuers have produced no response.

Back problems, especially backache, following childbirth are thought by some almost to be part of the territory of being a parent; frequent bending down or over an infant will certainly cause some strain on the back. However there is evidently a belief that epidural or spinal anaesthesia may be responsible for such backache.

A common complaint is that staff have not ensured that the placenta and membranes are delivered in their entirety, and that this has resulted in either haemorrhage or uterine infection in the postnatal period. The matter of causation here is not as straightforward as a lay person might think: the presence of haemorrhage at this time is not necessarily due to retained products of conception, but this does appear to be a common belief.
**Case 171 (DGH)** Claims products must have been retained because she had to have two "D+C"s. Histology showed no placental or membranous tissue, and it appears she had a uterine infection which caused decidual/endometrial bleeding.

This case is dropped after an expert report is obtained. Even where it is shown that some placental or membranous tissue has been retained, the matter of negligence cannot be assumed, as in this similarly unsuccessful case:

**Case 213 (TH)** The midwife has recorded placenta as complete, membranes as ragged. Expert report: "Throughout Britain, in one year, hundreds of women will be admitted for evacuation of the uterus a few weeks after delivery because of retention of small pieces of placenta. Such is a normal complication of normal delivery. To allege negligence over this is ludicrous."

A dead baby is a tragic outcome, and it is perfectly natural that parents in this situation should look for explanation, and even perhaps someone to blame. While obstetric medicine strives to identify at risk situations which may predispose to this terrible outcome, and then intervene to prevent the tragedy, such attempts will never prove completely successful. The trauma suffered by parents in these circumstances can only be imagined; whether the initiation of a legal action helps to accelerate and conclude the grieving process, or whether the adversarial legal system generates more antagonism and prevents supportive counselling by health care workers, is a matter of some debate. What is clear from this research, however, is that legal actions based on the fact that a child has been either stillborn or has died soon after birth, do occur.

In some ways such cases are related to many of those concerning cerebral palsy, the charge against staff being that the delay in delivering the child was so significant that the child did not survive at all (rather than survived but is brain damaged). There are certain situations or conditions which are associated with an increased risk of intrauterine death, one being diabetes. When the extra monitoring advised in such cases is made difficult by conditions such as obesity, the possibility of a poor or tragic outcome is higher.

**Case 209 (TH)** By the end of pregnancy the woman weighs well over 100kg, so ultrasound scanning and CTGs become difficult.

Expert report: "If Mrs. D had been less obese at the start of her pregnancy, and if she had maintained good diabetic control throughout, the outcome might well have been different."

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3 'D+C': Dilatation and curettage - an operation to ensure the uterus is empty
An uncharitable view might be that the expert has concluded that the woman has tried to find someone else to blame for her child's death rather than look closer to home for reasons. This case was unsuccessful. In another case, a diabetic pregnant woman failed to attend her antenatal clinic appointment; when she next attended, she said she had felt no fetal movements for three weeks. An intrauterine death was confirmed on scan. Unsurprisingly this action did not succeed.

In another action the parents sued when their baby died. In this case fetal distress was diagnosed, and delivery by caesarean section occurred fifteen minutes later; despite this prompt delivery, the child was asphyxiated at birth, and had a stormy neonatal history before dying almost three months later. It was held that staff diagnosed the distress promptly, and acted as quickly as possible to deliver the child; given this, the action failed.

Certain conditions may be the subject of debate concerning causation:

Case 145 (TH) Baby is born with a midline skin defect over sagittal suture; area of alopecia and scar. Maternal grandmother is adamant it's due to the forceps delivery. Notes go to expert; are returned within a week, and the case is dropped.

In this case a condition known as cutis aplasia - a congenital patchy absence of hair - appears the most likely explanation. Several legal cases have been initiated in this manner, the lay assumption being that a bald patch must be due to either forceps, fetal scalp electrode, or amniotomy hook. Some of these cases succeed (one did where it was held that a midwife had dislodged a piece of scalp when removing a FSE; damages of £750 were awarded), but many fail. It can be argued that insufficient explanation of such congenital conditions will fuel legal claims; the question of explanations is examined in Chapter 8.

The cause of an injury may be admitted, but the defenders may claim that the mere presence of a condition is not itself evidence of negligence. One such condition is Erb's palsy, in which the roots of the brachial plexus are over-stretched. This is a recognised complication following shoulder dystocia (difficulty with delivering the shoulders once the baby's head is born), since forceful traction is required in order to accomplish delivery.

Without showing that the defenders negligently failed antenatally to identify a baby so large that shoulder dystocia was probable, such cases are unlikely to succeed. One case which does appear likely to succeed may owe more to the failure on the part of midwifery staff to document the difficulties they had encountered with delivering the
shoulders; without case records or consistent staff recollections which describe such difficulties, it is assumed that this was considered to be a normal delivery, and in such a case the presence of Erb's palsy indicates that unnecessary force was used.

Pursuers may claim that deficiencies in a child's eyesight are attributable to events surrounding birth or the newborn period. One of the most notable medico-legal cases in recent years concerned allegations of negligent monitoring of blood oxygen levels in a neonate which resulted in blindness (Wilsher v Essex HA). This was a neonatal case; an obstetric case concerned allegations that midwifery staff had not identified eye infections at birth, resulting in the baby going blind in one eye. This case failed, however; the action was only raised when the child was eight years old, although the blindness had been diagnosed eight months after delivery; and it was shown that eye swabs taken at birth and after discharge home showed there was no infection present. In fact the child had a congenital cataract (which in theory ought to have been diagnosed on routine examination in the newborn period); an ophthalmologist commented (Case 150 [TH]):

"Even if (the) cataract had been detected at birth I do not think this would have changed our management as the prognosis for unilateral cataracts is extremely poor..."

Causation, then, is a problematic notion, and not one which can be automatically assumed in clinical matters. Clinicians have a duty to explain conditions to patients / parents, and doing this more effectively may help to reduce the number of (legally) meritless claims which are made. Some of the pitfalls of explanation and apology are discussed later, but these pitfalls should not be allowed to obscure the need to furnish patients with adequate answers when outcomes are poor.

Division of liability
One factor which in the past could affect the settlement of legal claims was the division of liability when more than one member of staff was found to have been negligent. This is less a matter for concern now that all hospital employees are covered by NHS indemnity, but before 1990 there was considerable argument in many cases about how the financial liability should be divided up.

Before 1990 hospital doctors had to belong to a defence organisation (most still belong); if doctors from different organisations were involved, then those MDOs might argue as to their respective member's liabilities; if both medical and midwifery

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4 Wilsher v Essex Health Authority [1986] 3 All ER 801, CA
staff were involved, then the MDO(s) and employer might argue along the same lines. At any stage if all the staff concerned were midwives, then the employer accepted full liability.

In one (pre-1990) case in which several staff apparently ignored ominous CTG traces, the question of apportioning blame arose. The expert suggested 70% for the consultant in charge, 20% for the registrar, and 10% for the midwives. Given that the likely settlement figure was high (preliminary estimate of damages was £340,000), the two MDOs and the employer each tried to minimise the liability for the member of staff for whom they were responsible.

In another case in which a registrar delivers the baby's head using forceps and then gets a midwife to try and deliver the body, but neither notice that the cord is around the baby's neck and the baby subsequently dies, the midwife is held to be partly liable: the first expert report suggests she is 20% liable, the registrar 80%; the second report claims that the registrar, having delivered the baby's head, had clearly accepted responsibility for the delivery and so he ought to be 95% responsible.

A further, tragic, case involves another failure to diagnose severe fetal compromise:

*Case 169 (DGH)* A student midwife looks after a woman in labour, but is apparently poorly supervised. She expresses concern to the senior midwife on duty, but it is not very clear if medical staff were quickly informed: the midwife claims she did inform them, and so they must share the blame.

The MDO eventually agrees to a 40% liability for their member, with the employer accepting 60% on behalf of the midwife. The consultant notes that the child "has 100% disability".

Division of liability is much less an issue now (since most defenders will be NHS employees), and this change has removed the scope for this rather unseemly squabbling. However the simplicity of the employer's full financial responsibility does not mask the fiscal implications for the health service; these are discussed in the next two sections. It is conceivable that in the future an employer could turn round and demand recompense from an employee's MDO or trade union / professional body (Dimond 1994), although this has apparently been ruled out for the time being (RCM, personal communication).

**Legal costs**

In personal injury litigation legal costs are usually met by the unsuccessful side. In one case, discussed in the 'Quantum' section below, a Sheriff, expressing sympathy with an unsuccessful litigant, reduced her financial liability in this regard to nil. In
another case an unsuccessful pursuer's legal bills mounted up to over £90,000; she initially announced her intention to appeal against the court's findings, then requested the defenders to pay her legal bills if she agreed to drop the appeal.

Many pursuers will be funded by the Legal Aid scheme; if they are successful, the amount they secure in damages will be reduced so that the Legal Aid Board recovers its costs. The importance of securing Legal Aid is demonstrated in one case in which a pursuer becomes bankrupt during the course of the legal action. Her Legal Aid is withdrawn because the Legal Aid Board fear being unable to recover any of their outlay should her negligence action succeed, because any damages she might secure would go to her creditors.

Within a delictual system, people have the right to pursue a legal action if they feel they have suffered negligence, providing they are prepared to pay for the legal fees involved, at least initially; should Legal Aid be secured subsequently, then such costs may be defrayed. When a case is dropped, it is very common for the pursuer's solicitors to request a disposal of the case "with no costs either due or by" (also known as a 'drop hands settlement'), meaning that neither side will bear the other's legal costs. Given that the pursuers have acknowledged that the case will not proceed, this in effect means that the defenders are left liable for their own costs, which can be substantial, particularly if the action has involved seeking advice or an opinion from an advocate or clinical expert.

Case 228 (DGH) There is uterine rupture at onset of the second stage of labour. Previous caesarean delivery of twins. Hysterectomy is carried out.

No specification of allegations of negligence are given, and the case is dropped after an expert report obtained.

The cost to the pursuer is legal fees plus the expert report; costs to the health service are the time, effort and money tracing staff, and collating reports. The time involved in investigating a case may be considerable, and often it is dropped with no reason given. The costs to the health service of running the bureaucracy necessary to conduct this work are difficult to verify; the CLO have started to do this, and at least one health authority in England now assesses its own costs, and it may be that unsuccessful pursuers will be required to contribute to such costs. In one Sheriff court action the Sheriff, while allowing the pursuer's case to go ahead, found against the head of claim brought by her husband, and made him liable for the defender's costs.
It seems rather absurd that legal costs can outstrip damages awards, but this is not uncommon in the relatively minor cases, and even in some which are more serious:

**Case 52 (DGH)** A recto-vaginal fistula develops after an episiotomy; the defenders agree to settle the case. The claim is settled for £1000, with a further £1426 in pursuer's costs, and £648 in legal department costs.

In this case damages constitute less than a third of the overall cost of the action. In a case in which a midwife dislodges some scalp tissue with a fetal scalp electrode, damages of £750 are awarded; pursuer's costs of £1,150 are also awarded, and legal department fees total £1,598, so the damages are only just over a fifth of the total cost for the defenders. Another case which sees legal costs soar above damages concerns an injury to a baby's head from forceps; compensation is put at £2,500 while the pursuer's costs amount to £8,750. In such cases, speedier resolution could lead to considerable legal savings.

The defence will look to the likelihood of victory in a case which is bound for court: paying the other side's fees in such a case could be very expensive. In one recent case the defence settled shortly before the court action was to proceed, having calculated that the court might hold for the pursuer. Estimated court costs were £10,000 a day for each side (personal communication), and the hearing had been estimated to last twenty days. £400,000 in court fees, on top of already incurred legal costs and a large sum in damages, was held to be too much of a risk.

One of the (less dramatic) costs of a legal action is replication of case notes and other relevant documents so that the staff concerned can refresh their memories; a reason for legal delays is that on occasion the full case notes are not sent to witnesses. However, case notes can be voluminous, and not all the contents may be strictly relevant, as noted by the legal department in a letter to a consultant:

**Case 552 (DGH)** "I am also returning to you a bundle of reply slips about case discussions which I found in the notes but which I am very reluctant to photocopy millions of times for lawyers - they don't seem to have any significance at all and we shall just fell a rain forest or so if we keep photocopying them for everybody."

In another case the legal department question whether the pursuers really want the entire case notes copied: not all appear relevant, and as there are well over 1,000 sheets in the records the bill for copying these (at 25p per sheet, 1996 prices) would be over £270. The solicitors insist, and the records are duly copied at the pursuer's expense.
Legal costs may amount to a considerable burden on the public purse; streamlined dispute resolution, such as using one expert for both sides or an arbitration panel to avoid the expense of solicitors, may reduce this. While few would decry the right to seek legal advice and pursue legal action, in some cases the lack of legal merit is clear; in such cases the health service is put to the expense of unnecessary investigation. It is possible that targeted 'de-briefing' (discussed in the 'Talking to patients' section below) may reduce this expense.

Quantum
Quantum literally means 'how much'. The matter of deciding quantum in the law of delict (tort), rests on the notion of restoring the pursuer to the position (s)he would have been in had the delict not occurred. In medico-legal cases damages are intended to compensate for the degree of harm suffered.

There are paradoxes in this approach since the degree of negligence and the degree of harm may not be proportionate. Hypothetically, a marginal degree of negligence, for instance delaying slightly too long before intervening in a labour where fetal compromise develops, could result in a brain-damaged infant, and the quantum could be very high (running into the million-pound range or higher); gross negligence (persistent delay despite overwhelming evidence of fetal compromise) in this instance could result in the baby being so severely affected that it dies; in this event, damages are rarely more than a few thousand pounds.

While the law attempts to restore the pursuer to a position comparable to the one she would have been in had the negligence and harm not occurred, there are inevitable difficulties in deciding how to quantify the harm. In the following summaries, only a very brief account of some of the details of each case can be given, and it is not intended that these details necessarily explain the amounts in damages which are quoted. The quantum is cited only to give a 'ball park' idea of the amounts which different types of case may succeed in obtaining. Citing the varying amounts also contradicts one solicitor's remark that obstetric legal cases are easy to spot because they have "a £1m price tag on them"; it will be noted that many are settled for much more modest sums.

Case 44 (DGH) A Rhesus-negative woman is given Anti-D immunoglobulin after her delivery, but the dosage is insufficient; she develops antibodies which are not detected in a subsequent pregnancy through combined hospital and GP errors. As a result, her child is stillborn. £4,000 are awarded.
Just how a financial package is intended to compensate for the loss of a baby is difficult to explain. In another case, in which a registrar fails to deal competently with a situation in which the cord is around the baby’s neck at birth and the baby subsequently dies, damages are demanded under two heads of claim: firstly for solatium (damages given by way of reparation for injury to feelings), and secondly for loss of society (not being able to ‘enjoy’ their baby). In this second case, damages are awarded under both heads of claim: £3,000 for solatium, and £4,500 for each parent for loss of society, making a total of £12,000. The difference between this and the first case is that loss of society can only be awarded once the person in question (the baby) has enjoyed full legal personality. To achieve this, the baby must be born alive; loss of society therefore cannot be claimed for a stillborn baby. The difference between a stillbirth and a baby who is liveborn but who dies moments after birth may appear marginal, but in the law this distinction is very significant (questions of inheritance, for instance, may also depend on a baby being born alive, even if only for minutes).

Another difficulty in deciding quantum lies in trying to predict the likely course of a condition over what may be a long time:

**Case 539 (DGH)** Erb’s palsy results from a normal delivery; nothing in the case notes indicates any difficulty with the delivery, and it is concluded that the injury must have resulted from excessive force. The pursuers suggest £10,000 in damages. The difficulty in determining a figure is that the case concerns a baby, and obtaining a long term prognosis is a problem.

This case is undecided; a court may have to arbitrate on the figure: there is a reluctance on the part of the defenders to endorse a sum which might be taken as a precedent for future cases.

In an attempt to decide quantum, very often case law will be examined. If similar cases have succeeded in obtaining a certain amount in damages, then it makes sense to follow that precedent.

**Case 395 (DGH)** A retained swab after a forceps delivery. Because it’s thought that the woman suffered little serious discomfort as a result of this, £200 is offered. The solicitors describe this as ‘derisory...little more than a nuisance value settlement.’ £400 is then offered. The pursuer’s solicitors claim £1,000, citing Edmonds v Bains.

The legal department read this case, and then cites two others (Quinn v Bowie and Paton v BSC). On the basis of these it now offers £600. This is negotiated up to £700, which is agreed upon.

5 Edmonds v Bains (Feb 1967) Kemp & Kemp Vol. 2
It will be seen that a considerable degree of negotiation regarding quantum occurs between the defenders and the pursuers in a case which the defenders concede or which the pursuer wins. The problem with looking to case law is that only a handful of medico-legal cases get as far as the court stage, and so finding a case which is directly comparable may be difficult. In those cases decided out of court - the majority - there is usually no publication of the decision or the amount in damages; a case may be reported in the media, but even then the matter of quantum is not usually disclosed. Because of the lack of case law, those solicitors specialising in this area have to acquire an anecdotal knowledge of the likely level of damages. However, case law is preferable:

*Case 416 (DGH)* Severe PPH, leading to hypovolaemia and severe adult respiratory distress. Admitted to intensive care.

The patient has recurrent bleeding, then collapses. In Theatre, "substantial piece of placental tissue" removed. Placenta had been thought initially to be doubtful, then said to be complete.

This case is indefensible, and is quickly conceded, but the matter of quantum takes some time: the pursuers, claiming £10,000, cite Kralj v McGrath, in which an obstetrician had attempted an internal cephalic version of a second twin; the procedure failed, and the baby subsequently died of its injuries. The legal department claim that there is no case which parallels this one; damages of £6,000 are eventually awarded.

It is extremely difficult to put a price figure on cases of harm and distress, but in case it appears that damages awards are sometimes conjured out of thin air it should be noted that damages are often quantified in a very precise way:

*Case 572 (III)* A child develops cerebral palsy, and the family incur costs in purchasing equipment and adapting their house in order to be able to give adequate care. The child then dies; the case is to be conceded, and the defenders make the following offer:

General damages £10,000; Bereavement £3,500;

Special damages £24,335.98 (20 items):

1. Solicitors' fees for sale and purchase of house = £939.3 + £1,311.63
2. Building extension and shed £1,000
3,4. Suction pump, washing machine and tumble dryer £745
5. 2 pushchairs £278
6,7. Fan and swing £70
8. Listening device - no cost given
9. Car £3,990

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6 Quinn v Bowie (No. 1) 1987 Scots Law Times 575
7 Paton v British Steel Corporation 1983 Scots Law Times 82
8 Kralj v McGrath 1986 1 All ER 54
10 Loss of earnings £4,133
11 Petrol + car expenses £3,500
12 Babysitting £872
13, 14, 15, 16 Bedding and towels, Clothing, Toiletries, Cleaning items £3,366.81
17 Food £1,410.24
18 Telephone £800
19 Gas and electricity £1,500
20 Toys £400

This very precise quantification requires explicit pricing of goods and services. Where such pricing becomes more debatable is in the area of assessing future or apparent loss of income. In one case a woman sues because she claims she is unable to return to work (in a factory) because of a negligently repaired episiotomy. The legal department query whether the pursuer actually intended to return to work after having had her baby; her firm don't seem sure - nothing was documented. Although the case is conceded, it cannot be settled for some time because of the argument about loss of earnings.

In cases which involve a brain damaged child, loss of future earnings may be considerable:

*Case 134 (TH)* A child born with cerebral palsy as a result - it is eventually conceded - of staff negligence. The pursuers' summary of future costs includes "Average gross non-manual earnings of £15,641.60 p.a."

They continue: "The said child is unemployable. But for his said condition, he is likely to have obtained employment and earned a wage well above the national average." His father earns twice the national average; the mother also has well paid work.

Another paradox in quantifying harm is that, in such a situation, a child of parents who are either low-waged or unemployed would not be able to claim as much, despite the degree of harm being comparable. In fact in this instance £310,000 (plus costs) are awarded; £850,000 had been claimed.

What might at first appear to be very similar claims - for example retained swabs cases - may be settled for very different amounts: always the attempt is to quantify the degree of harm caused. In one such case, the swab is removed after ten days by the GP; it's argued that the patient suffers little except discomfort, and £400 is agreed between the two sides. In another case, the swab is not removed until the postnatal check at seven weeks; in this instance, £2,000 is awarded. If the pursuer can show that she has suffered extreme distress because of infection caused by such a retained swab, then she may be able to claim a higher figure. Such distinctions show the
limitations of studies which only identify the principal reason for raising a legal action.

The estimates of defenders and pursuers as to quantum do not always meet, even allowing for the fact that each side knows it will probably have to negotiate to some extent:

*Case 255 (DGH)* A cervical tear occurred at emergency caesarean section. Registrar sutured this with routine closure. Initial writ in the Sheriff Court claims £50,000.

Although the pursuer loses this case in the Sheriff Court and is ordered to pay a contribution towards legal costs, the Sheriff has some sympathy with her and modifies her contribution to nil under the terms of the Legal Aid Act. Hypothetical damages were £6250.

The difference between what is claimed and would have been awarded in this case had the pursuer succeeded is considerable. Quantum may cause lengthy arguments, even in relatively minor injuries. It is sometimes argued that the pursuer may bear some responsibility herself, in which case the amount of damages should be less:

*Case 370 (TH)* A woman who had an allergy to a particular form of sticking plaster (this was clearly stated in her notes) nevertheless has such an adhesive dressing placed on her arm to secure an intravenous infusion. The pursuers claim £3,000. £192 was claimed for the loss of wages of the pursuer's husband, who had to take time off work because his wife could not look after the baby with swollen hands.

The defenders feel that the pursuer did not bring the matter to their attention quickly enough, and therefore she must bear some responsibility. She was drowsy at the time.

There is difficulty in establishing a suitable amount for solatium in such a minor injury. The defenders offer £275. The pursuer's solicitors say this is unrealistic: £800 would be fair, but they will accept £500 in order to settle quickly.

Quantum is certainly a problematic area of the law, with the possibility that apparently similar cases may receive hugely different amounts in damages. Among clinicians there must be an awareness that even a minor clinical error may in fact lead to large financial losses for their employer. However because of the chance elements involved (such as whether patients decide to sue or not) there is a danger that raising clinical awareness in this way will only lead to a rise in defensive practice. This is discussed in Chapter 9. The fact that the degree of negligence and the degree of harm may be hugely disproportionate is a negative feature of a fault-based system, and does not help clinicians to connect their actions with possible future legal proceedings.
Settling cases

It is not uncommon for the first intimation of a claim to be served in the form of a writ; this usually occurs if the expiry of the triennium is imminent, and is done in order to keep the claim 'live'. Many claims do not get as far as the formal serving of a writ, either because the claim is repudiated and this is accepted by the pursuers, or because the claim is so indefensible that the defenders agree straightaway to settle. In this eventuality a writ may then be served which sets out the basis for quantum. The absence of a formal writ does not mean that litigation has not occurred.

One reason for settling a case is that it will be much less expensive to do this than to continue defending it; this course of action (one the MDOs strenuously denied they supported when they had much more say in defending actions before the introduction of NHS indemnity) is much more likely to be chosen when the likely damages are low. In one case concerning cerebral palsy, £50,000 are claimed; quite how the pursuers have arrived at this sum is not known, given that most cases of cerebral palsy, if successful, may obtain several times that amount, and so the option for the defenders to concede the case and minimise their losses is tempting (this case is still on-going).

Although the MDOs denied that they agreed to settle a case which their member might want to defend, there is no doubt that financial considerations meant that this was sometimes considered as an option:

*Case 172 (DGH)* Postpartum haemorrhage following caesarean section eventually leads to hysterectomy in a woman aged 22. Defenders prepare to defend the action, as they believed the placenta to have been complete, and haemostasis achieved.

It transpires that this would have been a very expensive case to defend from the MDO's point of view: several members were now working abroad (one in New Guinea), and would have had to have been flown back for the court case. In the face of this, a settlement of just £5,000 was agreed with the pursuer. Legal costs were considerably higher than this.

In another case in which a baby born by the breech has a fractured humerus, the consultant notes that although the birth injury is excusable in this instance (the breech delivery was difficult: there was cord compression, and it was hard to get the extended arm down), it might be better to settle the case since the sum is likely to be small, and one of the probable witnesses is now in either Hong Kong or Australia. It is also possible that this may have something to do with not antagonising parents who believe they have a justified claim and who may create a lot of adverse publicity if they do not receive compensation of some sort, although this is only conjecture.
However, minimising publicity may be one reason for settling a case. It is usual in such cases for the decision alone to be made public; the amount in damages is not disclosed, and neither is there usually a detailed description of the case which the press might pick up. In settled cases there is a standard form of discharge which states that although compensation is paid to the pursuer, this is on the basis that no liability is accepted by the defenders. This does appear anomalous, given that the defenders have actually conceded the action; in only one case examined here, however, have the pursuers insisted that this clause in the discharge form be deleted (the case concerned a pursuer who had retained part of a stitching needle, and had developed complications from this; she obtained £55,000).

While settling a case may be preferable in terms of minimising costs, and while this may be much more tempting now with local budgets held by Trusts which cannot rely on a larger employer (a health board) absorbing a large damages payment, this can be seen as denying clinicians the right to defend their actions. (It should be noted that the CNST scheme and the new Litigation Authority have adopted some of the role of managing damages payments on behalf of Trusts.) The obverse of this is that, for financial reasons, some cases may militate against early resolution. In one case concerning cerebral palsy (Case 618 [TH]), it is immediately obvious that the actions of two junior members of staff are indefensible; however the legal department note to the MDO:

"This sounds like a tragic case, and I regret that concern for the financial impact of a large settlement on the (Trust) and its Obstetric and Gynaecology service militates against any immediate concession of liability."

This is a serious admission, and one which strengthens the argument in favour of dispersing the costs of large damages payments, either through an insurance scheme such as CNST, or through structured payments rather than a lump sum payment, given that life expectancy in some cases of cerebral palsy is not high.

Only a very small minority of cases get as far as the court stage. Some have been described in this chapter, but only brief details are given. Even those cases which go to court may not receive much in the way of publicity: the legal press may only report them if they offer a new interpretation or development in medico-legal actions, and unless they concern a subject which the general media find sufficiently newsworthy, they will probably never get more than one or two paragraphs in a local paper.
Summary
The legal aspects of these cases take many forms. Of greatest interest is the way in which the law either does not operate particularly efficiently (some of the solicitors' letters bear testimony to this) or produces anomalous results (the sections on causation and quantum described some of these). While the former is open to improvement through better training of solicitors in medico-legal matters and the establishment of bodies of competent solicitors who will act for pursuers, the latter is less amenable to change unless there is wholesale reform of the law. The need to establish causation looks set to remain, and this will continue to provide much of the argument in these cases. Lord Woolf's proposed reforms have yet to be implemented, but these may go some way towards reducing the adversarial nature of this part of the law; as such they are certainly to be welcomed.

A distinctly worrying feature for health service managers is the question of damages awards. Even if the incidence of litigation is falling (as appears to be the case), the capacity for one large compensation award to wreak financial havoc on the delivery of health care is obvious. Chapter 5 showed that the level of damages for one case may exceed the million pound mark. The poor predictability of cases makes providing for such eventualities problematic: large premiums could divert money away from essential health care unnecessarily.

Reasons for settling cases vary; while some (such as avoiding having to defend an expensive action in the courts) may be denied officially, they do on occasion occur. The implications for justice from these unusual cases are worrying; clinicians are denied the possibility of defending themselves, and pursuers may be left with the incorrect belief that staff were negligent. While it would be naive to think that this sort of outcome will never arise in legal actions, it does, however provide ammunition for those who advocate change to the current system.
Chapter 8

Influencing factors

Chapters 6 and 7 examined legal cases from clinical and legal perspectives; while these help to illustrate and sometimes explain how cases originate and are pursued, it is necessary to delve further into the peculiar circumstances of individual cases in order to build up a picture of the features which affect the origins, conduct and outcome of legal actions. Doing so highlights how certain factors are extremely difficult to tackle, while others may be targeted in an effort to reduce the incidence of litigation.

Chapter 8 is divided into four sections: 'Talking to patients' examines the circumstances of communication failure, and discusses the problematic area of how much information patients should be given before labour or specific procedures. The possibility of pre-empting litigation through a full and frank explanation or apology is also addressed. 'Recollections' looks at the problems which patients and staff alike encounter when trying to remember specific occurrences or sequences of events; less amenable to targeted improvements for patients, the practice of thorough documentation by staff will almost certainly aid recall.

'Motives for litigation' describes some apparent reasons for suing, but cannot claim to provide simple answers to this complex problem. Lastly, 'Delays' examines some of the most common reasons for delays in investigating and processing legal claims; many of the areas identified in this section may be more responsive to targeted change.

TALKING TO PATIENTS

Communication

This topic has already been broached in the section on differences of opinion among staff, when it was seen that such features sometimes led to a breakdown in communication. Allegations about staff-patient communication crop up regularly in legal cases. At all times improved communication is likely to lessen patient dissatisfaction; the other side of the coin is that poor communication can always lead to mistrust and mistakes. In one case the pursuers specifically mention the distress the woman suffers when apparently hearing doctors and midwives openly disagreeing about whether or not there is fetal compromise during labour, although in fact the
legal action concerns another matter entirely. It is a matter of conjecture that this perception of staff contributed to the decision to sue, but it seems clear that having one's faith in clinical staff damaged in this way may be a factor.

Communication will become difficult in times of stress; trying to ensure that a patient has understood something clearly when she is either in pain or upset because of events is a skill not held by every clinician. Equally, some of the problem may be due to the patient being unable to understand or unwilling to accept certain facts. In one case the consultant obstetrician notes (Case 351 [TH]):

"We would be very willing to try further attempts at verbal explanation but feel this should be done with a third party present to support the couple in their understanding. Our reason for saying this is the resistance to explanation and the belligerent attitude particularly of Mrs. G which we have encountered."

An obvious cause of communication problems is a language barrier: obstetric jargonese aside, if the patient or her family do not speak English well, and are unable to use the services of an interpreter, then problems are much more likely to occur.

Case 261 (DGH) Failure to send an ambulance, leading to the baby being born at home.

The negligence which is alleged seems to be that the midwife taking the call did not appreciate that delivery was imminent.

Case complicated by the fact that English is not the family's first language, and in his excitement the pursuer's husband, according to staff, was barely intelligible. Damages are claimed for "physical pain and shock and distress".

Even in circumstances where negligence does not appear to have been present, the need to have good communication channels between patient and staff is self-evident. The following case concerns a family who have a child with cerebral palsy, with the mother claiming additionally for the pain and suffering she allegedly suffered at the time of her caesarean section:

Case 501 (DGH) Expert report: "There has been no medical mismanagement...(but) throughout the entire time there has been poor and unsympathetic communication with this unfortunate lady and while this cannot be quantitated in a legal sense it has been the major cause of her grievance."

Effective communication during deliveries which are problematic for one reason or another is also critical. The ability of a patient who has gone into premature labour or who is haemorrhaging to take in information will be reduced; careful and sympathetic explanations may be tried, but when staff are themselves stressed problems can arise.

Case 497 (DGH) Concerns a premature infant (born at 29 weeks); mother has fulminating pre-eclampsia. The father is told the baby was stillborn; the staff then note a heart beat of 40
beats per minute, and resuscitation is started. By 10 minutes of age still the only sign of life is a weak heart beat. The baby subsequently dies.

The distress caused by being told that your child is dead, and then to see staff trying to resuscitate him, can scarcely be imagined. While no negligence was established in this case, the actions of some staff clearly left much to be desired. It is unreasonable to expect staff to be unmoved by the stress of the situation, but professional staff are expected to cope with this and maintain effective communication.

The use of medical jargon may confuse those who are not familiar with it, particularly where the same term can mean different things, depending on the context.

Case 3 (DGH) There is a misunderstanding when staff say to a patient who appears to have an infected postnatal vaginal discharge "We could take a swab from your vagina". The patient takes this to mean that a gauze swab has been left inside her following perineal repair, and this has caused the infected discharge.

The hospital maintain it is a misunderstanding due to the use of the word 'swab', and claim staff meant they could use a bacteriological swab to identify any organisms causing the infection.

A simple misunderstanding in this instance leads to the involvement of solicitors.

The overlap between obstetrics and neonatology can also provide room for mistakes to be made, or for patients to receive conflicting advice. Some of the most critical times at which differences of opinion can surface have already been discussed in the section on causation. In one case (No. 351 [TH]) a consultant neonatologist notes that:

"Difficulties of communication were compounded by threats of legal action against the obstetricians during the phase of critical illness of this infant."

In cases where the child is severely or even terminally ill, the ability of parents either to accept this, or indeed to take on board any information about the child's prognosis, must be reduced.

Case 84 (DGH) The pursuer's consort claims the baby's ventilator was switched off as there was a large likelihood that the child, if left to live, would be severely handicapped. The consultant paediatrician states that the ventilator was switched off only when the heart had stopped, and all other signs of brain death were present. In discussion with the parents it was mentioned that, had the child lived (original emphasis), he would almost certainly have been severely physically and mentally handicapped.

The information given by staff working in the neonatal area can critically affect the course of action taken by pursuers.
Pursuer's solicitors claim that the parents have been told by the consultant paediatrician that their child's condition is related to his birth.

The baby is readmitted at 8 days of age with a history of fitting. Paediatrician finds no obvious cause for this, and apparently tells the parents it's birth-related. With hindsight he says that the boy's problems "are more severe than can be easily explained on the basis of the forceps delivery." Expert report criticises the paediatrician's remark to the parents.

By this stage he has given the parents the belief that they can sue successfully, although in fact the solicitors subsequently inform the defenders that the claim has been dropped; however, another action against the hospital is pursued, and, having dropped the original action, it is then raised again three years later with a new firm of solicitors.

Communication is clearly a problematic area. Not all clinicians are adept at explaining things to patients, and stressful circumstances may compound this by making some patients resistant to explanations. Competent staff will be expected to cope with tense situations and maintain good lines of communication, but this will not be helped by the inappropriate use of jargon, an unwillingness to listen, or a lack of sympathy. Resistance to communication on the part of some patients may never be completely overcome, but if misunderstandings are to be minimised this must be a goal for clinical staff.

**Known complications**

The explanation in advance of known complications may provide a defence in cases where negligence is alleged. This aspect of information-giving has apparently reached remarkable heights in the USA with regard to obtaining consent prior to surgery: some consent forms are said to be as long as four pages.

One case concerns the allegation that an intrauterine death ought to have been somehow prevented; the defence rests on the fact that the patient is diabetic, and that intrauterine death is a known complication of this condition. Providing adequate steps are taken to monitor the pregnancy, and the timing of delivery is consistent with good practice, then clinicians ought not to be guilty of negligence.

Retaining the placenta after delivery of the baby is another well known complication, and it does seem that some women have a predisposition to this:

*Case 488 (DGH)* Claims negligence in not removing all of the placenta, which then becomes infected. She has delivered three children, and twice before retained her placenta.

Transfused twice for PPH.

This time piecemeal removal of an adherent fundal placenta under general anaesthetic.
This woman would seem to be predisposed to retaining her placenta after delivery; staff appear to have dealt with the situation in an exemplary fashion, and it is unfortunate that she feels the need to pursue this claim using solicitors, since the claim is extremely unlikely to succeed.

Very many such complications concern caesarean deliveries; this relates back to the apparent belief by some members of the public that a caesarean section is a straightforward procedure which happily precludes the need to go through a labour (see the section on Choice above). Although unforeseen occurrences can arise even in elective cases, most complications are likely to occur when the operation is performed as an emergency.

Case 235 (DGH) Ureteric fistula developed after caesarean. The woman had been in labour for a long time; tissues were oedematous and friable. The ureter was accidentally ligated.

Case 361 (TH) Claims a clip or stitch at caesarean occluded one ureter. Ureteric obstruction is recognised one month later on readmission. Immediate post-operative pain was not thought to be particularly significant; she mobilised well, and was discharged home apparently normal, so obstruction at that time was thought unlikely.

Both these cases relate to complications which affect the mother, and which can cause considerable distress. Nevertheless, while the first one may even be predictable, there is little that staff could do to prevent it occurring, short of having decided to operate sooner. Again, such decisions could offend those who wish to minimise obstetric intervention in labour.

A fairly common basis for legal claims are that the baby has suffered injury from the caesarean; the following is typical of such actions:

Case 223 (DGH) Cut to baby's head during emergency caesarean for fetal distress. Very vascular lower segment. Cut is closed with steristrips.

Consultant Obstetrician: "It seems to me that Mrs G is very fortunate to have a live baby, and although one regrets the mark on the baby's scalp, the difficulties in determining the depth of a very vascular lower segment can be considerable..."

Such claims rarely succeed, particularly if the operation has been an emergency and there has been some concern to deliver the baby rapidly. As long as the surgeon can show that he or she proceeded with due care, such relatively minor injuries, while no doubt distressing to the family concerned, do not usually provide evidence of negligence, although one case described below in the section on Apologies and Explanations does succeed.
Providing patients with information on known complications is a vital component of the doctrine of informed consent. However, this can be taken to extremes, and there have been suggestions that the law move from a requirement for informed consent to one of 'rational consent' (Mason and McCall Smith 1991: 252).

Retrospectoscopy
One of the most difficult approaches to counter is the assertion that a different course of action ought to have been adopted at the relevant time in order to avoid certain known complications. This being wise after the event can be termed 'retrospectoscopy': Divers (1994) used the term 'retrospectoscope' to describe the instrument by which perfect vision can be acquired with hindsight; this is a fairly common feature of legal claims. In one case the solicitors argue that an elective episiotomy would have avoided the perineal problems which their client subsequently developed; this is an area which has seen demands for a drastic reduction in intervention, and in fact episiotomy rates are now far lower than they were in the 1970s largely due to 'consumer' demand.

Perhaps the most common claim made under this heading is that a caesarean section ought to have been carried out; Roberts (1993) points out that in today's litigious climate, such a contention should not go unchallenged. In one case (No. 111 [DGH]) in which a baby develops Erb's palsy, the solicitors write:

"Our client considers that (the Erb's palsy) resulted from lack of care by her medical attendants in failing to adopt the alternative Caesarean method of delivery..."

This was the woman's first pregnancy, and the baby was large (over 4 kg), but to assert that in any situation in which a large baby is anticipated the woman ought to have a caesarean section is absurd, and would incense those who are calling for minimal intervention in this area. Another case sees the solicitors claiming that their client ought to have had a caesarean section because the baby was postmature. Such attempts to claim greater wisdom find little favour with clinicians who have to deal with such issues without the benefit of hindsight. In Chapter 9 there is the belief expressed that caesarean sections are given more readily to those who are more articulate (and possibly more likely to sue). From a study in Los Angeles in the early 1980s, Gould et al (1989) point out that there is a clear socio-economic distinction seen in a woman's likelihood of receiving a caesarean, so much so that it may be termed an operation of affluence. While the North American situation is not directly replicable here, it may be that similar considerations occasionally occur. Such
considerations in avoiding known complications of labour of course attempt to be wise before the event.

Rare occurrences
While known complications will frequently provide grounds for a successful defence, rare occurrences are more problematic. By their very nature they will be topics which are unlikely to be discussed in the antenatal period, and so when they materialise, in addition to causing distress, they may also cause resentment. One such occurrence is the onset of coccydynia - pain in the region of the coccyx aggravated by movement or pressure. In several cases it is alleged that the condition has occurred as a result of negligent performance of forceps delivery. However the condition may develop spontaneously after a normal delivery, and so the assumed causative element - the use of forceps - may be incidental. Either way it is very difficult to prove that the forceps did in fact cause the damage.

One case concerns a very serious development after a caesarean:

Case 576 (TH) Pursuers claim anuria resulted from negligence at section. Defenders claim she developed postpartum haemolytic uraemic syndrome, which was quickly diagnosed and treated. Unfortunately some renal cortical necrosis occurred, and the woman is on dialysis awaiting a transplant.

Urologist states that she has the smallest arteries he's seen in either adult or child, and also has cardiac disease. It may be supposed that her renal arteries are small, which would predispose to acute cortical ischaemia.

Although the result for the woman is tragic, it appears that staff coped adequately with this unexpected complication, and so the case is unsuccessful. The following case relates to an unforeseen (and tragic) outcome for one baby:

Case 179 (TH) Attempted forceps for failure to progress; this fails, and delivery is by caesarean. Started under epidural anaesthetic; the mother is still very distressed, and a general anaesthetic is required. Delay of 7 or 8 minutes. The cord prolapsed through the uterine wound at this time, but was not noticed because the obstetrician placed a gauze swab over the wound while the general anaesthetic was prepared. Baby born very asphyxiated.

This case is still ongoing, and will presumably be decided on whether the obstetrician ought to have noticed the cord.

The following extremely rare (and, once again, tragic) occurrence demonstrates the limitations of a fault based legal system:

Case 203 (TH) Pursuer's solicitors claim she is "permanently paralysed" as a result of an epidural. Forceps delivery, following which either amniotic fluid embolus (AFE) or pulmonary embolus appears to have occurred.
An epidural haematoma is diagnosed; this is evacuated. Stocking anaesthesia and paralysis of lower limbs noted.

Neurological discharge note: the working assumption is that the haematoma was caused by the removal of the epidural catheter in the presence of anticoagulation (for the AFE). The haematoma is thought to have caused the paralysis.

This is a tragic case which gets no compensation since there is not apparently any evidence of negligence. Such cases may provide ammunition for those who advocate a no-fault compensation scheme for medical accidents; this matter is considered in the conclusion.

Another unusual case concerns the discovery of a swab which is passed vaginally 53 weeks after a caesarean section:

*Case 198 (TH)* The theatre register claimed a complete swab count. Theatre midwife who writes a report states that she’s sure the count was complete because she’s signed the register to say so.

The swab, however, is the same as the swabs used only in Theatre. It’s assumed that it was left in the uterine cavity, and then slowly worked its way out through the cervix.

Since this case is indefensible, the amount of damages must be assessed; to do this a psychiatric opinion is required, since a depressive illness related to these events has been claimed. The psychiatrist, apparently without knowing the full details of the case, agrees she’s suffering from a depressive illness related to her delivery, but states:

"The fact that she believes that the swab had been working its way through from her uterus to her vagina is in keeping with her poor intelligence..."

The psychiatrist’s incorrect assumption about this patient’s ability to understand events led to an unfortunate conclusion that she was imagining things. It seems however that her version of events was correct, and she succeeds in her legal action and is awarded damages.

The onset of a rare complication demands that staff react in an appropriate manner; if they do so, then it is unlikely that negligence will be established. By their very definition, rare occurrences will test staff abilities, but it is the ability to deal both with the routine and the unexpected which distinguishes the competent professional.
Apologies and Explanations

It has been claimed that many pursuers are not intent on securing damages payments or pursuing a vendetta against staff members believed to have been at fault, but are only concerned to receive a full and frank explanation and, where appropriate, an apology from the relevant staff. In a bid to head off possible claims, units are now being advised to instigate claims management policies which aspire to provide detailed explanations to patients who have suffered loss in some way.

Without knowing the incidence and nature of legal actions before and after initiating such procedures it is not possible to determine their effectiveness, but at the very least they can be seen as helpful in their attempts to reduce formal litigation, as well as being good manners. One study (Vincent et al, 1994) found that few patients who had decided to take legal action considered the explanations which they had been given were adequate, a point which may seem obvious, but which highlights the care which must be taken over explanations. Sadly, they will not always be completely effective, even when the pursuer has no real case to pursue.

Case 193 (TH) Part of a stitching needle is left in situ at caesarean section. The consultant, who was supervising an SHO doing the closing up, knew of this. He probed but couldn't find the needle fragment, and felt it would be better to retrieve it later rather than continue probing.

The needle is located later by X-ray, and the patient given full explanation of situation and plan of management. Fortnightly X-rays are carried out to keep track of the needle, and elective surgery is performed 10 weeks later.

The needle is found, and the wound heals well.

Despite these full explanations, this pursuer clearly feels that she has a case. However, nothing the consultant or SHO did (or did not do) was negligent, and the case is dropped. Known complications or eventualities may provide a defence to a charge of negligence, and have been discussed.

In another case (No.490 [DGH]) the consultant obstetrician operated on a patient because he (correctly) anticipated problems at caesarean section. On notification of the legal proceedings, he notes:

"It is my opinion that Mrs B has always been a difficult patient to deal with to her satisfaction...When she was discharged she left me with the impression that she was clear about the sequence of events to date, had understood the oft-repeated explanations, and was satisfied with her treatment. It is disappointing but not surprising that she has apparently had second thoughts."

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Explanations can sometimes be made difficult by the problematic nature of perinatal outcomes. While many members of the lay public appear to believe in a relatively simple cause and effect relationship between events and outcome, this is often not the case, as was shown in the section on causation. In cerebral palsy it is now believed that as little as 8 - 10% of cases are due to intrapartum events (and not all of them can be held to be anyone's fault), yet there remains a strong belief that a simple explanation must exist. The dissatisfaction from one pursuer's husband in one case (No. 532 [TH]) is evident:

"About 4 or 5 weeks (later) (my wife) went to see (the consultant) to find out what had happened. (He) said to her 'it was one of those things'. I cannot tell you how much distress that this conversation caused (my wife) and myself."

In another case which concerned a scar on the baby's cheek (the injury occurring during an emergency caesarean section), the patient and her husband sought explanation from the obstetricians, but felt "angry at the flippant manner in which the case was treated", and so went to solicitors. Claims management requires a degree of sensitivity which does not appear to have been present in this case.

The question of apologies is one which can be problematic, as is shown by the following comment from a consultant obstetrician (Case 31 [DGH]):

"I apologised to J because in a mature and understanding world it is proper to express regret to any patient who considers that she has had a difficult time. That apology is not of negligence, it is of understanding and good manners, and let us hope that type of relationship never be lost in this litigation conscious world."

This sums up very well the tightrope which must be walked between expressing empathy and sympathy, and the desire not to be seen to be admitting guilt when it is not believed that negligence has occurred. Certainly there have been cases where the expression of regret has been taken as an admission of guilt. One senior registrar puts this very well in writing to a senior hospital executive (Case 179 [TH]):

"I did not state that I wanted to apologise for what I had done. I said that I was very sorry that the baby had died."

The dangers of unguarded explanations or expressions of sympathy are well demonstrated in one case concerning a baby who develops cerebral palsy. The midwife who looked after the woman in labour writes a personal note to the parents three weeks following the birth, expressing her admiration for their courage in coping with the situation.
Case 583 (TH) Legal department note: "...although (this) does not amount to an apology or an admission of liability, it is probably not wise for midwives to write to patients following disastrous births. My advice is that the (hospital) should encourage a policy of not conducting such correspondence with potential litigants..."

Legal department to Director of Midwifery Services (DMS): "I am not sure whether you have a policy about whether staff should write to patients and their relatives in this way. It seems rather heartless to ask them specifically not to do so."

DMS to legal department: "Isn't it difficult? I could not in all conscience instruct staff not to write to patients in this way...I am inclined to believe that the best policy would be to allow (staff) to use their personal judgement, and accept the risk that we might be left to pick up the pieces."

Legal department note: "It is all very well for (the DMS) to say 'we might be left to pick up the pieces', but picking up the pieces can cost as much as £500,000."

This case occurred a number of years ago, and the amount of damages mentioned can be adjusted upwards, as the section on quantum demonstrated.

It is clear that apologies and explanations, while desirable and a crucial part of sympathetic claims management, are not without their dangers: in one case (No.631 [TH]), the defence solicitors advise that a particular registrar (who had delivered a baby who subsequently died) should not be present at a case conference with the parents

"because his being upset about the case could be apparent at the meeting and be interpreted by the family as a sign of guilt."

This suggestion was resisted by the hospital authorities, who felt it entirely proper that the doctor ought to be present. Nevertheless, the feeling of walking on thin ice is strikingly depicted.

De-briefing

This term has come into usage recently in perinatal care to denote the procedure by which a patient who suffers an adverse outcome is given the chance (if appropriate along with her husband or partner) to voice her criticisms and concerns, the theory being that many formal complaints and legal claims are frequently based on misunderstandings. Despite the unfortunate militaristic overtones of the term, it appears now to be in common use.

Anaesthetists have seen the virtue of such a procedure in the postnatal setting, in order to clarify the events of labour or delivery for a patient. This appears to have resulted from complaints made about inadequate anaesthesia, particularly from an
epidural or spinal anaesthetic. Despite the obvious good sense of asking patients whether they felt they received sufficient pain relief, it is not an infallible procedure:

*Case 354 (TH)* Epidural anaesthesia inadequate, leading to the need for a general anaesthetic. The patient is noted to have a psychiatric history. When two anaesthetists saw her (three and five days post caesarean) she does not complain of having felt pain during the operation: in fact she says the analgesia had been good.

Given that this patient required a general anaesthetic because the anaesthesia was not sufficient, her assertion that she had no complaints might have been treated with scepticism. It has already been seen that some people are somewhat intimidated while in hospital, and the likelihood of their asserting their preferences or opinions is low. At home again, and with time to reflect on events, some will feel that they have been hard done by, and may seek legal advice to boost their complaint.

Obstetricians and midwives are now following the example of anaesthetists in trying to identify possible complaints before they become actual complaints or legal claims. This matter is addressed in Chapter 11.

**RECOLLECTIONS**

**Recollections of patients**

Patients' memories can become distorted over time, and while those with a poor outcome should now in theory be given a chance to express their views (whatever they may be), all the good communication and targeted de-briefing of patients may not be enough to convince some people that they have no justified cause for complaint. Of course those who do have justification for their grievances are perfectly entitled to seek legal advice and, where appropriate, compensation.

The recollections of staff may be as inaccurate as those of patients, but in the case of staff they usually have case records to help jog their memories. Patients are unlikely to have contemporaneous accounts of the events in question, and the combination of an inadequate grasp of details at the relevant time and the effect of distorted memories over a period of time may produce some strange accounts.

Many recollections relate to the labour or delivery period, as in this case concerning a caesarean section:

*Case 226 (DGH)* The writ states that the pursuer "screamed throughout the operation". The consultant obstetrician says this is not true: it would be "intolerable to the surgeons, anaesthetists and nursing staff." He also says that, contrary to a claim in the writ, there was no general anaesthetic given.
The registrar who operated says he knew the woman from her first pregnancy and thought they had a good rapport. He says it is absolutely untrue that she complained she was in pain at any stage during the operation. In fact the woman was given IV Thalamonal, an analgesic, after the baby had been born.

It appears that this intravenous analgesia was so effective that the woman believed she had had a general anaesthetic. It is a distinct possibility that memory has had a confounding effect in this case, since it is almost three years before the complaint is made (just before the expiry of the triennium).

In another case the pursuer claims that an unsupervised student performed an episiotomy and then repaired it without anaesthetic; the records show that a staff midwife carried out the episiotomy, that a midwifery sister was also present, and that a registrar repaired the perineum.

The presence of case records can do much to support the recollections of staff; in one case (No. 234 [DGH]) the expert notes that:

"Mr. P. alleges that after his wife's waters broke (at 2.20) they were left alone again. This is not borne out by the case records...."

Case records are not proof *per se* of what happened; just because something is written down does not mean that it is necessarily true, but in practice courts have relied heavily on such records, providing they are contemporaneous and consistent with the recollections of various staff members and of other documents. An improvement in documentation is one of the most notable claimed features of the response of clinicians to the fear of litigation (see Chapters 9 and 10).

*Case 262 (DGH)* Pursuer claims that after an initial hospitalisation she was discharged, but came back a week later and insisted on readmission, which took place. The case notes do not bear this out: as planned, she was seen two weeks later for a repeat ultrasound scan and readmission.

Pursuer goes to see her GP five years after the events in question, and it is another five years before she consults a solicitor.

In this situation, it is small wonder that memories can be inaccurate. It is possible that the desire to find a cause for some distressing outcome may blunt one's memories. In one case a woman sues claiming that her dyspareunia is due to her episiotomy repair (claiming the stitching was too tight); in fact her case records note that she had presented with this condition six years before this, her first pregnancy. Memories can become distorted over time, particularly when the outcome is tragic: in one case a
woman is admitted with a possible antepartum haemorrhage, which staff appeared to believe was just 'show' (Case 414 [DGH]):

Consultant: "The records would suggest that her initial bleed had been of a minor nature and that there was no indication to keep her in hospital at that stage. However on subsequent discussion she...described the bleeding as having been at least an egg cup full...on review some two months later her memory of the amount of the bleeding was vastly increased and she described this as having been pints of blood that soaked her bed clothes."

The tragedy of losing her baby may have conspired to make the memories more vivid than the actual events. In another case a couple initiate a complaint eleven years after the child's birth; when the child was four months of age he is diagnosed as having seizures. The consultant paediatrician who saw the baby at this time notes (Case 18 [DGH]):

"I saw the parents repeatedly and at no time subsequently did they describe to me what they now claim happened at the child's birth."

A patient's recollections of the time of labour may be affected by several factors, including exhaustion, the effects of opiate or inhalational analgesia, and the outcome of the pregnancy. It is accepted that information given to labouring women must be tailored to take account of these factors; a consultant writes in some exasperation of one patient (Case 90 [DGH]):

"Mrs. H. complains that she was not kept fully informed, but very experienced and dedicated Labour Ward staff are well aware that during labour patients are not receptive to detailed information..."

Understandable distress at the turn of events may colour perceptions. In one case a pursuer claims that she begged the obstetrician to section her once the fetal heart rate dropped. In fact it had stopped altogether and this was confirmed by scan, hence the consultant's refusal to carry out a caesarean section. The consultant says he did not speak to the husband when he came in, so the husband's claim to have begged the consultant to section his wife is untrue. At no point was the fetal heart rate noted to be slow: it was present and normal at the morning check, but not later that morning when further monitoring was attempted.

In another case (No. 400 [DGH]) in which a premature baby unfortunately develops cerebral palsy, the Summons states:

"(The pursuer) felt the baby starting to be born. There was no doctor present at this time. A nurse arrived, and appeared to attempt to push the child's head back into the birth canal of the pursuer. The pursuer thereafter required to have her vagina incised in order to facilitate the birth of the baby."
The contradictory nature of this claim appears to escape the pursuer's solicitors, for if the nurse (sic) was attempting to delay the delivery by 'pushing the child's head back into the birth canal', then an incision to facilitate the delivery would have been completely unnecessary if not impossible. The consultant obstetrician points out that controlling the delivery of the head to prevent sudden decompression is routine, and that episiotomy in the case of premature delivery is commonplace. He adds:

"Mrs. N had received analgesia about two hours before the delivery which could have impaired her memory of events. I do not see how a ludicrous claim can be made that there was an attempt to push the child's head back into the birth canal. No one would contemplate such a manoeuvre - it could not be done."

The recollection of lengths of time can vary when distress is present. One patient who, during the night, was given the wrong baby to breastfeed, told staff immediately that she had fed the baby for a minute. Once at home she found that the mother of the baby she inadvertently fed lived close by, and she developed an anxiety condition. In her claim she says that she fed the baby for ten minutes and not one.

The perceived reasons for what occurs in the delivery room can also affect recollections and may be used by pursuers to explain subsequent developments. In one tragic case in which the baby develops cerebral palsy it is claimed that the midwife examines the woman internally and attaches a heart monitor probe, and then runs to the sink 'heaving'. The patient is taken soon after to Theatre for a caesarean. The pursuers appear to believe that something occurred during the internal examination which caused the cerebral palsy, and which was so nauseating that it also caused the midwife to vomit. It is explained that, although the midwife has no memory of running to the sink 'heaving', she was herself pregnant at the time and suffering from nausea, and that this is the more likely reason.

Patient recollections at times may clearly be inaccurate, and may be affected by several factors. In labour the ability to comprehend detailed information is generally held to be reduced; extreme tiredness and the side effects of analgesia make perception problematic. When the issue is complicated by reinterpreting events in the light of subsequent outcomes or the distorting effects of time on memory, the scene may be set for unfortunate confrontation.
Recollections of staff

While it is true that patients will not usually have contemporaneous records to aid their memories, and that staff do, this does not necessarily mean that the memories of staff will be any the clearer. It can be argued that the patient herself (or her husband) may have particularly vivid memories of the time in question, and that to expect staff to remember every patient they look after is unrealistic, especially when there is a long gap between events and an action being raised. The problems with vivid memories becoming distorted by the knowledge of the outcome has already been discussed. Another example makes this point:

Case 620 (DGH) SHO sutured the perineum, but it becomes infected, and requires resuturing and eventual reconstruction. The patient later claims that the SHO continued stitching even when she was 'begging for analgesia'.

The SHO dictated a letter to the GP immediately after suturing, because of a piece of tissue being sent for histology. He wrote "This delightful lady... I would not have spoken in these terms had there occurred in the room the kind of conflict that Mrs. H. alleges. I recall her as a woman who at the time was very happy at the way she had been treated."

Perinatal legal cases may take several years to come to light; while those affecting the patient herself will usually be governed by the statute of limitations and so must be made within three years, cases involving the child can take many years (in cases where mental incapacity is present there is effectively no time limit).

The relevant legal office will forward case records to staff in order to help their memories, but this is not always effective:

Case 383 (TH) Following a stillbirth, statements are given by three midwives:

1) "I confirm that it is my handwriting in the...notes...I have no recollection of the incident."

2) "On reading the notes...I have no recollection of the case."

3) "Following refreshing my memory about this lady by reading her case notes I find that I remain unable to recollect this situation."

These are all dated eighteen months after the relevant incident. In another case five midwives' statements all begin with the phrase "I have no recollection..."; such an uncanny similarity of phrase might raise suspicions that an element of collusion is present. One midwife's entire statement was "I have no recollection of this particular case", which cannot be faulted on grounds on brevity, but does little to clarify the course of events. This case also concerns a stillbirth; seeking to explain the collective
amnesia the Director of Midwifery states "Staff do not remember the lady, and there have been 38 stillbirths (in the 30 months since)."

A slightly more helpful (and typical) instance of staff recollections occurs in a case concerning extensive perineal trauma; there is a gap of sixteen months between the relevant time and the requests for statements being made.

_Case 14 (DGH)_ Statements by two midwives:

1) "I have no recollection of this lady. I have made my statement entirely from my entries in the midwifery notes."

2) "I have little recollection of Mrs. C, but on reading the casenotes I recognise my handwriting and signature."

While the quality of the staff's actual recollections are little different in this case, they appear to have been more prepared to provide the legal office with an account of events based upon their respective case note entries.

It should not be assumed that staff are never able to recollect patients or events. One midwife described her memories with a representative from the legal department (Case 604 [TH]):

"I remember the case vividly, it's the worst night I ever spent...My midwife's sixth sense told me there was a sick baby who should be got out as soon as possible...a junior doctor assessed her as fully dilated, but she wasn't...after I took over the CTG trace was rotten...there were other signs of fetal distress, like meconium staining, and the fetal blood gases were borderline rather than reassuring...I kept calling the doctors in hoping they would decide on a Caesarean section, but they didn't and you can't tell a doctor he's got to section..."

In this instance such clear memories were believed to be damming from the point of view of the defence, and her formal statement, being _Proof of Evidence_, was less descriptive.

Courts have not always accepted the evidence presented by staff: Easterbrook (1996a: 382) notes that in _Parry v North West Surrey HA_ the court rejected the claims made by the doctor and midwife as being untrue, also rejecting the testimony of the midwifery expert.

It is unrealistic to expect staff to remember details about events which occurred many months or years earlier; recollections can only be helped by full and detailed contemporaneous documentation. While many staff appear to believe their standard

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9 _Parry v North West Surrey Health Authority 1995 (unreported)_
of documentation is high (see Chapter 9), the prevalence of inadequate clinical records in legal cases indicates that this is not always the case.

**Motives for Litigation**

There have been a number of explanations advanced as to why people sue (Felstiner et al. 1981; Vincent et al. 1994). In matters concerning alleged medical negligence one claim is that pursuers are looking for explanation and apology rather than seeking to punish clinical staff. This is difficult to assess, although anecdotal evidence suggests it does occur. One report in the literature suggests reluctance on the part of a potential litigant to go to law, despite encouragement from others to do so (Lindsay, 1994); another offers to explain why people do not sue (Lamont, 1993), citing deference and a fear of taking on the establishment.

In most of these legal cases it appears from the line taken by the pursuer's solicitors that the pursuer (or occasionally another family member) believes that staff have acted negligently, and that the family have a right to compensation of some sort.

In one case (No. 539 [TH]), which concerns a child who suffers an Erb's palsy, the solicitors write:

"...Our clients, who are not litigation minded, requested us not to take any legal steps, particularly because of the high standard of care which appears to have been devoted to the child since her birth."

If the pursuers are not litigation minded, it does beg the question as to what they felt they would achieve by contacting solicitors. In another case a woman makes a formal legal complaint against the hospital for allowing a photographer into the postnatal ward; she claimed that he took photographs of her without her permission, and then pestered her for money (this case was excluded from the incidence of litigation analysis, since it is not a clinical claim). Having been rebuffed by the hospital, who claim that she must have given her name and address to the photographer for him to know where to send the bill, three months later she brings an action concerning her treatment. Her motives for doing so can only be guessed; the claim is repudiated by the defence, and no more is heard.

One very plausible reason for initiating litigation is that it is an outlet for anger. In one case (No. 529 [TH]) in which a baby develops cerebral palsy subsequent to meningitis (this not being detected, it is alleged, due to staff error), the consultant neonatologist notes that
"Both (parents) were very angry indeed at the time of the illness. Even at that time they were trying to find someone to blame..."

The sense of wanting to blame someone for such a tragedy can perhaps be imagined; people react to stress in very different ways, and while some (it is claimed) seek explanation and apology, others may want to exact retribution.

One possibility for examining why people bring legal claims is to look at those claims which start out as complaints only.

**Case 538 (TH)** Emergency caesarean caused scar to baby's cheek. Father alleges they went first to the consultants to complain, but felt "angry at the flippant manner in which the case was treated", and so have now gone to solicitors.

The matter is settled for £9,500 plus costs, which is an expensive way for the hospital to find out that staff appear unsympathetic. In another case which does not concern any allegations of clinical negligence, the first letter of claim comes after this pursuer has her complaint upheld by the Ombudsman. She now looks for compensation. Despite there being no allegation of negligence, because of the Ombudsman's findings the defence seem prepared to make an ex gratia payment of £500. In another case a patient claims she had an inefficient epidural anaesthetic. Her initial complaint goes to the hospital; at the time she appears to accept the explanations and apologies, but later decides to go to a solicitor.

In a case concerning a retained gauze swab, the woman writes first to the consultant who admits that "there can be no excuse." About a month later she contacts a solicitor; admission is made, and the case is settled quickly.

Other more critical cases have also started out as complaints: one, in which the baby develops cerebral palsy, also involves the Ombudsman before the patient contacts a solicitor. In another, in which the baby is stillborn, formal investigations of the midwife's actions by the Chief Area Nursing Officer and the National Board are carried out, and although no action is taken against her this appears to fuel the patient's sense of having been unjustly treated.

Some of these cases succeed, others do not; there does not appear to be any consistent background to legal cases which originate as complaints made to the hospital. Insensitive handling of one such complaint almost certainly caused the patient and her husband to seek legal advice; the lessons to be drawn from events such as this are obvious.
One aspect concerning motivation to sue is the length of time it takes pursuers to raise their legal action. The range of such time has already been examined in Chapter 4, and it is also intriguing to note the variation. One factor would be the length of time it takes someone to become aware that they might have a reason to sue: in most cases the reason, if not apparent immediately, becomes so in the first year after delivery. Injury to the mother will usually be evident straight away; damage to the child, as noted earlier, may take longer to become apparent, but in either case a delay of several years before seeking legal advice cannot be easily explained. In one case in which it is alleged that products of conception are retained, the first complaint is made by the pursuer; then, almost three years later, the solicitor's letter arrives. In another case, excluded from the main study because the child was born in 1969, the action was not raised until 1990. The solicitors claim:

"As regards limitation, it is open to Miss P. to raise an action up to three years following her 18th birthday. This period will expire (in 6 weeks) and accordingly this is a matter of extreme urgency."

There appears to have been little sense of urgency for 21 years; it is possible the family have only become aware that litigation is an option - there was considerable publicity in 1990 about this, with changes to the Legal Aid requirements effectively making certain cases much easier to raise. Several other cases concerning children born in the late 1960s or early 1970s have also been excluded from this study.

In another case concerning a child born in 1982, the mother goes to see her GP in 1987 and complains about the care she received; it is another five years before she consults a solicitor. In a case in which the baby develops cerebral palsy, the first complaint is made to the hospital; a full explanation is given by the consultants. Three and a half years later, solicitors are contacted. Again, such delays are hard to explain.

Serial litigants
There have been allegations made in the USA that some people are 'serial litigants', and it would appear that some US obstetricians have refused to treat any patient who has already been involved in allegations of negligence, the fear apparently being that such patients are likely to sue again (Black 1990a). From this research there is little evidence of pursuers being involved in litigation more than once. One, referred to above, is only included once in this study because her original legal complaint was not clinically based. Another litigant to pursue more than one action has already been discussed in the preceding section on communication: she sues on behalf of her child who has cerebral palsy, formally drops this claim, then sues concerning a retained
swab; when this action is repudiated, the original action is resurrected, and it is possible - although this is only conjecture - that doing this is a means of increasing pressure on the defence to settle the second action.

A similar case sees a mother sue over the birth of her second child, who suffers an Erb's palsy; when the hospital announces their intention to defend this action the mother 'phones to say how angry she is at this. As she and her solicitors move to serve a writ on this action, she initiates another action concerning her first child, who has a degree of brain damage. Whether the hospital's decision to defend the original action influenced this is again a matter of conjecture.

A more unusual case (No. 565 [TH]) sees a mother sue over alleged negligence at a forceps delivery; her child has cerebral palsy, but it is established that the child's condition at birth is good, and that the brain damage is more likely to have been caused by the father of the child picking the baby up at one week of age, and hitting the mother with it (for which he was imprisoned). The mother subsequently sues over alleged negligence at a subsequent operation at that hospital, and over the caesarean delivery of another child at a different hospital, claiming severe pain during the operation. She 'phones the legal department and says that

'a mate of hers had received £12,000 for a whiplash injury and she reckoned she ought to get a lot more for a handicapped child.'

While this unfortunate woman does not have her troubles to seek, she appears unlikely to be successful in her claims. Another patient to sue more than once does so concerning the same incident: she drops the original action (concerning a caesarean delivery), but then raises it again almost eight years later. She claims that, due to subsequent medical treatment, she "has been led to believe that there had indeed possibly been negligence at the time of delivery." The consultant concerned agrees to her notes being released again, but states "I am sorry she was not able to accept the recommendations of (the original expert)." Once again she subsequently drops this claim.

The reluctance to accept that a claim has been unsuccessful is understandable, but some pursuers appear unable to let the matter go. It is commonplace, having got nowhere, for pursuers to instruct a new firm of solicitors. Given that not all solicitors appear terribly competent in pursuing medical legal matters, this may be sound common sense, but it can be taken to extremes: some of the legal cases examined here have taken long to conclude because the pursuer has gone onto her third or even
fourth firm of solicitors. In one case (No. 356 [TH]) where the pursuer is on her third firm, and now wants the notes sent to a third expert, the legal department notes wearily in a letter to the employer:

"I appreciate this is becoming a little ridiculous, but hopefully this should be the last referral, particularly (since) any claim...should be time barred (within a few months)."

Usually when the pursuer's nominated expert supplies a report which is unfavourable to the pursuer's case, the matter is dropped; one firm of apparently inexperienced solicitors (they had already written to the legal department asking them to "Advise us of the appropriate body in London to write to to obtain the names and addresses of doctors who may be willing to assist") seem unwilling to do this:

*Case 501 (DGH)* "We have already taken an opinion from Dr. F...in his opinion there was no medical negligence involved. In these circumstances surely a second opinion is desirable from everyone's point of view to clear up this matter once and for all."

This makes it sound as if they may go on requesting further opinions until they get one they like.

There is no simple answer to the question of why people sue; anecdotal evidence suggests that some people with good reason to sue do not do so, and certainly some meritorious cases studied here have not been pursued with the requisite degree of enthusiasm, the result being that the case falls. Equally, some litigants' cases have little or no legal merit, yet are pursued tenaciously. Motives for litigation remain largely obscure, but may be revealed by further research. Conjecture from the limited data available here, while tempting, is resisted.

**Delays**

A frequent complaint about legal action concerns the delays which often occur once the legal process is begun; reasons for this vary, and are discussed in the following sections. The time taken to raise an action has already been examined in Chapter 4.

**Delays in tracing case records**

Once an action is raised, the defenders set about investigating the allegations made by the pursuer; initially this means tracing the relevant case notes, and identifying what happened and which staff were involved. There have been cases where the delay in identifying the case notes is due to a pursuer having changed her name after the period in question; her solicitors give her current name which is of no use to the hospital records department. Other delays may be due to the solicitors requesting only the baby's notes, or only the mother's notes, when actually they need both.
Occasionally there is delay because the case notes relating to the child are still in use: in particular this may be so with a child who has cerebral palsy and requires regular medical treatment.

Frequently the delay is due to bureaucratic difficulties. This can cause serious problems: in one case there is no action over the first four years because the original case notes are lost somewhere between three hospitals and the legal department. There have been suggestions that such delays are a stalling tactic on the part of the defence (Beech 1990: 2); this claim is specifically rebutted in one case (No. 530 [TH]):

Consultant paediatrician: "I am afraid that the notes were lost somewhere in the bowels of the hospital and only a very determined effort enabled us to unearth them. My delay in responding was not because there was something we wished to hide but rather simply 'technical'."

Other delays have occurred because staff have obtained the notes from the records department for their own use: in one instance a research doctor obtained the notes two years before the action was raised, since when they had simply gone missing. Since no legal action was anticipated at the time, it would be wrong to deride this disappearance as malicious.

There have been times when the hospital records system leaves much to be desired:

Case 367 (TH) Employer to Consultant: "It is now over a year since I originally wrote to you."

Consultant to employer: "I have repeatedly asked for the case notes over the last year and have been consistently told by the records officer that it was impossible to obtain these records because the records department at (that hospital) was undergoing reorganisation."

This sort of excuse would do little to persuade those distrustful of bureaucracies that the health service is 'user-friendly'. In another case (No. 406 [DGH]) the legal department have trouble arranging a defence, because the hospital has released the case notes to the pursuer's solicitors. The department writes indignantly:

"This is not a very satisfactory position. As you will be aware, principal medical records should only be released in response to a court order. I would be obliged if you could advise the medical records officers at (hospital) of this."

At times only parts of the case notes are available; in cases concerning cerebral palsy this may be critical, since one of the most easily lost parts of the notes is the CTG trace. These come in a variety of sizes of paper, and for many years no satisfactory storage system was available, the traces typically being tucked into the inside back
cover of the case notes. It should be remembered that in many cases which retrospectively allege negligence at birth, there is no hint at the time that the baby has suffered any kind of asphyxial insult, and particular care in storing the traces may not be anticipated.

In one of the cases discussed above it was seen that a doctor had presented a CTG trace at a medical meeting, and had used a thick black pen to illustrate the points he was making. For the CTG trace to be unavailable is as much an obstacle to the defence as to the pursuer; there is an argument (favoured by those who advocate the widespread use of electronic fetal monitoring) that in the absence of a trace which shows unequivocally that no FHR abnormalities were present, it is open to the pursuer to claim that the child's condition is directly related to intrapartum asphyxia which was not recognised and dealt with.

The attraction of CTG traces for researchers has at times meant that vital traces have been unobtainable, as noted by the legal department in one case (No. 612 [TH]):

"A lot of the research into CTG traces locally was done by a junior research doctor...who is now working in (country). Contact with (this doctor) has led to a large number of cardboard boxes containing CTG traces being returned to the records department..."

There is now a general acceptance of the need to keep medical records relating to childbirth for at least 21 years, given the effective lack of a statute of limitations for cases concerning brain damaged children (25 years appears now to be favoured by many units). This was not always the case, and in some cases all or parts of the records have been destroyed. In one case (No. 173 [DGH]) the solicitors enquire why the X-rays have been destroyed; the hospital's reply is that:

"X-rays are kept for 6 years; there was nothing untoward seen on these films, so there was no reason to keep them".

As they were pertinent to a legal claim it would have been prudent to keep them, although clearly the line must be drawn somewhere: no hospital has infinite storage space, or the facilities or finance to convert all records into electronic form.

The ownership of case notes is a topic which has caused some heated debate. In one case the midwifery notes could not be traced for some time; it transpired that the pursuer had taken them home with her, and her husband refused to return them to the hospital, stating they belonged to the family.
Delays in legal actions sometimes occur because the pursuer’s solicitors do not themselves request that they be sent a copy of the case notes so that they can nominate an expert who will produce an opinion. Sadly this is not an uncommon experience: cases examined in this research have revealed delays of up to three years in requesting the case notes. This level of inexperience in the procedures of medical litigation might be overcome if lists of solicitors with a sound knowledge of this area of the law are produced and made available to potential litigants. Delays, however, still occur, and only conscientious efficiency in the mechanisms for storing and retrieving records will improve this situation.

Delay in tracing staff
Once the case notes are collated, the process of piecing together the relevant events begins, and one of the first tasks is to trace the staff concerned. In cases which take several years to come to light, this may pose significant problems. There is a high degree of job mobility among health service staff, with many clinicians trained in Britain moving around as the job market or personal circumstances dictate, which may include going to work abroad for a while. Equally many clinicians trained outwith Britain may work for a few years in a series of hospitals in order to gain experience and membership of professional bodies. Given the high turnover of clinicians, particularly amongst junior medical staff, and especially amongst 'locums' who may work in one hospital for no more than a weekend, tracing those involved in an incident even one or two years previously may be problematic; it certainly will be if the events in question occurred some ten or more years ago, which does happen.

Due to the increased awareness of the needs to maintain good records of all kinds from a medico-legal standpoint, hospitals are now much more careful to keep track of their employees; that this was not always so is illustrated by the following comment from one hospital services manager:

Case 529 (TH) "Medical staffing and the personnel department did not keep records of medical staff employed by this authority at the time in question (1985). It was only by examining the records in detail that I was able to elucidate even the names."

For clinicians who go to work abroad for a while there is the possibility that they have maintained their membership of their medical defence organisation (MDO), and so a contact address may be found. In one case, however, the relevant registrar moved abroad and resigned from her MDO as well; in another, the MDO records were less than helpful in tracing a particular obstetrician:
Case 365 (TH) MDO to legal department: "Unfortunately the Dr. R. which we identified turned out to be a dentist and an elderly one at that."

In another case the MDO is described by the legal department as being 'less than helpful' in tracing one of their members, since they demand a search fee of £100 + VAT.

A particular difficulty may arise if entries in the notes are not legible, and the absence of a countersigning signature may make identification extremely difficult:

Case 386 (TH) Consultant obstetrician to legal department: "...midwives and doctors are writing in the same part of the clinical outpatient record in the maternity case sheet. On looking at that (particular) case sheet we found it essentially impossible to work out when an entry was made by a midwife and when an entry was made by an obstetrician. This whole issue might further complicate the detective work required when an obstetric case is being looked at years later."

The legal department notes, regarding the identity of the (north European) author of a particular entry:

"It usually requires a great deal of detective work by comparing clinical notes with the correspondence of the same date so that you can work out whether the Arabic hieroglyphic is actually (a name)."

Occasionally this detective work is faulty: in one case an obstetrician is identified, and the case notes sent to him for comment. He is rather puzzled, and writes back saying that at the relevant time he was working in an Ear, Nose and Throat department.

It has been known for a graphologist to be consulted in order to identify the author of an entry in the case notes, a needless use of public money considering the ease with which such identification ought to be made.

Having identified the relevant staff there may be problems in obtaining useful reports. This problem is compounded if the staff in question now work in another country: in one case one of the midwives involved was found to be on an 'International Friendship' hospital ship, next port of call somewhere in Australia, then on to Papua New Guinea. Another case concerning a birth injury was thought to be quite defensible, but was conceded since the quantum was likely to be small, and one of the probable witnesses was believed to be in either Hong Kong or Australia.

Particular difficulties are encountered when a case takes many years to come to light, since certain members of staff are likely to have retired. Of course the ultimate cul de sac in tracing relevant staff occurs when the clinicians concerned have died. Delays
can only be overcome by hospitals insisting on clear (signed) entries in the casenotes and maintaining accurate records of current and past staff:

Delays in the legal process
Having obtained the notes, and identified the staff involved, the pursuers will usually request that a nominated expert produces an opinion: in many cases the case notes are only released to the expert. Delay can occur here, for those chosen to act as the providers of expert opinion tend to be the very senior members of the profession, who generally have many other clinical, administrative and academic commitments. One expert wrote to the legal department claiming that the delay is often encountered because of legal inaction:

Case 621 (TH) "My experience as an expert witness is that our legal colleagues demand expert opinions at short notice, we then hear nothing from them, often for years."

However it is not uncommon for a delay of several months to occur waiting for the expert report. In one case this was because the pursuer's solicitors instruct a professor whose interest is gynaecological oncology, when the case concerns neonatology. In a case concerning a child with cerebral palsy the solicitors ask for the casenotes to be sent to a consultant neurosurgeon; they are, but he does nothing for eighteen months and is apparently reported to the GMC.

In another case the legal department write to the nominated expert care of the employer to see why he hasn't returned the case notes. It transpires that he died some months earlier. It is not known if he produced a report, but as the pursuer's solicitors have been silent it is assumed he did and they do not wish to pursue the matter further.

It is quite natural to expect those chosen to produce expert reports to be busy: on occasion they are uncontactable, as in this case concerning cerebral palsy:

Case 400 (DGH) Pursuer's solicitors to legal department, explaining the delay: "Our local agents have attempted to contact Dr. H. on a number of occasions both in writing and by telephone and he has not responded to them whatsoever."

In another case (No. 431 [DGH]) concerning an intrauterine death, the pursuer's solicitors explain the delay:

"We were successful in engaging the services of an independent consultant to consider our client's records; despite various attempts he seems physically incapable of furnishing an opinion. We are therefore disengaging from him."
Such delays can occur just as easily in the case of the defenders; in another cerebral palsy case (No. 425 [DGH]) the MDO writes to the legal department:

"This is becoming most embarrassing! I have written yet again to our expert, this time asking him to let me know if he cannot provide us with an opinion within the next three weeks (otherwise) I will go elsewhere."

Until the introduction of NHS indemnity for hospital doctors in 1990 the interests of such doctors were the concern of the relevant MDO. The MDO for each doctor involved in the case had to be contacted separately, and these would liaise with their member before allowing him or her to produce a report for the legal department. While this procedure is not now essential (it no longer being mandatory for a hospital doctor to be a member of an MDO), most doctors will consult their defence organisation before agreeing to produce a report. Delays could occur due to the MDO's bureaucracy or lack of efficiency; in one case from the 1980s (No. 491 [DGH]) the following occurs:

June. Legal department, in response to pursuer's solicitors enquiring about the delay: "We regret the delay. Hope to hear from the MDO soon."

August. Legal department: the relevant MDO will discuss their member's liability at the September meeting.

October. Legal department: an expert instructed in this case did not return the notes in time for the September meeting.

MDO to legal department: "We did not have an October Council meeting owing to a lack of cases."

October again. Legal department: the MDO will discuss this case in November.

This sort of delay is very unedifying, and not one which impresses the pursuers. In another case (No. 252 [DGH]) concerning a failure to diagnose spina bifida, the pursuer's solicitors write in exasperation:

"We think we have been extremely patient until now. However we are disappointed with the lack of progress from your end. We have instructed Edinburgh agents to proceed with all haste with a court action..."

The delay seems to be because three defence societies are concerned, and they are deciding on the division of their respective liabilities. As stated before, this aspect of litigation is only an issue now if one of the defenders is not a hospital employee.

Very often the reason for the delay is not immediately clear; letters will be sent requesting updates on the state of affairs, but for one reason or another no answer will be forthcoming. One cause for such delays is that the pursuers may be seeking a
second expert report. Quoted above was one solicitor who, having obtained one unfavourable report, claimed that "surely a second opinion is desirable from everyone's point of view to clear up this matter once and for all". While they may believe this to represent their client's interests, it could be argued that it is only prolonging their agony and increasing their expenses. The solicitors are, however, honest enough to admit that this is what they would like to do; more often it would appear that pursuer's solicitors will keep quiet if the report they receive is unfavourable, and perhaps try and find another expert who may produce an opinion more favourable to their clients. One case (No. 118 [DGH]) in which cerebral palsy features sees the following:

February 1992: the pursuer's solicitors say they are hopeful of getting a supportive opinion.

October 1993: the legal department remind them of this.

April 1994: a further letter from the legal department asking if they're any further on. They say at that time they have instructed another expert.

September 1995: the legal department write again. The reply brings the news that the solicitors are no longer acting for the pursuers (they've changed firm).

The new solicitors say 'How about a nice ex gratia payment to settle it all?'

Since the case concerns cerebral palsy and the pursuer has Legal Aid, there is no hurry for her to close the case, except that she's not getting anything for her pains. A factor which pursuers may not take into account is that, having made allegations of negligence against doctors and/or midwives, the staff are left with these accusations hanging over them. Until the case is decided one way or the other they are left with this uncertainty and the fear that they may have caused or contributed to a tragic outcome. The feelings expressed by some staff involved in this way are described in Chapter 9.

A frequent cause for delay is that the pursuers have, as in the last mentioned case, changed solicitors; in effect this puts the case back to square one, for the new solicitors will have to go through exactly the same procedures as their predecessors. In one case delay is caused through the first firm of solicitors losing their client's file; in another concerning cerebral palsy, the second firm nominates the same expert who produced an opinion for the first firm.

In one case (No. 567 [DGH]) some delay is caused by a rather puzzling name on the writ served by the pursuer's solicitor, as explained by the legal department to the relevant hospital:
"You will note that an anonymous second defender, Dr. X, has been added in the heading, and frankly I am not sure what the implications of this may be. I have never come across anything of the sort before... I am only guessing, but I suspect that the Statement of Claim was settled by the Counsel some time ago and that he put Dr. X in his draft expecting (the pursuer's solicitor) to find out who this was and fill in the name...

This particular solicitor causes some anguish for the defenders, and appears to be doing little to advance the cause of his clients:

Legal department to hospital manager: "As usual I am having no luck in getting (him) on the telephone. He is never there, and my messages are never answered... (He) seems to be quite unversed in medical litigation; (he) has just issued a summons asking for copies of the relevant medical records. We actually released these to his medical adviser (seven years ago)!"

This case has been ongoing for fourteen years. Delays will also be caused in those cases which proceed towards the court stage. Court timetables are busy, and in order to give sufficient warning to all witnesses a date well into the future is usually agreed. In some cases witnesses have to be flown back from distant parts of the world, and this often cannot be organised quickly.

The court process being somewhat unpredictable, the length of court time anticipated may have to be reviewed: one case sees a Diet of Proof fixed for a date in February, then postponed until May because one day is thought to be inadequate; the pursuers then write and say their expert cannot make the new agreed date, and so further delay occurs.

All delays will be frustrating for the pursuer and for the staff concerned. Moves to speed up the procedures, perhaps by making them less adversarial, have been suggested. It is possible that instead of each side nominating an expert, both sides could agree on one expert who would furnish a report on which the case could perhaps be decided; this would also reduce costs. Instead of each side instructing solicitors, it may be that the case can be heard by an arbitration panel with both medical and legal representatives. This would certainly reduce delays caused by different solicitors pursuing essentially similar courses of action.

Delays in closing legal files
A number of reasons for delays in the course of legal actions have been examined; sadly there may also be some delay in closing the legal file. Very often the pursuer's solicitors will not inform the legal department that their client is no longer pursuing the action. The legal department will not close the file until a lengthy period of time has elapsed, knowing that the delay may be due to other reasons.
Case 427 (DGII)  Case notes (three files) sent to pursuer's expert June 1990. Legal department write to him April 1992 asking if he's still got them. Write again in July 1992 asking for an answer to the first letter.

He replies to the second one saying he's lost the first one and can't remember what was asked: could they send him a copy of the first one please?

It transpires that he returned the notes to the medical records office once he'd completed his report instead of to the legal department.

In this instance the action might have been closed two years earlier than it actually was because of this failure to inform. The pursuer knows her case has not been successful, but the staff involved remain unaware of this. In another action which concerned allegations about an over-tight episiotomy repair, it eventually transpires that the pursuer "had simply forgotten about the action because she did not want it to go any further".

One case concerning a retained swab could have been settled much more quickly than it was: the defence concede straightaway, and an offer of £1,500 is made within two months of the claim being raised. The swab was removed on the fourth day, was not infected, and appears to have caused little long term harm, but the pursuers hold out for another thirty months for more money before accepting the amount offered.

In an action concerning haemorrhage at caesarean section, the pursuer changed solicitors, then said she didn't want to pursue the action, but does not put this in writing. She fails to keep an appointment with her new solicitors, and is uncontactable. Another pursuer who changes her firm of solicitors and resurrects the action a year after the legal department last hear from her original solicitors, then apparently fails to give them any instructions: repeated requests by the legal department bring no response, and so the legal department, who were about to close their file, are left not knowing whether they can do so.

In an action concerning a child with cerebral palsy, the mother of the child eventually writes to the Court of Session confirming that they are dropping the action, but the Court of Session cannot accept this as evidence since it was the husband who was the named pursuer. In this action the refusal of legal aid appears to have been a deciding factor in dropping the action: this occurred before the changes in Legal Aid in 1990 which effectively allow legal aid to be granted for actions brought on behalf of a child.
In another case, perversely, the pursuer's solicitors say that the pursuer has been offered legal aid on two occasions, but has refused them both; she has been uncontactable for a long time so now the solicitors are closing their file, and the defenders can do so too.

What these cases illustrate is that delays can occur for many reasons and at any stage in the course of the action. While some of them may be reduced by more accurate record keeping within the hospital, others appear to have been part of the legal process; Lord Woolf’s suggestions for reform of the procedures for pursuing medical accident or negligence claims aim to reduce such delays.

Summary
Chapter 8 has described many of the factors which have been shown to influence perinatal litigation. The descriptions of the clinical and juridical nature of legal actions (as in Chapters 6 and 7) could not provide sufficient information on the complex interplay of perceptive and administrative features for an informed risk and claims management strategy. While never denying a pursuer with a justified case the right to pursue it legally, the frequency with which communication failure and poor recollections compound the perception that an injustice has occurred, means that these areas must be targeted. In practical terms this requires an open relationship between clinician and patient which does not fit the traditional hierarchical role adopted by many professionals; it is also probably true that not every clinician can be taught to communicate effectively, and so, while easy to prescribe, such aims will be difficult to achieve.

Why some patients and not others become litigants is a matter of speculation and debate, but it ought to be possible to introduce counselling and de-briefing procedures which could head off a certain proportion of claims. Improvements to the administration of record keeping (both clinical case records and information about staff whereabouts) may also make a significant difference to the process of investigating a legal case.
Part III: Conclusion

Chapter 6 examined legal cases from a clinical perspective. Given that all these cases are clinical in origin, it might be tempting to conclude that understanding the clinical nature of legal claims is all that is required. However, no case originates in a clinical vacuum, and Chapter 7 aimed to fill in some of the legal background; this explained why it is that many legal claims have rather uncertain starts, and others anomalous conclusions. Still this does not provide an adequate understanding of all the circumstances of perinatal litigation, and so Chapter 8 detailed many of the influencing factors which have such a profound effect on the origins, process and outcomes of these cases.

From this it is clear that legal cases may often be viewed in several different lights; merely describing the principal reason for suing ignores the complex interplay of clinical, legal, perceptive and administrative factors, and precludes an informed understanding of this phenomenon. While the clinical setting is the focus for all of these legal cases, they should not be viewed as a series of unfortunate individual incidents, but rather as a frequently unavoidable aspect of the clinical setting. That they are often unavoidable is evidenced by the fact that clinical outcomes - for a number of reasons - will not always be optimal, and expectations in society appear to be high. Because of the plethora of reasons for litigation, any attempt to tackle this issue must view the matter within its context. For a large majority of cases this is the intrapartum period, and while this may appear to narrow down the necessary focus for risk management, in fact this area covers a wide range of situations. Identifying the clinical care aspects (such as the interpretation of CTGs and the matter of adequate supervision) helps to focus on the types of situation which form the basis of legal actions, and does so in a way which merely listing the formal heads of claim (as in Chapter 5) cannot.

It is axiomatic that improvements in the quality of care will reduce the scope for litigation. While easy to prescribe, the process of continuing education of staff, ranging from the adequate supervision of students, junior clinicians and patients, to a thorough understanding of CTG traces by clinicians of all grades, and the sensitive implementation of local policies and protocols, presents a significant challenge to health service providers. A relatively straightforward aspect is the matter of retained swabs, where a simple counting procedure could help to avoid one (indefensible) head of claim. However, other areas for management are more complex; the constant
need for departments to stay within their budget, and even to show savings, means that simplistic notions of providing more staff (while attractive) are unrealistic. Sufficient cover must be arranged - often at short notice in the event of staff sickness - to cope with an unpredictable workload. Motivation of staff of all grades will help to ensure that the highest standards are being aimed at, but (anecdotally) disgruntled clinicians, wary of frequent organisational change within the health service and unconvinced about job security, may be less than fully motivated. A managerial impetus to convince staff of their worth, while at the same time demanding of them commitment and enthusiasm, may provide the lead which is required.

Risk management relies on being able to predict risk; the cases described here have showed that poor outcomes frequently occur with little or no warning. It will be remembered from the discussion of cerebral palsy cases that many of the parous mothers had no poor obstetric history to alert staff to the possibility of a poor outcome, and treating every first time mother in such a cautious way would be both impracticable and offensive. Risk management then will never completely avert poor outcomes; when such occur, effective claims management is required.

The legal aspects of these cases which have been described are necessarily selective; it is not within the scope of this thesis to describe all of the juridical aspects of perinatal litigation. The ones I have selected are either those aspects which require to be better understood by defenders and pursuers alike (such as those on causation and quantum), or those which are most amenable to targeted improvements (such as solicitors’ letters and settling cases).

There is of course a considerable degree of overlap between Chapters 6 and 7 and Chapter 8. Chapter 8 aimed to examine those aspects of legal cases which appeared to exert considerable influence on legal cases but which could not be described as either solely clinical or solely legal. The origins of delays in such actions lie in both clinical and legal camps, and it is not possible to classify such matters as communication and recollections under the clinical heading.

What Chapter 8 has tried to show is that a combined effort to improve communication skills, together with dealing sensitively with patients who express dissatisfaction and making the administration of record keeping more efficient, may help to reduce the incidence of litigation.

The need to live up to the pledges of government and other charters means that a willingness to provide woman-centred maternity care is essential; this initiates the
necessary open relationship between patient and clinician, which, when present, will do much to obviate the misunderstandings and differences of opinion which may form the basis of litigation. Involving women in decision-making in their pregnancy care provides scope for autonomy, informed consent and choice; providing sensitively presented information about clinical conditions which occur when a pregnancy is not straightforward should help to reduce the level of dissatisfaction which is inevitable when a pregnancy outcome is less than optimal. Risk management, in addition to identifying the conditions which might lead to complications, must gain the cooperation of the patient concerned; if not, her receptiveness to advice when it is given will be minimal.

In practical terms such management does not involve treating all patients as potential adversaries, but in ensuring that there is an adequate understanding of what pregnancy and labour entail. Some of the difficulties involved in doing this are discussed in Part IV.

The management process does not end with the birth of the baby, or the discharge home from hospital afterwards: an openness to be consulted about clinical events or outcomes, even long after the time in question, must be a priority for managers and staff alike; staff receptiveness to such ideas are discussed in Chapter 11. The distorting effects of memory can lead to significant misinterpretations, and some patients in this position evidently seek an explanation of occurrences through a solicitor; such a procedure ought to be unnecessary if good counselling or de-briefing services are available. The stress involved in litigation, for both pursuers and defenders, is not helped by the frequent delays which occur; tinkering with the present system can do little more than mitigate such pain. An absolute obligation for the sharing of information between sides and a requirement that mediation be undertaken as a first step, are possibilities for reform; avoiding the adversarial nature of the current process is essential if mistrust and antagonism are to be reduced. From the clinical side this must be tackled by an openness to consider grievances whenever expressed - this is sensitive claims management. There should be an awareness too on the pursuer's part that unfounded allegations of negligence might even be considered defamatory.

This is not to deny the right of an injured person to claim compensation, but the fallibility of the current system is all too clear from the examples given in Parts II and III of this thesis: the lack of experience of some solicitors, the requirement to prove causation and harm in order to establish negligence, the vagaries and delays of the
legal process, and the low rate of success for perinatal litigants, all indicate that alternatives must be addressed. The Woolf recommendations go some way towards aiming at this, but it is clear that many cases are initiated which have little or no legal merit, and only serve to increase the need for bureaucratic investigation and consequent expense. Reducing such cases will allow more consideration for those cases with genuine merit; however settling cases because of financial imperatives does little to imbue staff with a sense of confidence in or advance the cause of justice. Such cases may be fairly rare, but examples have been seen in Part III; if held to be an unavoidable part of the legal process, this surely adds weight to calls for reform of that process.

From the health service's point of view, organisational procedures for speeding up the investigation and conduct of a case can also be looked at, such as formalised procedures for recording staff entries in case notes and improved storage of records (particularly CTG traces); the accurate recording of staff whereabouts will allow for a detailed picture of the situation in the unit in question to be constructed when particular events are under examination.

None of this, of course, happens in a vacuum: the personal or individual element may conspire to make such aspirations problematic; however, only by addressing the organisational as well as personal features of clinical care can managers hope to establish a framework under which staff and patients alike will not feel threatened, and indeed will feel able to relate effectively.

The influencing factors identified in Chapter 8 illustrate how a combination of improved personal and organisational approaches may help to tackle the negative features of litigation, such as antagonism and delays. Effective administration and good communication are the keys to risk and claims management; while the latter in particular rests on a need for openness and understanding on all sides, the nature of this particular clinical situation provides an extra challenge for clinicians. That this is sometimes problematic is explored in Part IV.
Part IV

Clinical attitudes and reactions
The possible clinical effects of litigation have been referred to throughout this thesis. In Chapter 2 it was shown how various authors have commented on this in the literature; the possible consequences of (among other things) the long time it takes to initiate and conclude a legal action were alluded to in Chapter 4; the clinical background to litigation was discussed in detail in Chapter 6, and in Chapter 8 several of the perceptive and administrative features relating to perinatal legal cases were discussed with reference to how those working within health care might (or ought to) react.

There is no doubt that obstetrics / midwifery is one of the most common areas in medical negligence litigation, and it is certainly the front runner in terms of damages awards (Capstick and Edwards, 1990). There is a concern that health care provision in the UK is being threatened by such awards (Symonds 1985). It will be remembered from the literature review that concern has been expressed that an increase in litigation has seen a corresponding rise in defensive clinical practice, and the costs involved here have been commented upon (Carson 1988; Ennis et al, 1991). More recently the health service's drive to invest NHS finances in insurance schemes which aim to cover large damages payments has been criticised (Fenn and Dingwall, 1995). However in all cases little has been done to try and quantify the extent of the problem - if indeed it is a problem; clinical staff are at the centre of these concerns, yet it appears that their views have not been sought in other than a piecemeal and anecdotal fashion.

The two surveys reported in Part IV examine the perceptions of and attitudes to litigation among midwives and obstetricians in Scotland and in the two English areas in which analysis of legal files took place (one a health authority, the other a city hospital). Copies of the two survey forms are reproduced in Appendices C and D; the process of targeting midwives and obstetricians has been discussed in Chapter 3, and details about the characteristics of respondents can be seen in Appendix E.

1790 midwives and 211 obstetricians responded to these postal surveys, and it will be seen that some interesting differences of opinion between doctors and midwives were found. From within the midwifery respondents it was possible to analyse the views of the English midwives with a comparable sample of Scottish midwives; the basis for and details of this Scottish-English midwifery sub-sample are given in Appendix F.

Part IV is divided into three chapters: Chapter 9 examines the views of litigation generally, and ascertains the rate of personal involvement among the respondents. It
describes the opinions of these clinically-based staff concerning the possibility that defensive clinical practice is prevalent, and it explores the nature of midwife-obstetrician relationships.

Chapter 10 looks at the intrapartum period in some detail, and investigates the views of clinicians with regard to supervision, cardiotocography, cerebral palsy, and the labouring woman's capacity for choice and consent. These features have all been described in Parts II and III of this thesis, and constitute some of the most frequently acknowledged aspects of perinatal litigation.

Chapter 11 extends the analysis and discussion of the question of communication in the clinical setting. It looks at the incidence of complaints against respondents, probes their attitudes towards communication and rapport, both between patient and practitioner and between doctor and midwife, and describes the views of staff concerning the prevalence of counselling procedures for patients who have suffered an adverse clinical outcome.

Throughout this report percentage figures for response rates have been rounded either up or down to the nearest percentage point, except for the smaller figures. However not all the respondents answered all of the questions, and so sometimes the figures given do not add up to the total response rate; in such cases percentage figures are given for those who answered the relevant question.

In some of the figures the abbreviation 'NAND' is used: this stands for 'Neither Agree Nor Disagree'.

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Chapter 9
A litigation minefield?

Clinicians are popularly believed to view litigation as a potential minefield. The prospect of having to stand up in court and defend one's actions is something which few could relish, and yet little (except anecdotal) knowledge exists about the views of clinical practitioners about this complex situation. In Chapter 9 the views of staff concerning this matter are reported; it begins by detailing attitudes towards the incidence of litigation, and the reasons for its occurrence; it establishes the level of personal involvement in this large sample of clinicians, and assesses some of the reactions to the perceived threat of litigation. This includes the possibility that clinical practice is becoming defensive, and that practitioners are leaving their specialty because of the fear of litigation; it finishes by examining interprofessional relationships.

The incidence of litigation
The various claims made about the incidence of litigation were noted in Chapter 2 (Capstick and Edwards 1991; Acheson 1991), and Chapter 4 identified a dramatic rise throughout the 1980s in Scotland and the two English areas, with a significant fall-off since 1993. Respondents were asked whether they felt there had been a rise in litigation in obstetrics / midwifery over the last ten years, and, if so, what they believed had caused this.

209 obstetricians answered this question, with 189 (90%) agreeing; six (3%) thought it hadn't, and fourteen (7%) were unsure. These answers were almost identical to those of midwives (86%, 3% and 10% respectively):
Figure 9.1

Do you feel there has been a rise in litigation in obstetrics / midwifery over the last ten years?

% age

Yes  No  Don't Know

Doctors of all grades were of the opinion that litigation has increased, with the consultants (at 98%) most likely to agree; least likely were the GPs, at 78%. Comparing GPs and all hospital doctors almost reached statistical significance (p=.056). It was interesting to note that all of the English doctors agreed, compared with 90% of the Scottish hospital doctors.

Midwives of all grades were also strongly of the view that litigation has increased (least likely to agree were I grades - 82%; most likely F grades - 88%). There was a similarly limited range of opinion when analysed by size of unit, indicating that wherever midwives work, they feel litigation to be increasing. This contradicts the theory that a 'culture of litigation' is most likely to be found in the very busy larger units, which have a high turnover of staff, and more high risk patients. By length of experience those midwives who have worked for less than three years were the group least likely (at 76%) to agree with the question.

Given the lack of published information on the frequency of litigation, these answers probably reflect a popular feeling rather than a knowledge of actual figures, or knowledge of people involved. However, this should not detract from the strength of feeling evident in the answers. None suggested that litigation has tailed off in recent years, although from this research this appears to be the case.

Perceived reasons for litigation

Respondents who had said they thought there had been a rise in litigation were asked to suggest why this might be so; the most common answers are shown in the following Tables (many respondents offered more than one explanation):
Table 9.1  Most commonly cited causes by midwives of a perceived increase in litigation

<table>
<thead>
<tr>
<th>Most common causes</th>
<th>Cited by (%)</th>
<th>n=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased awareness</td>
<td>57%</td>
<td>1032</td>
</tr>
<tr>
<td>Increased expectations</td>
<td>22%</td>
<td>404</td>
</tr>
<tr>
<td>The media</td>
<td>20%</td>
<td>355</td>
</tr>
<tr>
<td>More litigious society</td>
<td>11%</td>
<td>194</td>
</tr>
<tr>
<td>Influence of USA</td>
<td>6%</td>
<td>114</td>
</tr>
<tr>
<td>Deterioration in NHS</td>
<td>4%</td>
<td>71</td>
</tr>
<tr>
<td>Financial gain / Greed</td>
<td>3%</td>
<td>51</td>
</tr>
<tr>
<td>Loss of trust</td>
<td>2%</td>
<td>36</td>
</tr>
<tr>
<td>The desire or need to blame</td>
<td>1.8%</td>
<td>33</td>
</tr>
</tbody>
</table>

Table 9.2  Most commonly cited causes by doctors of a perceived increase in litigation

<table>
<thead>
<tr>
<th>Most common causes</th>
<th>Cited by (%)</th>
<th>n=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased expectations</td>
<td>50%</td>
<td>105</td>
</tr>
<tr>
<td>Awareness</td>
<td>26%</td>
<td>56</td>
</tr>
<tr>
<td>Media / publicity</td>
<td>18%</td>
<td>39</td>
</tr>
<tr>
<td>General change in the public</td>
<td>18%</td>
<td>38</td>
</tr>
<tr>
<td>Legal Aid changes</td>
<td>12%</td>
<td>25</td>
</tr>
<tr>
<td>The need for money</td>
<td>4.7%</td>
<td>10</td>
</tr>
<tr>
<td>Desire / need to blame</td>
<td>4.3%</td>
<td>9</td>
</tr>
</tbody>
</table>

Two obstetricians added further comments about how society generally may have changed:

A 'me generation' attitude of wanting compensation for any untoward incident, however trivial.

Greater feeling by the general public that if anything goes wrong someone must be to blame - applies to anything from medical to bad weather, train crashes etc.!

Although increased awareness was the most commonly cited reason among midwives, the notion of increased expectations brought the most additional comments:

I feel people are too quick to criticise medical/midwifery staff if anything goes wrong. They expect us to work under increasing pressure, pay us peanuts and expect unrealistic care...

I believe that nowadays people's expectations may be too high. If a pregnancy has either an undesired or even a tragic outcome this is viewed as negligence rather than a possibly unavoidable occurrence. There is now a commonly held belief in
the UK that one should receive financial recompense for loss or injury irrespective of the circumstances.

Several explanations for such high expectations were offered:

I think midwives, and information available, set women's expectations too high, and they will never realistically reach it. We as a group do not discuss enough in the antenatal period the possibility of the ideal not being met.

Parents' (and grandparents') expectations of a live and healthy baby from every pregnancy are very high in our culture. I feel this is unrealistic, and that the medical profession are partly to blame for fostering this by giving an impression that obstetric technology and intervention has an answer for every problem.

The notion of a more litigious society was highlighted by comments about the American influence, lawyers, and the apparent belief that money can be made easily:

I feel that litigation in general has risen in the last few years due to an 'Americanised' attitude of "Sue if you think you can get anything for your trouble" - an attitude which lawyers seem to wish to perpetuate, probably because it's in their own interests.

Potentially a rise in cases in this area due to a firm of lawyers who are representing clients for a proportion of any settlement - no other fees.

Unfortunately the few I am aware of in my area are from people from poor but militant backgrounds who see it as a way to make money quickly.

Public awareness and public ignorance to gain money by whatever means possible.

It should be noted that contingency fees, mentioned by one respondent, whereby a solicitor negotiates in advance of accepting a case a percentage of any damages which might be won, are not in fact legal. The Law Society of Scotland fears the potential abuses of such a system (for instance a small firm of local solicitors accepting a percentage for a case, and then 'selling it on' to a larger specialist firm more likely to win, still accepting some of the arranged percentage) and the consequent tide of bad publicity which would ensue. The alleged deep unpopularity of American lawyers is cited as what might be expected were this aspect of US law to be copied here. Speculative fees, on the other hand, a 'no win no fee' arrangement, are legal. The belief that people from particular social class groups are more likely to sue was not borne out by the figures shown in Chapter 5 (Figure 5.5).

Some clearly felt that an increase in complaints and litigation reflects unfortunate changes in society, as the following comments show:

An attitude of 'Let's complain / sue and see what we can get.'
Clients who know that they can very often end up with cash in an out of court settlement regardless of the validity of their complaints.

Loss of respect due to poor professional conduct by a minority.

There were many other causes cited, among them the influence of consumer groups, increased technology, poor communication, easier access to notes, inexperienced and unsupported staff, and clinical error. There were several who felt that changes in the health service accounted for a rise in complaints and subsequent litigation:

- Government's "Patients' Charter" - it has back fired - patients now encouraged to complain.
- Patient's Charter - but no Charter to protect staff.
- Staff shortages; junior medical staff being left in situations for which they have not been trained.

Some respondents felt recourse to litigation to be understandable, and even a positive aspect of modern health care:

- Unwillingness on behalf of medical staff to apologise - they're so frightened of legal action if they admit liability that they say nothing...parents feel that their only way of finding out what happened is to go to a solicitor.
- I like to look at it in a positive way, i.e. women are more aware of their rights.
- I think litigation is on the increase because people are better informed and more assertive than previously, and rightly so.

On the whole, however, respondents appeared to view litigation with undisguised trepidation; one midwife summed up her reasons for a perceived rise in litigation this way:

- Public awareness, cute lawyers and the £ sign.

The perceived reasons for increasing litigation are numerous; however most notions of an increase in awareness and expectations are rather vague. As a measure of how directly affected midwives perceive themselves to be, they were asked how often they had discussed this matter with colleagues.

575 (32%) said they had discussed it often, 1046 (59%) had discussed it once or twice, with only 153 (9%) never having discussed it. By grade, the most likely to have discussed it often were the H grades (57%, or 16 of 28). There was no consistent association between grade and answering 'Often', however, and the H
grades were a small group. However there was a clear association between this answer and increasing length of experience, which is perhaps not surprising:

Figure 9.2

![Graph showing the percentage of midwives who have often discussed the possibility of being sued by length of experience.]

Doctors were also asked whether they had discussed personal involvement in litigation with colleagues (as distinct from discussing the possibility of being sued, which was covered in the following question); 70 (33%) had discussed it often, with a further 102 (49%) having discussed it once or twice. 38 (18%) said they had never discussed it. By grade consultants were by far the most likely to have discussed it often, but it was also striking that the English doctors were far more likely to have discussed it often (57%, compared with 33% of Scottish hospital doctors; p<.05). The GPs were far less likely to discuss this - 42% said they had never done so. There was, perhaps unsurprisingly, a distinct shift in answers depending on the respondent's length of experience: those who had never discussed it averaged 7 years in obstetric practice, those discussing it once or twice had an average of 13 years, and those discussing it often averaged 17 years. Discussing with colleagues the possibility of being sued showed very similar responses, and again the English doctors were far more likely to say they had done this often (62% compared with 38% for the Scottish hospital doctors; p<.05).

Perceived reasons for an increase in litigation varied, but the two most common explanations for both doctors and midwives were increases in awareness and expectations. It may be that many of the respondents meant broadly the same thing when using these different and rather vague terms. Some of the less commonly-cited reasons, such as an apparent North American influence and the desire or need for money, are difficult to assess without targeting those respondents personally. Although little can be concluded from these responses, they add some detail - and colour - to the largely anecdotal picture which has existed up until now.
Personal involvement: doctors

Personal involvement in perinatal litigation concerning allegations of negligence varied: just over half the obstetricians (which included 32% of the consultants) had never been involved:

Figure 9.3

The likelihood of being personally involved in litigation concerning alleged negligence was again positively associated with increasing length of experience. Those who had either never been involved, or had only been involved once or twice, had an average of twelve years' experience, whereas those involved three or more times had an average of twenty years' experience (p<.00001; calculation by Anova). With increased experience came more senior status: the consultant grades were involved most often, and almost all of those involved more than three times had at least fifteen years' experience.

This may simply reflect the possibility that the longer an obstetrician's involvement and experience, the more likely they are to have direct experience of litigation: with consultant status there has traditionally been the acceptance of responsibility for the actions or omissions of those working within the consultant's team, as one consultant explained:

(Never personally involved, but) Patients under the care of 'my' team have been involved 6-10 times.

With the development of midwife-only care in certain units, and a significant reduction in the amount of input obstetricians may soon have to the care of many 'low risk' women, this may be about to change. It is possible that the vicarious responsibility of the consultant may be significantly reduced by such moves. However, to confound
However, to confound the theory that increasing length of experience necessarily predisposes to legal involvement, analysis of the length of experience of the consultants was carried out (using Anova): this was very similar across all answers, as shown in the following Table. Likewise, size of unit appeared to matter little, although there was a weak positive association between legal involvement and increasing number of personal deliveries.

<table>
<thead>
<tr>
<th>Times involved in litigation</th>
<th>No. of consultants</th>
<th>Average length of experience (years)</th>
<th>Average size of unit (deliveries)</th>
<th>Average no. deliveries p.a.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>29</td>
<td>22</td>
<td>3360</td>
<td>42</td>
</tr>
<tr>
<td>Once / Twice</td>
<td>37</td>
<td>19</td>
<td>3768</td>
<td>50</td>
</tr>
<tr>
<td>Three to five</td>
<td>17</td>
<td>22</td>
<td>3179</td>
<td>53</td>
</tr>
<tr>
<td>Six to ten</td>
<td>7</td>
<td>22</td>
<td>3771</td>
<td>65</td>
</tr>
<tr>
<td>More than ten</td>
<td>1</td>
<td>20</td>
<td>4500</td>
<td>150</td>
</tr>
</tbody>
</table>

If length of experience and size of unit do not help to explain a consultant's likelihood of legal involvement, the answer must lie elsewhere. Respondents were not asked the circumstances of their involvement, so it is not known whether the increased involvement in clinical matters - measured by conducting more deliveries - predates and predisposes towards legal involvement, or whether it is a result of such legal involvement, and in fact occurs in an attempt to supervise juniors more closely and help prevent the circumstances in which further legal actions may arise.

Unsurprisingly, those of consultant grade were by far the most likely to have acted as an expert witness in legal actions, although the numbers are relatively small: only 30 had done this three or more times within the last five years. Most respondents correctly believe there to have been an overall rise in the incidence of litigation, and there is presumably a corresponding rise in the need to seek out expert testimony and comment. Certainly it is this researcher's experience, having read many legal files, that the same names crop up frequently; there have been moves mooted to establish lists of expert witnesses (or those prepared to write expert opinions) in an attempt to simplify the legal process (Sharp and Chamberlain, 1992), which is not infrequently held up by delays in obtaining expert reports. Those acting as experts in this manner are likely to be senior members of the profession who all have many other commitments, and the legal process - already slow - is made no quicker when awaiting the arrival of a report.

Personal involvement varied, and cannot simply be ascribed to being part of obstetric experience. Without probing further on an individual basis, the circumstances of such
involvement will not be known. Nevertheless, for almost half the respondents to have been involved means that litigation is no stranger to many obstetricians. How they have reacted to this is explored later in this chapter.

Personal involvement: midwives

Few midwives had been personally involved: only 80 (4.5%) of the whole sample, compared with 49% of the doctors. These respondents were mainly clinically based; length of experience and size of unit varied:

<table>
<thead>
<tr>
<th>Size of Unit (dels per year)</th>
<th>Grade</th>
<th>Length of experience (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 100</td>
<td>E</td>
<td>Less than 3</td>
</tr>
<tr>
<td>100-999</td>
<td>F</td>
<td>3 - 6</td>
</tr>
<tr>
<td>1000-1999</td>
<td>G</td>
<td>6 - 9</td>
</tr>
<tr>
<td>2000-2999</td>
<td>H</td>
<td>9 - 12</td>
</tr>
<tr>
<td>3000-3999</td>
<td>I</td>
<td>12 - 15</td>
</tr>
<tr>
<td>4000-4999</td>
<td></td>
<td>15 - 20</td>
</tr>
<tr>
<td>5000 or more</td>
<td></td>
<td>20 or more</td>
</tr>
<tr>
<td>Unspecified</td>
<td></td>
<td>Unspecified</td>
</tr>
</tbody>
</table>

Of the eighty who said they had been personally involved, eighteen came from the English sample; Chi square analysis of this ratio (18 from 231 compared to 62 from 1497) was highly significant (p<0.01). Without knowing more about the circumstances of such involvement it is difficult to know how much emphasis can be put on such a finding; the rate of litigation by hospital noted in Chapter 4 showed the English units at or near the top of their size of unit 'league' for the years when litigation was at its height (1988-91). It may be that personal involvement in litigation encouraged some midwives to respond to this survey, although, if this is so, the overall low rate of involvement (compared with the obstetricians) is difficult to explain given the fact that midwives were involved at least peripherally in most of the legal files analysed.

44% of the total sample (n=779) stated they knew of a midwifery colleague who had been involved, and 33% (n=590) knew of a medical colleague. The questionnaire did not ask where such colleagues worked (e.g. in the respondent's current unit / area of work or a previous one), and so analysis by these variables is less enlightening; however those working in units of 2,000 deliveries or more were more likely to know of such a colleague, and the Labour ward in both cases was the most common area of work for the respondent.
There appears to be no automatic correlation between knowing of someone involved in litigation and a belief in a general rise in litigation: 27% of those who said they didn't think litigation had increased (and 32% of those who answered Don't Know) did know of someone involved in litigation; it would appear that not everyone will generalise about such subjects based on their personal knowledge. There may of course be some overlap in people's minds between litigation and complaints.

The question specified legal action relating to alleged negligence; a high proportion (87%) said they believed a rise in litigation had occurred, yet only 57% said they knew of anyone involved. It may be that, as with people's attitudes to the crime rate, many people's fear of litigation is much higher than their actual experience or first hand knowledge.

Some respondents gave accounts of personal involvement in or knowledge of legal cases:

I am presently working in a unit where we are in the throes of litigation. Information has been 'leaked' to the press causing irreversible damage to our unit. Our clients are distant with little trust. It has affected us all very badly; it will take us years to get rid of this bad press....

I found the period relating to the allegations of negligence to be very stressful. I felt very isolated, even though I had reassurances from the RCM and obstetric and midwifery management that nothing would come of it. Afterwards I wanted to form a support group for midwives who had been in that position. I wanted to be there for them, because I felt no one was there for me.

I have personally just finished with a litigation case which was settled out of court. Poor attempts from management - no back up or reassurances by anyone except the solicitor who read through statements and reassured me all would be well. It was a very traumatic five years awaiting the outcome.

A feeling of a lack of peer support when something goes wrong was made by several respondents:

From close experience I have noticed that other members of staff shy away from a staff member involved in litigation.

I feel nowadays that you would really be on your own if problems arose, and that your midwifery colleagues would not back you up as they once would have...It gives me the feeling of working on my own rather than as part of a team.

A more frequently cited comment was the perceived failure on the part of midwifery managers to give support to clinical midwives. This was sometimes accompanied by claims that junior medical staff, by contrast, appear to receive comprehensive support from their seniors:
Management tend to come down very heavily on midwives and offer little or no support even if the midwife is deemed not to be at fault (shoot first, ask questions later).

Many fellow midwives feel that in litigation cases midwives are often not given total support from their managers, whereas medical staff appear to 'rally round' and 'stick together'.

There is no support given to the midwives involved, and all too frequently the senior midwives are quick to point the finger of blame and cry out for statements to be written and convey a feeling of guilt. Of the people I have known involved, the senior medical, midwifery and administrative staff behaved like being involved in a witch hunt.

Unfortunately no respondents specifically said they were supervisors, and while it may be assumed that those who gave their grade as 'Manager' enjoy this status, no comments were offered to balance this apparently one-sided depiction. Those midwives involved in litigation were certainly left with a bitter taste in the mouth. There would appear to be great room for improving the support given to these practitioners: the low success rate for pursuers indicates that, at least as far as the law is concerned, most of these clinicians have not been guilty of negligence, and yet they are left to deal with a prolonged period of stress.

Less than 5% of the midwifery respondents said they had been involved in litigation, but almost half knew of a midwifery colleague who had been involved. However this low rate of first hand experience did not inhibit some respondents from making very forceful comments about this subject. Even if not directly involved, litigation appears to have a considerable effect.

Defensive clinical practice
One of the most potentially damaging side-effects of litigation is the matter of defensive clinical practice, and this has been discussed in Chapter 2. The subject of defensive practice is one which is difficult to define, and one which divides practitioners with regard to its merits / demerits and implications for practice. It is widely held to be an issue in North America (Cetrulo and Cetrulo, 1989), and experiences there have been held up as a warning of what might happen here should defensive practices become more prevalent (Black, 1990a; Ennis et al. 1991). A reduction in the level of recruitment to obstetrics has been identified as a result of the fear of litigation (Pinker 1991). Respondents were asked whether they had changed their clinical practice at all within the last five years as a result of the fear of possible litigation.
Perhaps surprisingly, given such a large majority of both midwives and obstetricians feeling litigation to be on the increase, less than half (45%) of the doctors and just over half (53%) of the midwives said they had changed their clinical practice. Of the doctors, consultants were the most likely group to say this (56%), but it was very striking that the English doctors were much more likely to say they had done so: 76% compared with 42% of the Scottish hospital doctors, and the same proportion of GPs (p<.01). Cross border differences by consultant grade were also noted, with nine out of ten English consultants saying they had done so compared with 43 out of 81 Scottish consultants (p<.05).

Among midwives there was some association between increasing length of experience and a Yes answer, but this was not absolute; neither was there a consistent association in terms of size of unit:

Figure 9.4

Midwives who changed their clinical practice as a result of the fear of possible litigation (analysed by length of experience)

<table>
<thead>
<tr>
<th>Years</th>
<th>&lt;3 5.9</th>
<th>3 - 8.9</th>
<th>6 - 11.9</th>
<th>9 - 14.9</th>
<th>12 - 19.9</th>
<th>15 - 20 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>%age</td>
<td>60</td>
<td>50</td>
<td>40</td>
<td>30</td>
<td>20</td>
<td>10</td>
</tr>
</tbody>
</table>

Figure 9.5

Midwives who changed their clinical practice as a result of the fear of possible litigation (analysed by size of unit)

<table>
<thead>
<tr>
<th>Deliveries a year</th>
<th>Up to 100</th>
<th>1000-1999</th>
<th>2000-2999</th>
<th>3000-3999</th>
<th>4000-4999</th>
<th>5000 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>%age</td>
<td>60</td>
<td>50</td>
<td>40</td>
<td>30</td>
<td>20</td>
<td>10</td>
</tr>
</tbody>
</table>

Respondents who said they had done so were asked to state in what way(s) they had changed their practice; the most common answers are shown in Tables 9.5 and 9.6.
There has been a growing appreciation in the last few years of an increasing caesarean section rate, and the Scottish Caesarean section audit has been implemented in an attempt to limit and even reverse this trend. It is acknowledged that even by following stricter guidelines for performing caesarean sections, the overall rate for a unit is unlikely to be reduced by more than 1 - 1.5%. This rate may fall further in years to come as fewer 'repeat sections' are required.

It is disappointing therefore, if entirely understandable, to find that obstetricians still feel that they are being pushed into carrying out caesareans; it will be remembered from Chapters 7 and 8 that claims made by pursuers include the assertion that a caesarean should have been carried out when it wasn't, or should have been carried out sooner than it actually was.

The changes in clinical practice cited by midwives are shown here:

<table>
<thead>
<tr>
<th>Table 9.6 Examples by midwives of a change in clinical practice due to the fear of possible litigation</th>
<th>Cited by (n=)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation improved</td>
<td>742</td>
<td>42%</td>
</tr>
<tr>
<td>Obtain permission for all procedures</td>
<td>136</td>
<td>8%</td>
</tr>
<tr>
<td>Get medical advice earlier</td>
<td>73</td>
<td>4%</td>
</tr>
<tr>
<td>Adhere more to unit policies</td>
<td>37</td>
<td>2%</td>
</tr>
<tr>
<td>Monitor (eg CTG) more often</td>
<td>24</td>
<td>1.3%</td>
</tr>
<tr>
<td>Update skills more</td>
<td>19</td>
<td>1%</td>
</tr>
<tr>
<td>Double check more</td>
<td>14</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

It will be noted that for midwives improved documentation is far and away the most commonly cited change in practice. It occurred across all sizes of unit, with those working in the larger units slightly more likely to cite this reason. By area of work, it was noted to be most commonly cited by those in the Labour Ward (47%) and those working either in a team or a rotational post (45%), and least in those working in a
neonatal unit (36%) and on the Community (35%). The importance of good
documentation is hard to overstate: Cetrulo and Cetrulo's point (1989: 563) that "To
many, the accuracy and completeness of the medical record reflect the quality of a
patient's care. A poor, incomplete, or sloppy record suggests that the care was of a
similar quality" highlights this view from a medico-legal standpoint.

With so many respondents citing this reason, there were many comments added; the
following is a small sample:

> Because a patient complained about a colleague of mine almost two years after
her delivery, especially the midwife's 'decision making', each of us in our unit is
now more aware of entering every remark / decision we make in the notes.

> We have recently undertaken update in documentation and record keeping which
is as a result of increased litigation.

> I think the fear of litigation in midwifery is at the back of your mind constantly. In
our unit we are very strict in noting lots of information which may appear
unimportant at the time, but may be vital if problems arise. This includes writing
on the CTG trace when senior midwives or medical staff have observed it.

Some evidently felt the increase in documentation has gone too far:

> Ensuring that I write everything down regardless of how trivial it may be.

> Document everything, relevant or not.

> Improved (in fact almost paranoid) record keeping.

Obtaining permission for all procedures was the second most commonly cited change
in practice. This may be viewed as basic good practice, or as defensive. Compared
with the claimed improvement in documentation this was not frequently cited, being
given by 8% of all respondents; however it was noticeable that those who gave this
example of a change in practice were much more likely to give the Labour Ward as
their place of work (11% did so).

Other reasons cited included working less (or not at all) in the Labour Ward - a
clearly defensive response; trying to follow research-based practice more often; and
challenging medical decisions sooner. The following is a selection of the many
comments cited:

> Adhering to policy rigidly instead of viewing the individual.

> Don't deliver babies anymore.
Have no qualms in summoning further assistance if I feel there is, or may be, a problem with either mother or baby, no matter how high I may have to go (i.e. consultant).

Swab counts before and after episiotomy repair.

Treat everybody as a potential threat.

Take a 'witness' in difficult situations - re documentation.

I've become independent!

One midwife said she now routinely records membranes as 'ragged' rather than 'complete' following delivery, echoing the point raised in Chapters 6 ('The standard of case records') and 7 ('Causation'). The use of 'appears complete' or 'ragged' instead of 'complete', while understandable in terms of trying to cover oneself, may confuse the investigation if a legal action is brought based on allegations of substandard care contributing to haemorrhage.

Obstetricians seem to feel the need for increased documentation rather less, although it can be argued that documentation is not strictly speaking an example of clinical practice. Nevertheless many legal cases have been lost on the basis that documentation was either poor or missing completely, and the need for thorough case records has been detailed in Chapter 6.

An improvement in documentation, or increased supervision of junior staff, may be held up as a distinct improvement in standards of care, which reflects the ambiguity with which many view the whole notion of defensive practice. One practitioner's defensiveness is another's good sound clinical practice. One SHO who claimed not to have changed practice added:

But as a trainee I am always keenly aware of potential litigation, and follow advice of my consultants.

Respondents were also asked, irrespective of whether or not they had changed their own practice, whether they felt obstetric clinical practice generally to be becoming defensive. A large majority of the doctors (77%) did so, with only 13% disagreeing, and 10% unsure. GPs, at 53%, were less likely to agree, and there was some difference between the English and the Scottish doctors:
Figure 9.6

Obstetric clinical practice generally is becoming defensive

Some comments were added:

Knowing that any patient might sue leads us to be more aware of what we say and do, and therefore must, at least to some degree, influence our line of management.

I hope not - there is no need to become defensive - just do what one believes is correct and document carefully the reasons, and if necessary the evidence (i.e. studies or audits, etc.)

Doctors who said they had not changed their own practice were even more likely to say that practice is becoming defensive than those who had themselves changed; by the same token, 15% of those who had changed their own practice did not believe clinical practice generally to be becoming defensive.

Nevertheless, a large majority did feel this change to be occurring, and once again the most commonly cited example was more caesarean sections:

<table>
<thead>
<tr>
<th>Table 9.7 Doctors' examples of defensive practice</th>
<th>n=</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>More Caesarean sections</td>
<td>69</td>
<td>33%</td>
</tr>
<tr>
<td>More investigations (eg scans)</td>
<td>24</td>
<td>11%</td>
</tr>
<tr>
<td>Quicker intervention</td>
<td>22</td>
<td>10%</td>
</tr>
<tr>
<td>More use of CTG</td>
<td>14</td>
<td>7%</td>
</tr>
<tr>
<td>Induction of labour</td>
<td>5</td>
<td>2.4%</td>
</tr>
<tr>
<td>More forceps deliveries</td>
<td>3</td>
<td>1.4%</td>
</tr>
<tr>
<td>More documentation</td>
<td>3</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

Midwives were slightly less sure that clinical practice is becoming defensive: 1051 (59%) said Yes, with 450 (25%) disagreeing, and 270 (15%) unsure. By grade there
was little difference, except that the managers were much less likely to agree (3 of 8 saying Yes, 4 saying No). There was some variation when analysing responses by unit size, with those in the smallest units (up to 100 deliveries a year) least likely to agree (53%), and the most likely being those in the next size of unit (100-999 deliveries a year (69%). However it was noticeable that the less experienced midwives (up to six years) were more likely to agree than those qualified for 12 or more years. In this latter group there was an almost exact association between answering yes to both the previous question and this one, whereas this association did not exist for the less experienced midwives (Figure 9.7). While it may seem that the more experienced midwives are answering the second of these questions based upon their personal experiences, in fact the association between responses to both questions is not absolute, as was the case with the doctors. 53% of those who answered 'No' to the first (i.e. had not changed their own clinical practice) answered 'Yes' to the second (they did think clinical practice is becoming defensive), whereas 43% of those who thought clinical practice is not becoming defensive said they had changed their own practice.

Figure 9.7

Change in clinical practice (first column) compared with belief in general defensive clinical practice (second column)

The Scottish-English matched pairs showed more English-based than Scottish-based midwives agreeing (p<.05) that practice is becoming defensive. In fact the most commonly cited instances of defensive practice could be argued to be principally or even solely medical features of perinatal care:
Table 9.8 Midwives’ examples of defensive practice

<table>
<thead>
<tr>
<th>Example</th>
<th>n=</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>More caesarean sections</td>
<td>352</td>
<td>20%</td>
</tr>
<tr>
<td>Earlier intervention</td>
<td>210</td>
<td>12%</td>
</tr>
<tr>
<td>More CTG in normal labour</td>
<td>147</td>
<td>8%</td>
</tr>
<tr>
<td>More A/N monitoring and investigations</td>
<td>97</td>
<td>5%</td>
</tr>
<tr>
<td>Induction of labour</td>
<td>68</td>
<td>4%</td>
</tr>
<tr>
<td>More forceps deliveries</td>
<td>57</td>
<td>3.2%</td>
</tr>
<tr>
<td>More fetal blood sampling in labour</td>
<td>55</td>
<td>3%</td>
</tr>
<tr>
<td>Refer more quickly to medical opinion</td>
<td>52</td>
<td>2.9%</td>
</tr>
<tr>
<td>More ultrasound scanning</td>
<td>48</td>
<td>2.7%</td>
</tr>
<tr>
<td>More unit policies</td>
<td>18</td>
<td>1%</td>
</tr>
</tbody>
</table>

Despite these examples being primarily obstetric in origin, as noted above it was the midwives in the second smallest units who were most likely to agree that clinical practice is becoming defensive, when it might be thought that the midwives in the bigger units would be more likely to agree, given these units' greater obstetric presence and higher rates of use of obstetric technology. Comments from midwives covered a wide range of matters. One of the most common areas concerned caesarean sections, with many midwives citing "Caesarean section on request". Another claimed:

LSCS carried out quicker on professional groups more likely to sue (impression only).

The view that a patient's socio-economic status can affect the way she is treated was asserted very strongly by one midwife:

I do think that if the woman is in the legal profession, or her partner is, it can sometimes affect the way she receives care. I know of one obstetrician who wishes to see such women personally. He also wrote in the antenatal comments section 'Lawyer!' Another senior doctor later added the comment 'So what?', which infuriated the (first) obstetrician, who blamed midwifery staff.

This belief that 'consumer demand' may sway the decisions of practitioners was a common theme:

I've seen practitioners intervene sooner than they would otherwise, especially if the couple in question are professionals.

More easily swayed by demands from clients - social induction, social C/S.

If women are assertive then they can easily persuade staff to do extra tests.
It is ironic that at a time when some consumer groups are advocating a less interventionist model for maternity care, one perceived effect of the Patient's Charter has been to empower women to demand more tests and procedures.

Several midwives commented more generally about the way they feel defensive practice is spreading:

- The fear of litigation can cause defensive practice - I think this is fairly obvious when we see the present caesarean section rate. Medical colleagues have a fine line to tread in today's climate, but it is sad that some Labour Ward policies restrict midwives from practising as they would like, and prevent mothers the opportunity of 'carefree' deliveries.

- I was involved in litigation; thankfully the case was dropped. It caused me considerable grief, and following this I turned out to be 'defensive' in my practice. My consultant gave me counselling and great support, and I have now reverted back to less defensive means; nonetheless, more wary regarding the situation...

- Doctors and midwives becoming over cautious - eg someone complains of a headache - admitted, bloods taken.

Of course what one practitioner views as good safe practice may be viewed by another as defensive, a point which illustrates just how hard it is to measure whether defensive practice really is on the increase:

- As an independent midwife I have been accused of "practising defensively" by colleagues! This takes the form of making sure I have checked everything thoroughly and that the woman knows about her body and pregnancy, and will inform me if she thinks a problem is arising. All this is documented.

It is not just with obstetricians that this is deemed to be a problem. As the following comments show, defensive practice is encountered by those working in the neonatal area:

- Very often investigations are carried out on a neonate all at one time instead of realistically going through them in the order of most likely given the clinical signs / symptoms. There is a tendency to do all that is mentioned in a textbook.

- More blood tests on babies.

- Routine blood sugar estimations on neonate's weight alone.

Many Community midwives commented on the perceived expansion of defensive practice among their GP colleagues:

- GPs book more patients for consultant unit.

- GPs persuading women to have hospital deliveries.
GPs reluctant to undertake maternity deliveries they would have been happy to cope with say ten years ago.

GPs transfer in to consultant unit.

One midwife commented that the increase in 'defensiveness' took some of the enjoyment out of midwifery. Another, who had been personally involved in a legal case said it had made her rethink her career, and that as soon as she could afford it she would leave midwifery.

Defensive clinical practice is difficult to define, and even harder to quantify; nevertheless it appears to be a concern for a large number of practitioners, particularly in the current climate where a reduction in routine use of technology is being called for by some consumer groups and clinicians. It will be a concern for health managers too, considering the potential increased cost of possibly unnecessary tests and hospital admissions. Although difficult to measure, this is one area which requires further investigation. An extreme aspect of defensiveness is now discussed.

An exodus of clinicians?
It has been claimed that the fear of litigation is threatening recruitment to obstetrics, and may even be encouraging practitioners to leave the specialty or retire early from it (Pinker 1991; Saunders 1992). Respondents were asked whether they had known anyone to do this. 37 doctors (18%) said they knew of someone else who had either left obstetrics or retired early because of litigation. This may seem rather a high figure, but in fact 25 of these 37 came from just seven different units, and eight respondents came from just two English hospitals, and so it is possible that several respondents were thinking of the same person. Of course with job mobility amongst the junior grades (twelve answered that they knew someone who had left) it cannot be assumed that the practitioner who left was based at the respondent's current unit. Nevertheless, there may be some fallout from knowing of a colleague who has left obstetrics because of the fear of litigation; it may be that this promotes discouragement or at least a lack of enthusiasm about the job.

A more accurate measure of disenchantment was asking whether the respondents knew of anyone who had considered leaving (as opposed to actually leaving) because of the fear of litigation. Eleven doctors said they had done so themselves, and a further 57 knew of a colleague who had done so. Six of the eleven who said they had considered it themselves had answered that they had known someone else actually to
leave obstetrics, and three of the six said they also knew of a colleague who'd considered leaving.

Those who had considered leaving worked in slightly larger units than those who said they had neither considered this themselves, nor knew of anyone else to consider this, but this was not statistically significant (3554 compared with 3002 deliveries p.a.; p>.1). While it is tempting to speculate on the reasons for practitioners to consider leaving, it would be wrong to do this without more information. Nevertheless it is worth noting that almost a third of respondents had either considered leaving themselves (5%), or knew of a colleague who had done so (27%); this corresponds closely to the answers given by midwives when asked the same question (respectively 5% and 22%). Levels of disenchantment in perinatal care because of litigation appear to be fairly high.

91 (5%) of the midwives had considered leaving clinical practice; length of experience did not appear to be a significant factor, with midwives from all the length of experience categories included; this was also the case with size of unit and clinical work place.

<p>| Tables 9.9 a-c: Midwives who considered leaving midwifery because of litigation or the fear of litigation |</p>
<table>
<thead>
<tr>
<th>Size of unit</th>
<th>n=</th>
<th>Length of experience</th>
<th>n=</th>
<th>Area of work</th>
<th>n=</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 100</td>
<td>3</td>
<td>Less than 3</td>
<td>9</td>
<td>A/N, P/N, Clinics</td>
<td>11</td>
</tr>
<tr>
<td>100-999</td>
<td>8</td>
<td>3 - 6</td>
<td>23</td>
<td>Community</td>
<td>16</td>
</tr>
<tr>
<td>1000-1999</td>
<td>10</td>
<td>6 - 9</td>
<td>15</td>
<td>Labour Ward</td>
<td>25</td>
</tr>
<tr>
<td>2000-2999</td>
<td>17</td>
<td>9 - 12</td>
<td>12</td>
<td>Neonatal</td>
<td>8</td>
</tr>
<tr>
<td>3000-3999</td>
<td>12</td>
<td>12 - 15</td>
<td>6</td>
<td>Team / Rotational</td>
<td>31</td>
</tr>
<tr>
<td>4000-4999</td>
<td>12</td>
<td>15 - 20</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5000 or more</td>
<td>14</td>
<td>20 or more</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unspecified</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

With numbers as small as these, percentages are less revealing and little can be drawn from these figures since it is not known what were the circumstances of the respondents concerned when they considered leaving. For the eight who said it was the sole reason, three were qualified between 3 and 6 years, the rest all over 20 years; three gave 'Team / Rotational' as their area of work, two said Labour Ward, and one each said Community, Neonatal, and Wards / Clinics. As all of these respondents gave a place of work, it is presumed that none of them had actually given up work; it may be seen from some of the comments already made that several had considered leaving but were in fact still practising.
With such small numbers few conclusions can be drawn. A greater number (387 - 22%) knew someone else who had considered leaving (a proportion of these had also considered leaving themselves). Perhaps surprisingly there was little association with the length of experience of those who claimed this, although some increase was evident in the proportion of those working for 15-20 years (29%). Again, only a small minority (12%) claimed that litigation was the sole reason, and without contacting these respondents again it is difficult to know the circumstances underlying the reasons for thinking about leaving. A few comments were added to this question:

- Having worked with neonates for a long time (18 years) I would never return to midwifery for fear of litigation.
- Decided not to become an independent midwife. Not so much the fear of litigation, but because they cannot get indemnity insurance at a reasonable price, which in this litigious climate has made them cease to practice.

Two who said 'No' to considering leaving added:

- But general morale very low as job satisfaction has disappeared and autonomy fast disappearing.
- Many midwives are unhappy, and I am glad not to be starting my career now.

It is difficult to know what effect litigation might have either on recruitment or the rate of leaving a particular specialty, since most such decisions are likely to be taken on the basis of several factors. The RCOG feels it may be a problem for obstetricians, but midwives, shielded to a degree from litigation by the vicarious responsibility of the consultant, have been less affected. There is no evidence from this research of an exodus of clinicians, although a considerable proportion of both midwives and obstetricians claimed to be aware of a colleague contemplating this.

Interprofessional relationships

The former Chief Medical Officer, Sir Donald Acheson, claimed in a speech to midwives that obstetricians were telling him that litigation and the fear of litigation were starting to 'poison interprofessional relationships in the delivery room' (Acheson 1991). Respondents were asked whether they agreed with this claim.

Responses were mixed, with an almost even number agreeing and disagreeing. Figure 9.8 shows the responses of both doctors and midwives.
Do you agree with the view that litigation and the fear of litigation is starting to poison interprofessional relationships in the delivery room?

<table>
<thead>
<tr>
<th></th>
<th>Doctors</th>
<th>Midwives</th>
</tr>
</thead>
<tbody>
<tr>
<td>40</td>
<td>30</td>
<td>25</td>
</tr>
<tr>
<td>35</td>
<td>30</td>
<td>25</td>
</tr>
<tr>
<td>30</td>
<td>25</td>
<td>20</td>
</tr>
<tr>
<td>25</td>
<td>20</td>
<td>15</td>
</tr>
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<td>10</td>
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<tr>
<td>5</td>
<td>5</td>
<td>0</td>
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</tbody>
</table>

Str. agree | Agree | NAND | Disagree | Str. disagree
---|---|---|---|---

One consultant added:

Disagree on a personal basis, but some midwives have problems with some consultants, and vice versa!

Among midwives the balance is certainly towards agreeing with this statement: 37% compared with 23% disagreeing. By grade, Lecturers and Managers were least likely to agree; most likely were E and F grades (both 40%). More experienced midwives were less inclined to agree, with the 15-20 years group's answers showing a statistical significance when compared with those of the less than three years group (p<.05), and the 3-6 years and 6-9 years groups (p<.01).

There was no association when analysing this by size of unit, with those in the smallest units as likely to agree as those in the larger units. Perhaps more surprisingly there was almost no difference in the proportion of those agreeing / strongly agreeing when subdivided by place of work. Those who worked in the Labour Ward were barely more likely to agree than those working elsewhere (39% compared with 37% average), and were in fact slightly more likely to disagree with the statement (26% compared with 23% average).

There was some difference of opinion between those working in the Labour Ward, however, but there was no consistent trend in this:
Although the numbers strongly agreeing with this were relatively small, there was a statistical significance noted in the Scottish-English matched pairs, with 16 of the Scottish group strongly agreeing, compared to 5 of the English group (p<.05). However when Agree and Strongly agree are merged, this difference disappears. The eighty midwives who had been personally involved in litigation were no more likely than those who had not been involved to agree or strongly agree with Acheson; personal experience, it seems, does not colour such views. Fewer comments were added to this question; some stated that 'poison' was too strong a word to use; another who agreed strongly added ‘++’ to indicate the strength of agreement she felt.

Very slightly more midwives agreed with this statement than obstetricians; nevertheless over a third of each group did so, which does not suggest that work relationships are particularly healthy. It was striking to note that junior and middle grade doctors were more likely to be of this opinion than their senior colleagues; this reflected the midwifery responses, which found that the E and F grade midwives were more likely to agree than their senior colleagues. It might be thought that these staff, who work most often in the actual delivery room, are best placed to comment on such workplace relationships. If this is the case, then such tensions clearly must be addressed.
Summary

These respondents were strongly of the view that litigation has increased; while the incidence in the early 1990s was much higher than it had been ten years earlier, the level of litigation has apparently fallen since 1990. None of the respondents argued that this might be so. Attitudes towards this and towards the question of defensive clinical practice did not appear to be coloured by personal experience, which is perhaps surprising. Nevertheless there is a belief among many doctors and midwives that clinical practice is becoming defensive, a belief even expressed by individuals who claim not to be acting in this way themselves.

Few would argue that improved documentation is a bad thing, but other examples of defensiveness are harder to justify; an increase in the rate of caesarean sections and lowered confidence levels leading to a greater inclination to investigate or intervene are worrying features, both clinically because of the increased morbidity of such procedures, and financially. For the patients concerned there is likely to be lowered satisfaction levels when unnecessary investigations lead to non-essential treatments such as forceps or caesarean deliveries. Nevertheless clinicians must work without the benefit of the retrospectoscope.

Fears about an exodus of clinicians appear unfounded based on these findings, but some respondents clearly believe there is a significant degree of tension and even animosity in the delivery room. The potential this has for diminishing effective communication and promoting clinical error based on misunderstandings, is certainly worrying. The labour period attracts a large majority of legal cases; Chapter 10 now examines this period in more detail.
Chapter 10

The Labour Period

The intrapartum period is so clearly identified as the main focus for perinatal litigation, that it is necessary to examine clinical attitudes to its principal features. These characteristics have been noted in the literature review and examined in the discussion of cases in Part III, and were also referred to in Chapter 9 by respondents discussing the question of defensive clinical practice. These features include the supervision of patients and junior staff or students; the monitoring of fetal well-being in labour; the scope for autonomy for the labouring woman (dealt with here under the title 'Insistence'); levels of ability and confidence in interpreting CTGs; attitudes towards cerebral palsy and the Apgar score; and the essential matter of documentation.

Supervision

Supervision has been highlighted as a major feature of certain perinatal legal actions (Ennis and Vincent 1990; Doherty and James 1994), and examples from this research given in Part III. Respondents were asked whether they felt supervision of patients within their unit to be inadequate. Options given were 'Frequently', 'Occasionally', 'Very rarely', and 'Never'.

1664 midwives answered this, with 205 (12%) opting for 'Frequently', 620 (37%) for 'Occasionally', 677 (41%) for 'Very rarely', and 161 (10%) for 'Never'. Analysis of those who answered 'Frequently' showed some interesting fluctuations - this option was chosen more by those who were less experienced:
Figure 10.1

Supervision of patients / clients is frequently inadequate
(midwives; analysed by length of experience)

By size of unit there was an uneven positive association:

Figure 10.2

Supervision of patients / clients is frequently inadequate
(midwives' answers; analysed by size of unit)

Most notable, however, was analysis by clinical grade: in this, the negative association between a higher grade and likelihood of answering 'Frequently' to this question is marked, although the proportion of respondents answering this was relatively small.
Supervision of patients / clients is frequently inadequate
(midwives' answers; analysed by grade)

This indicates that the actual job done, rather than length of experience alone, may affect perceptions. In most units the bulk of direct patient care will be carried out by E and F grades (in Scotland at least), grades G and above having more of a supervisory role, perhaps being in charge of a ward or unit for that workshift. It might be thought that those in lower grades (E and F) may be more sensitive to patients' perceptions of supervision, since they are more often in direct communication with patients.

Those who answered 'Never' to this question were much more likely to be from the smaller units:

Supervision of patients / clients in our unit is never inadequate
(midwives' answers; analysed by size of unit)

Very few of the doctors (11 and 15 respectively; none from England) opted for Frequently or Never, with the vast majority choosing Occasionally (40%) and Very Rarely (47%). GPs were most likely to say Never, which perhaps reflects the nature of perinatal care in GP-run maternity units.
Of the eleven doctors who claimed supervision is frequently inadequate, all were from Scottish units, and eight came from just three separate units. One of these units had an annual delivery rate of 3,500, and the others delivery rates of 5,000.

A much higher proportion of midwives (12%, compared with 5% in the obstetric survey; p<.01) claimed that supervision of patients is frequently inadequate within their unit. As stated, these were more likely to be E and F grade midwives, qualified for less than twelve years, and working in larger units (3,000+ deliveries p.a.).

Respondents were then asked the same question with regard to supervision of junior staff within their own unit. Among midwives there appeared to be a sense that inadequate supervision was more of a problem for junior staff than for patients.

Figure 10.5

Supervision is inadequate: of patients and of junior staff
(midwives' responses)

<table>
<thead>
<tr>
<th></th>
<th>Patients</th>
<th>Junior staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>%age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequently</td>
<td>45%</td>
<td>40%</td>
</tr>
<tr>
<td>Occasionally</td>
<td>35%</td>
<td>30%</td>
</tr>
<tr>
<td>Very rarely</td>
<td>25%</td>
<td>20%</td>
</tr>
<tr>
<td>Never</td>
<td>15%</td>
<td>10%</td>
</tr>
</tbody>
</table>

Once again the 'Frequently' option was more likely to be chosen by those on lower grades (E grades compared with F, G and H grades: p<.05), and less likely to be chosen by those in smaller units.

One respondent divided her answer to this question by distinguishing between junior medical and junior midwifery staff. Others commented on examples of inadequate supervision:

Not enough extra staff to supervise. We had to deliver with Auxiliary helping. Very dangerous.

In the obstetricians' survey SHOs were far more likely than consultants (27% compared with 5%; p<.05) to say that such supervision is frequently inadequate.
Calculation by Anova showed no difference in unit size between those who answered Frequently and those who did not. More doctors as well as midwives cited Frequently or Occasionally for inadequate supervision of junior staff than for inadequate supervision of patients, but this was not statistically significant.

This led onto the claim made by Beech (1984) that women are often left completely alone for long periods during labour. One postnatal ward sister appeared to back up this claim, stating:

Going by postnatal debriefing, patients state they felt abandoned.

Reactions to this claim were heavily weighted towards disagreement, although 6 of the doctors (3%) and 75 (4.5%) of the midwives answered 'Frequently', and 13% and 19% respectively answered 'Occasionally'. Those who answered 'Frequently' came from units of varying sizes, although the numbers are comparatively small.

There may be a discrepancy between what a patient considers to be inadequate supervision and what a staff member would agree is inadequate. Patients' expectations (as noted earlier in Chapter 9) are thought to be high; it may be that patients are insufficiently aware of likely staff-patient ratios in the Labour room, especially in the larger units. If this is so, then more realistic antenatal preparation and explanation may be in order.

Consultant grade staff were asked whether they felt that in general they could rely on their junior colleagues to deal with potential or actual problems in the Labour Ward, and grades below consultant were asked whether they felt that in general they could rely on their consultant to provide adequate support in order to deal with such circumstances. Responses are shown here.
While most practitioners opted for the Usually / Sometimes answers, there was a striking difference in the numbers answering Always: only one consultant out of 91, compared with 27 junior grades out of 107. This difference was highly significant (p<.00001). Why the consultants should apparently be much less disposed to trust their junior colleagues in this situation than vice versa is not clear; it does beg the question about having a consultant presence on the Labour Ward at all times in order to deal with problems.

Respondents were asked whether they thought this to be a good idea. Half the consultants (and over half the Staff Grades) did so; the other junior grades were less keen. Perhaps surprisingly 73% of the SHOs said they did not think this a good idea.

Many units appear now to be developing policies and protocols in order to standardise care and help prevent clinical errors. The possibility that such policies can help to minimise the risk of mistakes or actual negligence was put to the doctors. A large majority (86%) agreed that they could, with the consultants slightly more likely to agree than their junior colleagues. At one time it might have been thought that such protocols and policies would be resisted because they disallowed individual autonomous practice; the reality now appears to be that they are felt to be a major safeguard against allegations of substandard care or negligence.
Ensuring adequate supervision may be problematic for health managers, particularly in the larger units. Without such adequate levels, however, the possibilities for error and sub-standard care are clearly much greater. Allegations about insufficient surveillance or monitoring have been so prominent in legal actions that this aspect of litigation, while tricky for budget-constrained managers, is one which must be addressed. Quite apart from allegations by patients, there is a significant perception by staff that supervision levels are inadequate at times. The provision within unit protocols for calling in a more senior member of staff in the presence of certain conditions may help to clarify the onus of responsibility which lies with individual clinicians (particularly the junior ones) to ensure that they receive adequate supervision.

Monitoring of fetal well being in labour
This aspect of perinatal care is of critical medico-legal importance, and has been debated at great length. There is a large literature on the subjects of CTG monitoring - also known as Electronic Fetal Monitoring (EFM) - and fetal blood sampling (FBS), particularly the former. Its place in current practice has been debated, not least because of the legal implications (Capstick and Edwards 1990); an escalating caesarean section rate has been claimed by some to be due in part to an increase in CTG use (Francome 1986: 101); levels of ability to interpret results are said to fluctuate (Ennis and Vincent 1990); and outcome measures appear to fail to make the case for routine monitoring, even in high risk patients (Haverkamp et al 1976; Luthy et al 1987), or with regard to the incidence of cerebral palsy (Grant et al 1989). More recently others have called for mandatory use of continuous EFM in the presence of certain factors (Gaffney et al 1994).

While over half of both the midwifery and obstetric respondents claimed the level of CTG use within their unit to be 'About right', 42% and 37% respectively answered that it is overused. The Scottish doctors were more likely to say this than their English counterparts (40% compared with 29%), as were the Scottish midwives in the midwifery matched pairs trial - 81 compared with 47 in England, which was highly significant (p<.0001). Without knowing how prevalent the rates are in different units in Scotland and England such answers are of course particularly subjective: it may be that CTG use is far more common or routine in Scotland.

There have been suggestions that CTG monitoring without fetal blood sampling (FBS) is worthless, because the heart rate is only one indicator of fetal well-being / compromise, and in any situation where distress is suspected, a blood sample may
help either to confirm or refute that diagnosis (van den Berg et al. 1987). This is not a universal view, however: it can be pointed out that the sample comes from what may be a bruised part of the scalp, and so may not be representative; neither can it conclude that distress/acidosi will not occur soon after the sample is taken. This procedure is less common than CTG monitoring - indeed many smaller units do not carry out this procedure at all.

Respondents were asked about FBS within their unit. Very few of the doctors (8%) thought it overused, but a third thought it underused. This compared with 15% and 13% respectively among midwives, although interesting to note was a much higher rate of answering 'Overused' in the Scottish sub-sample (25 compared with 8: p<.01).

At first glance this reflects the response to the previous question, but with FBS comparatively rare compared to CTG use, this difference is harder to explain.

With moves now to perform routine cord blood gas analysis after delivery in an attempt to provide retrospective evidence of fetal well being, it may be that the desire to carry out FBS will be lessened. There will still be the need to carry out this procedure in certain cases, and courts may still look to the timing and the results of such tests in determining questions of causation, particularly in cases where brain damage has occurred.

Respondents were asked whether in general it is desirable for a woman to be continuously monitored in labour. While MacDonald et al (1985) point out that there is no consensus of opinion about this when the baby is deemed to be at risk, Murphy et al (1990) note that continuous CTG use has somehow become integral to obstetric practice. In broad terms the argument lies between the desire to have a constant indicator of fetal well-being, and a desire to allow mobility and so encourage the normal process of labour. The question was deliberately phrased in such a broad way to allow for comments to be made, and several were.

Few respondents agreed that it is desirable to have continuous monitoring: 16% of the doctors compared with 79% saying it is not desirable (4% answered Don't Know). There was little difference between the grades, except that all the GPs said it is not desirable. Even fewer midwives favoured continuous monitoring (just 5%, a highly significant difference compared with the doctors: p<1.7).

Many comments were added to this question:
Table 10.1 Most common comments by midwives about CTG use

<table>
<thead>
<tr>
<th>Comment</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Used more than necessary</td>
<td>106</td>
</tr>
<tr>
<td>Only needed if high risk</td>
<td>75</td>
</tr>
<tr>
<td>Intermittent is enough</td>
<td>31</td>
</tr>
<tr>
<td>Overuse de-skills</td>
<td>26</td>
</tr>
<tr>
<td>Causes intervention</td>
<td>25</td>
</tr>
<tr>
<td>Restricts mobility</td>
<td>23</td>
</tr>
</tbody>
</table>

There were many more comments, most of which were unclassifiable in this way. Some were obviously in favour of CTGs, or at least found them very useful:

- Some clients feel safer being continually monitored.
- Sometimes it is easier to attach a monitor to a woman rather than stay with her.
- Yes (to continuous monitoring) - only from a purely selfish viewpoint, i.e. convenience!

Others were of a different opinion:

- CTG - overused; good midwifery practice - underused.
- Has not been shown to reduce perinatal mortality rate; it should not be used unless facilities for fetal blood sampling are also available.
- Machines often inaccurate.

Some worried about CTG use making them defensive or over-cautious:

- Always the worry of litigation. Mothers reassured by hearing FH.
- CTGs left to run 'just in case'.
- I feel it is tempting if the woman has to be left for a long time - continuous monitoring is used to keep the midwife happy.

The insistence of use by unit protocol or common practice was a fairly common theme:

- Birth plans are issued and the client wishes to mobilise, but superior in charge insists on monitoring!
- I don't always perform continuous CTGs. If I'm in the midwife-led part of the labour ward I can do my own thing. If I'm looking after 'non midwife-led' women, I feel pressured by the sisters on Labour Ward to perform continuous monitoring.
- Habit! We do admission CTGs, give analgesia - before you know, you can't take it off.
Interpretation of traces was also a common theme:

Midwives who tend to electronically monitor labour have difficulty reading the trace anyway.

Show me the substantial evidence for CTG interpretation or two 'experts' who interpret the same recordings in the same way.

One midwife summed up a dilemma posed by CTGs:

Since the introduction of electronic fetal monitoring the involvement of medical staff in normal labours must have increased by 500% due to the midwife being obliged to report any 'deviations'. The withdrawal of monitors would leave the midwives open to the claim of negligence if the outcome was adverse.

Comments by doctors included the following from a GP:

Not desirable to have a woman continuously monitored in labour. But greater swift access to expertise in an emergency would be a Godsend; also training (organised and funded) to maintain and enhance the basic level of skills we do have.

One SHO claimed that:

CTG is reassuring when satisfactory, and provides hard evidence of fetal condition during labour. It may be important to fall back on should a litigation case arise.

A Consultant countered this view:

No: There is too much monitoring in labour for no proven benefit. It causes a great deal of patient and professional anxiety, largely driven by fear of litigation.

Another SHO highlighted the tension between wanting to allow a normal labour, and also wanting 'hard copy' of the fetal condition in case something unexpectedly goes wrong:

Depends on view of mother and circumstances of labour. In a normally progressing labour with no epidural or other adverse circumstances, continuous monitoring is not necessary. However, the risk of an unrecognised intrapartum event may arise and there is then no objective evidence with which to discuss the case.

This SHO hints that there are occasions ("epidural or other adverse circumstances") when CTG monitoring should always be used; this situation is discussed below with reference to whether staff can insist on such procedures.

Staff views about CTG use differ greatly. While to some the CTG is a reassuring feature, others see it as a threat to non-interventionist practice. Its role in medico-legal matters has already been stressed, and clinical staff have a duty to ensure that
they are competent in its use; perceptions about ability to interpret the CTG trace are discussed below.

Insistence
The notion of a pregnant woman's autonomy has been discussed in the sections on 'Control and choice' in the literature review, and 'Consent and choice' in Chapter 6. These features are considered a critical part of modern health care, yet concern remains that in certain circumstances a patient's expressly stated request or demand may be overridden by staff.

Respondents were asked whether, in a situation where a woman in labour had indicated that she definitely did not want to have electronic fetal monitoring, there were any circumstances in which the respondent would insist upon carrying out this procedure. The reason for asking this question stemmed from a claim made by the solicitors acting on behalf of a pursuer in an action involving alleged negligence (Case 360 [TH]): the patient had requested minimal monitoring, and in fact, due to discomfort and at her request, CTG monitoring had been discontinued. Her solicitors stated in a letter:

"Continuous fetal monitoring when the decision was made to give a syntocinon infusion should have been insisted upon..."

The solicitors appear to be presuming to know the circumstances in which particular forms of monitoring are indicated, and the circumstances in which a woman's stated preferences should be ignored. With a 'retrospectoscope', which gives perfect vision in hindsight, such claims may be made with a feeling of justification. Of course this is not the situation in which practitioners looking after a labouring woman will find themselves. That said, the notions of autonomy and control are - from these responses - not matters which can be said to have been resolved by practitioners as a whole.
If a woman indicated that she did not want to have EFM during her labour, are there any circumstances in which you would insist?

For such a clear majority of midwives to favour this course of action may cause some concern to user groups and patients alike; the much vaunted autonomy of the pregnant woman appears very shaky when viewed against this finding. Concern may also stem from the feeling that a woman's care during her pregnancy or labour could differ significantly depending on which midwife is allocated to look after her.

There were some striking differences when analysing the 'Yes' answers by grade:

Grade of doctors who would insist on EFM under certain circumstances
This seemingly stark association between a midwife's job grade and likelihood of insisting on EFM is not wholly to be explained by her length of experience (Figure 10.11), indicating that while increasing experience may lessen slightly the likelihood, the role actually carried out by the midwife (as indicated by her grade) seems to be more important. The more junior grades may argue that grades H and above are unlikely to spend much time looking after women in labour, and so the question for them may be more theoretical.

For the junior staff to be more likely to say they would insist may reflect a lack of confidence in other methods of assessing fetal well being (such as intermittent auscultation), and perhaps too high a level of confidence in the accuracy and reliability of CTG machines.

Those who said they would insist were asked to state under which circumstances:
Table 10.2 Most commonly cited reasons for insisting on EFM

<table>
<thead>
<tr>
<th></th>
<th>Doctors n=</th>
<th>%</th>
<th>Midwives n=</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meconium staining</td>
<td>36</td>
<td>17%</td>
<td>&quot;Fetal distress&quot;</td>
<td>623</td>
</tr>
<tr>
<td>Any high risk</td>
<td>26</td>
<td>12%</td>
<td>Meconium staining</td>
<td>552</td>
</tr>
<tr>
<td>IUGR</td>
<td>25</td>
<td>12%</td>
<td>APH</td>
<td>192</td>
</tr>
<tr>
<td>&quot;Fetal distress&quot;</td>
<td>23</td>
<td>11%</td>
<td>IUGR</td>
<td>176</td>
</tr>
<tr>
<td>APH / IPH</td>
<td>18</td>
<td>9%</td>
<td>Syntocinon infusion</td>
<td>165</td>
</tr>
<tr>
<td>Previous Caesarean</td>
<td>12</td>
<td>6%</td>
<td>Prematurity</td>
<td>135</td>
</tr>
<tr>
<td>PIH</td>
<td>8</td>
<td>4%</td>
<td>PIH / PET</td>
<td>130</td>
</tr>
<tr>
<td>Syntocinon</td>
<td>8</td>
<td>4%</td>
<td>Poor obstetric history / previous section</td>
<td>108</td>
</tr>
<tr>
<td>Twins</td>
<td>8</td>
<td>4%</td>
<td>Twins</td>
<td>74</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4</td>
<td>2%</td>
<td>Epidural</td>
<td>64</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Induction of labour</td>
<td>49</td>
</tr>
</tbody>
</table>

This indicates that the questions of autonomy and control are unresolved; one obstetric respondent stated that it was not her right to insist upon any such procedure; several midwives pointed out that doing so could be construed as an assault. Clinicians encountering a patient who has defined pregnancy risk factors but who insists on minimal monitoring and intervention face a difficult decision in determining an appropriate level of technological surveillance. The fear of litigation is used as a reason for insisting on such monitoring, but in fact those respondents who had been most involved in litigation were slightly less likely to say they would insist on it. Of course it is not known what were the circumstances of their legal involvement; the question of intrapartum monitoring may not have arisen, but it certainly is an issue which has been raised in many legal actions.

Other fairly common reasons included breech presentation, prolonged labour, and following the administration of analgesia; less common were maternal diabetes, obesity, reduced fetal movements, and post maturity. It was disappointing to read comments like:

All patients within the unit have continuous monitoring.

Hospital policy of continuous monitoring.

Mostly because medical staff would dance up and down if we didn't.

We have criteria set by the obstetricians and dare not deviate from this.

Several pointed out how they would hope to avoid such a situation arising:
I would hope that my relationship with the woman would be such that I would never need to insist. That she would trust my judgement.

I do not believe it is in my power to insist - only to ensure the woman is making an informed choice, and I must support her wishes and plan her care appropriately in the light of her decision.

Such a situation would raise questions not only of autonomy but of accountability, something stressed by several respondents:

- I would advise her in these circumstances, and make sure she knew possible outcome if she still refused, and that I would not be held responsible.
- If she still absolutely refused then this would be documented and full responsibility would be laid on her.
- I would not insist, but I would make her and her husband aware of their accountability for their decisions.

Whether a midwife can abjure responsibility completely in this situation is open to question. Some clearly found it hard to decide what a 'duty of care' might involve; one said while she would not insist, she "would coerce with lots of persuasion if clear evidence of an at risk fetus." The need for a woman to make an informed choice was pointed out by several: if the midwife considers the woman not to be informed, can this be used to override the woman's expressed wishes? One stated:

- I would rarely insist, but very strongly recommend where there is evidence of fetal compromise (not just the risk of). If client was unable to make an informed choice, ie drink or drugged or insane then I might insist... (duty of care to fetus).

One midwife who said she would not insist, added "but the doctor may". In such a case, who would put the monitoring straps on the woman? Clearly if the woman refuses outright, to attempt to use EFM could constitute an assault, and should be unthinkable. There were many who put very forcefully their view that to insist is not the right of the midwife:

- I would never insist, that is not my right.

'Insist' is not a word in my vocabulary.

This is clearly a thorny issue; many midwives appear to feel that they may somehow be deemed to be negligent if they do not carry out EFM in certain circumstances. While good communication and explanation will reduce the likelihood of an antagonistic situation, conflict may still arise when views clash. A midwife's best recourse, having explained fully why she is advocating a particular procedure, but still
meeting refusal, is to document this thoroughly, if possible with witnesses, and then carry out optimum care under those circumstances.

Securing genuine autonomy for the pregnant or labouring woman remains a divisive issue. The desire to allow as natural a labour as possible must be weighed against the knowledge that practitioners are accountable for their actions, and may have to justify their decisions in written statements or even the witness box. In such cases knowing that the baby has developed a degree of brain damage, while undoubtedly tragic for the baby and family concerned, may also have a destructive effect on the clinician(s) involved.

**Interpretation of CTGs**

Given the medico-legal importance of CTGs it seemed pertinent to ask how confident respondents were in their ability to assess fetal distress in an intrapartum CTG. Although 'fetal distress' as a term is now being superseded in an attempt to be more accurate (practitioners are now encouraged to talk of fetal acidosis - as measured by scalp pH - or describe a particular fetal heart rate abnormality), it is still widely used and its broad meaning commonly understood.

Ranjan (1993) points out that a number of legal cases have hinged on the time delay between recognising distress and acting upon it; the ability to recognise distress is an obvious prerequisite to taking action, and it has been claimed that "It is clear that some junior doctors and midwives cannot recognise abnormal CTG traces" (Vincent et al, 1991). Certainly some legal cases have claimed that CTG abnormalities have been ignored or not noticed (Ennis and Vincent, 1990). Doherty and James' dictum that "CTG traces are only as valuable as those who interpret them" (1994: 96) appears both curt and accurate.

A range of possible rates (of probability of being able to assess intrapartum fetal distress accurately) was given, from 50% to 100% in 5% intervals. A few respondents (nine doctors and seven midwives) ticked the 50% box, adding 'Less than' above it; the full range of answers was used, and it was interesting to note that, overall, the confidence of midwives appeared higher than that of the doctors:
Confidence in the ability to interpret traces appears high among midwives, with over half the sample apparently able to assess fetal distress at least 75% of the time. It was interesting to note that claims of an extremely high probability of assessing fetal distress accurately (being able to do so 95-100% of the time) were made by 9.7% of those who gave their work place as the Labour Ward, but by a higher proportion of those in the antenatal/postnatal/clinics area (11.5%) and those in Team or rotation schemes (11.8%). It should be borne in mind that an abnormal fetal heart rate tracing does not necessarily indicate distress (as measured either by FBS or the baby’s condition upon immediate delivery), although in practice the connection seems to be assumed.

One doctor commented that

Over diagnosis of 'distress' is a large problem.

From the midwife's point of view there came this comment:

It can be very frustrating for midwives to inform doctors of a suspected abnormality, to have it ignored before client, and to have to repeatedly call the doctor back. It is also difficult for midwives to overrule, disagree with a doctor’s decision unless they are prepared to take it higher, eg consultant level.

Ennis and Vincent (1990) note that in some of the legal cases which they analysed, midwives had correctly noted a fetal heart rate abnormality, but this was ignored by the doctor. Reflecting the concerns raised by Vincent et al (1991) above, moves towards improving practitioners' understanding of CTG traces have been introduced.
in many areas. Doctors were asked whether they felt there was sufficient training, first of all of junior obstetricians, and then of midwifery staff, in this matter.

Regarding junior obstetric staff, overall answers were fairly evenly split, although there was a large difference between grades in those answering that training is insufficient.

Figure 10.13

The different proportions of Consultants and SHOs answering respectively Sufficient and Insufficient were highly significant (p<.01); clearly there is a gap in perception in this matter, and until steps are taken to improve the confidence of junior staff, there is always the danger that errors in interpretation will occur with perhaps devastating consequences in terms of outcome, and possible legal repercussions.

A higher proportion of obstetricians (65%) felt training of midwives to be insufficient (only 20% said it was sufficient), and this belief was echoed in the midwifery questionnaire. Midwives were asked what level of training in CTG interpretation they had had since qualifying. These were 'open answer' questions, and produced a lower response rate than might have been gained from offering a series of options. In all, 1181 provided answers; the 'While training' section answers were almost all along the lines of 'From qualified staff' and 'In college', but the 'Since qualifying' section produced a wider range of answers. The most common are shown in Table 10.3:
Table 10.3 Most commonly cited levels of training in CTG interpretation since qualifying

<table>
<thead>
<tr>
<th>Training Level</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>In service: with or without lectures</td>
<td>327</td>
</tr>
<tr>
<td>At least one study day</td>
<td>263</td>
</tr>
<tr>
<td>Minimal</td>
<td>226</td>
</tr>
<tr>
<td>None</td>
<td>212</td>
</tr>
<tr>
<td>Self taught</td>
<td>179</td>
</tr>
<tr>
<td>From colleagues</td>
<td>147</td>
</tr>
<tr>
<td>Regular updates</td>
<td>135</td>
</tr>
</tbody>
</table>

Some respondents gave more than one answer, and many other comments were offered. A feeling of inadequacy regarding this aspect of care was obvious from certain comments:

- Attended one day course 8 years ago.
- None - have asked for more.
- Yearly session. Discussion of case studies.
- On the hoof!
- Basic.

It is impossible to know exactly what level of training in-service education offers, as this is likely to vary between different units. Perhaps more worrying is that of those working in the Labour Ward, only 14% said they had regular updates, less than a quarter (24%) had been on a study day, 8% said their level of training had been minimal, and 5% said they had had none at all. This must be a matter for concern, for it is the midwife who will usually first pick up on possible problems, the SHO being the usual first line of reference when requesting medical advice. If a large proportion of both these groups feel that their training has been inadequate (the confidence of many midwives notwithstanding), the impression of a disaster waiting to happen is easily conjured.

Cerebral palsy
Cerebral palsy has been one of the most publicised features in the current debate about litigation, and the discussion in Chapter 5 showed it to be the most common head of claim in perinatal litigation. Awards under this head of claim are at the very top of the league of damages payments in medical negligence, mainly because of the cost of providing for a profoundly handicapped child for his or her entire life.
In such legal cases it is usual for the pursuers to claim that the handicap was caused either by non-recognition by staff of prenatal asphyxia (fetal distress), or that, having recognised it, adequate steps were not then taken to deal with the situation - usually by prompt delivery of the child. This being the usual line of approach from the pursuers, courts have spent much time looking at the question of distress and subsequent asphyxia.

The connection between fetal distress / birth asphyxia dates to the work of Little in the 19th century (Little, 1862; see also Appendix B), but serious doubt has been expressed in recent years about this apparent connection. Hensleigh et al (1986: 978) criticise the fact that "Untested, unproved and invalid theories that emerged in the 1950s stimulated the assembly of much data that are at odds with the notion that the pathways of causation for cerebral palsy and perinatal mortality are identical."

Current research shows birth asphyxia / trauma to be implicated only in a small minority (8 - 10%) of cases where cerebral palsy results, yet many legal actions alleging specific intrapartum causation are brought against obstetricians and midwives. Respondents were asked about the perceived causal relationship between birth asphyxia / trauma and cerebral palsy to see whether practitioners themselves are aware of the current research in this field, the argument being that if practitioners themselves are not aware, it is unrealistic to expect the lay public to appreciate this.
By and large the obstetric respondents appeared to know the relevant figures; midwives were much more likely to overestimate the causative influence of birth asphyxia / trauma. It would appear that midwives need to become more aware of the relevant research in this field, given the immense importance of legal actions concerning cerebral palsy.

While 40% of midwives who answered this question correctly estimated the rate as under 10%, many were clearly unsure (742 - 41% - did not respond to this question), and some gave huge over-estimates. If one aim of the current research into cerebral palsy is to show how it can only be detected and prevented in a small minority of cases, so reducing the number of hopeful (but hugely expensive and time-consuming) legal cases which are brought under this head of claim, then it seems that many midwives need to be educated about the reality of cerebral palsy. This in turn can be passed on to parents, who may otherwise feel that they have a justified and automatic case against practitioners if their child turns out to be handicapped. The need for informed decision making has often been made; disseminating information about this subject could help to resolve misperceptions which otherwise can lead to bruising adversarial legal actions.
The Apgar score

Lawyers have had to look at the subject of asphyxia when dealing with cases involving a handicapped child. The Apgar score has for the last 40 years been the method whereby the condition of the newborn baby has been assessed (see Appendix B). At first glance a fairly objective test, it has been seen in practice to cause considerable disagreement, and its predictive value for severe handicap shown to lack sensitivity (Nelson and Ellenberg 1981; Levene et al 1986; Ruth and Raivio 1988).

Blair (1993: 449) notes "the difficulty of reaching a clinically operational definition of birth asphyxia", but despite this the procedure is still almost universal, and courts may consider the Apgar scores when assessing whether a newborn baby has been asphyxiated (and if so, to what degree).

It was asked whether midwives are consistent when using the Apgar score (this does not relate directly to obstetricians). 1013 out of 1755 (58%) thought so, with 484 (28%) disagreeing, and 256 (15%) unsure. Grade appeared to matter little in this respect, and nor did length of experience. However there was some difference noted when answers were analysed by size of unit, with those in the largest units (more than 5000 deliveries a year) less likely to agree.

The next question asked whether midwives score the same as paediatricians. Far fewer agreed with this: 26%, while 49% disagreed, and 25% were unsure. Quite why there should be such a discrepancy between what midwives and what paediatricians are perceived to give as a score is unclear, although a few comments were made:

No two people score the same.

Paediatricians are often not present to give the 1-minute Apgar score, and yet if called for an emergency they sometimes fill in a 1-minute score!

Depends on the paed.'s experience - junior = lower Apgar scores.

The last quoted midwife indicates that junior paediatricians are believed to give lower scores than their more experienced colleagues. For such a supposedly objective scoring system to be apparently so subjective may cause concern. In 'The standard of case records' section in Chapter 6 it was noted that in one case three staff members gave three different Apgar scores for one baby. It would appear that continuing education is required in order to iron out any differences caused by a lack of understanding of the nature of the test.
Signatures may not be enough

Documentation has been raised as an important issue in legal actions (James 1991; Dingwall 1991), and was discussed in the section on 'Delay in tracing staff' in Chapter 8. One aspect in particular has been known to cause delays in investigating a legal case, and that is whether the author of an entry in the case notes is readily identifiable; one method of trying to ensure that this is so is to require practitioners to print their name. The delay may occur because a critical entry which is signed either illegibly or not at all can lead to difficulty in identifying the staff involved, particularly if there is a long gap between the incident and the date when the complaint or claim is made. In discussing risk management in obstetrics, James (1991) advocates signing all entries in the notes, and printing the author's name for ease of identification.

27% of doctors claimed that they always print their name, with a further 37% claiming to do this sometimes; 35% said they never did. Least likely to print names were the GPs (68% never did so). GPs have been known to claim that, with a much slower turnover of staff in general practice compared with hospitals, identification is not a problem. A similar point was made by one senior consultant:

*Don't need to - in the unit everybody knows the signature. Printing is a good idea though.*

A far greater proportion of the English doctors claimed always to print their name (57% compared with 25% of the Scottish hospital doctors; p<0.01), which was again reflected in the Scottish-English matched pairs trial of midwives. It would appear that English practitioners have taken this lesson on board much more readily than their Scottish counterparts.

Of the midwives 35% said they always printed their name, 25% said they sometimes did so, and 40% said they never did. No particular association between length of experience or size of unit was noted. One midwife who said she always did commented that to do so was now hospital policy. Another who said she didn't added "But current literature now says we should! Must start doing it!" Two comments pointed out perceived difficulties:

*I always sign. Anyone can print anything.*

*Signature Yes, but not print - some things are too impractical.*

Several claimed that there was no need on a personal level, since their handwriting was clear and legible. Another stated that she printed her name at the beginning of a shift, and signed it thereafter when making entries in the notes; an alternative
suggestion has been to print one's name on each separate page which is used, following which further entries can be signed. Whether or not either of these becomes mandatory remains to be seen, but it is clear that a simple measure like this could save a lot of time and expense should there be a need to review case notes at a later date.

Summary

The labour period is the area most closely associated with legal actions. Attitudes towards features identified in litigation, such as supervision and CTG interpretation, are divided. Many respondents felt supervision in their unit to be inadequate, at least on occasion. Those most likely to answer that this was frequently so were the more junior staff, and those working in larger units. For so many junior practitioners to feel that they are poorly supervised is a matter for concern: the lack of confidence implied by such claims does not suggest uniform levels of competence.

This lack of confidence was echoed by junior obstetricians with regard to levels of training in CTG interpretation. While many midwives acknowledged that the standard of training they had received in this art was woefully inadequate, it did not appear to diminish the confidence of many midwives in their perceived ability to interpret CTG traces. This paradox is difficult to explain. Equally problematic is the matter of the labouring woman's autonomy: for a clear majority of midwives to feel able to insist on something the woman has rejected almost certainly relates to the fear of being criticised (and subsequently sued), but this does little to enhance healthy relationships between staff and patient.

Midwives appeared much less likely than their obstetric colleagues to be aware of the statistical relationship of birth asphyxia / trauma to cerebral palsy: further education of staff would seem to be in order here if clinicians are to expect the general public to be aware. If this is done, then there may be a reduction in the number of legal claims made on the basis of a child's handicap. Given that the success rate for pursuers in this area was low (18%), this is one area which might be amenable to educational improvement.
Chapter 11
Complaints, communication and counselling

Chapters 9 and 10 examined many issues to do with staff-patient interaction, and gave the views of clinicians who have been involved in litigation or who otherwise feel affected by it. Chapter 11 now looks at the clinical setting, and discusses how often complaints are initiated, how this affects the staff in their relationships both with patients and with other staff, and what steps are taken to provide some form of counselling for patients who have experienced a poor clinical outcome, or who otherwise feel that the care they have received has been unacceptable.

In the 'Motives for litigation' section in Chapter 8 it was noted that complaints may at times precede legal action, and the prevalence of complaints against staff is explored below. Communication and rapport within the clinical setting have been noted to suffer when things do not go well (Dingwall and Fenn 1991; Doherty and James 1994), and clinicians' attitudes to these are examined. Lastly the existence of counselling procedures for patients are discussed, since this may be one simple and effective way of heading off some complaints which may otherwise present as legal actions.

Complaints
One area which may predispose towards instigating complaints or even litigation is the perception by patients of staff attitudes. Respondents were asked whether a patient had ever complained in such a way, firstly in relation to them personally, and secondly with regard to any of their colleagues. One doctor commented:

"It would be unrealistic to expect there never to be even the slightest disagreement between staff and patients. Fortunately in our unit for me personally this is exceedingly rare."

Although it may seem as if there is a natural progression from initial complaint to more formal action, it is claimed that the majority of complaints are not pursued rigorously; nevertheless, to obviate complacency, we should find out more about them (Lamont 1993).

However, as Whelan (1988: 71) points out, "complaints procedures are effective if they provide incentives to take a proper degree of care." Neuberger points out that very often patients do not want to go through complicated or formal proceedings, but are anxious "to get some form of apology and expression of concern". She goes on to
add that the medical defence organisations "have been fairly negative about expressing apologies on the basis that they could, in fact, consist of being an admission of liability of some kind" (cited in Wall 1991: 53). In one legal case (No. 31 [DGH]) a consultant wrote in some exasperation to a senior hospital official:

I apologised to (the patient) because in a mature and understanding world it is proper to express regret to any patient who considers that she has had a difficult time. That apology is not of negligence, it is of understanding and good manners, and let us hope that type of relationship never be lost in this litigation conscious world.

Clearly practitioners have to tread warily for fear of encouraging the perception that negligence has occurred. Nevertheless complaints must be dealt with sensitively: a reluctance to give a full and frank reply may be seen by some as evidence of a cover up.

41% of doctors admitted that they had been the subject of a complaint at some time, and the senior grades were much more likely to be in this group. Analysis by length of experience showed those who had not had a complaint made against them to have an average of 11.9 years in obstetrics; those with a complaint 15.7 years (p<.01; calculation by Anova).

The English doctors were also more likely to say they had been the subject of a complaint: 62% compared with 41% of the Scottish hospital based staff (p=.069); only 3 (out of 19) GPs had received such a complaint. A large majority of doctors (87%) knew of a colleague who had been the recipient of a complaint; all of the English staff were in this group.

Of the 1767 midwives who answered, 294 (17%) admitted that they had been the subject of such a complaint. More likely to be in this group were those of a higher grade (including nine of the 35 lecturers); there was clearly some association between this and length of experience; and again, those in larger units were more likely to be included.

How these complaints were handled sometimes caused distress:

I was an RCM steward for 12 years. I found that in the last eight years my manager would go immediately into a 'disciplinary' mode with midwives immediately a complaint was made. The midwives felt that they were being unjustly accused by the manager and that the complainants were automatically in the right and that they were automatically at fault.
While a sixth had said they had themselves been the subject of a complaint, a large majority (85%) knew of someone else who had. Perhaps surprisingly, those longest qualified (above 12 years) were less likely to say this than those qualified less than 12 years; size of unit showed no association, except for those in the smallest units, who were much less likely (at 66%) to say they knew of a colleague involved in such a complaint.

It has been noted above that some respondents feel that when a complaint is made, midwifery and administrative managers are all too ready to believe that the very existence of the complaint means that the practitioner is guilty. Comments like "In a court of law you are innocent until proven guilty. With the NHS it's the opposite", and "I feel both midwifery and hospital managers want staff to submit statements about complaints without referring them first to the RCM rep." make this point very forcefully. On the latter claim, practitioners are strongly advised not to write reports quickly or "under duress" (Brown 1990: 52).

One midwifery manager told me that complaints were once rare, but were now coming in 'like confetti'. Such a situation can be taken as indicating that women have lost their trust in the medical and midwifery professions, a claim made by Beech (1986). Did the respondents agree?

Very few doctors (10%) did, but the English-based staff were much more of this view (28% compared with 9%; p<.01). No GPs agreed. The respondent's grade and size of unit did not appear to affect answers. One SHO who disagreed added:

They are just more hesitant in placing their trust and quicker to question.

Very few midwives (131-7%) either agreed or strongly agreed; 377 (21%) were non-committal; 1104 (63%) disagreed, and 151 (9%) strongly disagreed. Those qualified less than nine years were more likely to agree, as were those in the smallest units (less than 100 deliveries a year). One who strongly agreed added '+++ to show her strength of feeling about this. Another who agreed added '20-30%'. One summed up her reasons for feeling that staff almost deserve this diminishing trust:

With the growing hypothetical Patients' rights - these rights often being over staff - then they have no confidence in us, because we are no longer united, we are all back stabbing to appear the nicest professional towards the patients; it's like a popularity competition. The end of the day patients would respect and have more trust in staff who are united and stop blaming each other...
Several divided their answers, ticking 'Agree' for medical staff, but 'Disagree' for midwives. One described the situation in her area:

A minority of women distrust the medical profession, and the general public is unaware largely of the skills of the midwife. Women in this area tend to be fairly conservative and not particularly well informed, and consequently quite willing for professionals to take control.

Such a lack of assertiveness diminishes the scope for the pregnant woman to exercise autonomy.

Did the midwives feel that in the last ten years there has been a "breakdown of trust between providers and patients" (Dingwall 1986: 39)? While only 7% had agreed with the statement that women have lost their trust with the medical and midwifery professions, 19% thought there had been a breakdown of trust. 1202 (68%) answered 'No' to this, with 234 (13%) unsure. By grade most likely to say 'Yes' were the I grades, with 10 out of 22 agreeing. Length of experience showed no direct association, although a small difference was noted between those qualified less than 12 years, and those qualified more, the former group being slightly more likely to say 'Yes' than the latter. Analysis by size of unit showed no strong variation.

There were many comments added to this question; they included:

I think a certain social group may have lost this trust because of pressure from 'strong' unprofessional groups and their misconceptions about midwifery practice. Once these things are explained to patients they understand why certain procedures may have to be carried out.

I feel that clients have good faith and trust in midwives but are not always informed of care available and choices they can make.

Generally there is distrust between midwives and managers.

Not a breakdown, but a weakening, definitely.

I would question if breakdown in trust has occurred in last ten years, but feel that women are more likely to express distrust and choose alternative methods of care, because we are now more open to provide them. They probably always had a distrust, especially following a bad outcome.

One who answered 'No' added "If anything this must be improving!" Although most of the comments attached to this question were from those agreeing, it should be stressed that many more respondents disagreed.

It is difficult to conclude much from these findings; staff are clearly aware of the potential for patients to complain, and while several mentioned a lack of support from
their managers at times like this, few seemed unduly concerned. The existence of trust between patient and clinician is vital to healthy relationships; from staff this requires a willingness to be open and to accept complaints when they do come in, even when the patient's motives or justification appear questionable. A siege mentality concerning dissatisfied patients will do little to create the kind of open dialogue which is essential if such grievances are not to become legal in nature.

Communication and rapport
Communication and rapport between practitioners and patients is essential for good care, particularly when a situation falls short of its ideal. In Chapter 8 the importance of good communication was discussed with reference to certain legal cases. Doherty and James (1994: 93) note that "many claims arise from failures of communication or resentment...failure to treat patients with courtesy and respect may fuel resentment," while in their study Dingwall and Fenn (1991: 104) maintain that when claims were received, some staff "seem to have been concerned to do the minimum necessary to respond to the grievance".

Respondents were asked how they would rate communication and rapport in their unit first of all generally, and secondly when something has gone wrong (Tables 11.1 and 11.2).

Table 11.1 Doctors: How would you rate communication and rapport between patient and practitioner in your unit:

<table>
<thead>
<tr>
<th></th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Terrible</th>
</tr>
</thead>
<tbody>
<tr>
<td>• generally</td>
<td>46</td>
<td>143</td>
<td>21</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>22%</td>
<td>68%</td>
<td>10%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>• when something has gone wrong</td>
<td>33</td>
<td>133</td>
<td>37</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>16%</td>
<td>64%</td>
<td>18%</td>
<td>3%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Table 11.2 Midwives: How would you rate communication and rapport between patient and practitioner in your unit:

<table>
<thead>
<tr>
<th></th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Terrible</th>
</tr>
</thead>
<tbody>
<tr>
<td>• generally</td>
<td>551</td>
<td>1024</td>
<td>164</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>31%</td>
<td>58%</td>
<td>9%</td>
<td>0.4%</td>
<td>0.06%</td>
</tr>
<tr>
<td>• when something has gone wrong</td>
<td>327</td>
<td>869</td>
<td>438</td>
<td>83</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>19%</td>
<td>50%</td>
<td>25%</td>
<td>5%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
There is a slight 'downward' shift in relationships with patients when things go wrong; midwives tended to be more pessimistic in such circumstances. However it is precisely when things go wrong that communication and rapport need to be sound and reliable. This, it is claimed, may lessen the incidence of litigation (Dingwall, 1991). At the very least it should serve as part of good care; the setting up of Birth Afterthoughts (Charles and Curtis 1994; Smith and Mitchell 1996) has been one practical example of this.

Little variation was noted when analysing the first part by size of unit or length of experience. Things change slightly when something has gone wrong, with clinical grades E, F, G and H a little less likely to characterise communication as 'Good' or 'Very good' than I grades or Managers; however numbers in these last two groups are small, and statistical tests unreliable. Nevertheless it is apparent that there is a downward shift in perceptions when things are not going well, and it is worrying that one in twenty respondents thought communication and rapport to be either 'Poor' or 'Terrible' in such a situation. A number of legal cases refer to situations where the tragedy of a poor outcome has been compounded by a perceived failure on the part of practitioners to counsel patients and explain events (Vincent et al, 1994); examples from this research were seen in Chapter 8.

There were some differences between the responses of the Scottish and English matched pairs, with the English more likely to characterise relationships as generally Very Good (p=.01), and as Good/Very Good when something has gone wrong, although this difference was not quite statistically significant.

Many respondents felt this to be an important area, as the attached comments showed:

I believe poor communication to be a main factor in the rise in litigation. Parents may often just want the truth, what really happened.

Communication is of the utmost importance in our profession. This in general is poor...In my experience most people's anger in the case of negligence is that they cannot get straight answers from the people involved, and indeed often cannot get to speak to them; this in turn makes them feel that there is some sort of 'cover up'.

It seems to me that parents sue a) in an effort to get more information about what happened to them if staff do not honestly answer their questions, or b) if they have a child who is going to need constant care for many years.

Although the ideal would be clear lines of communication, in practice there may be obstacles to this:
In my experience 'breakdowns in communication' have occurred when the husband or partner has become exhausted. Nerves are frayed and they are often less well informed about Labour Room procedures than the women. This is when the midwife is likely to be obstructed from performing her normal duties...it can alter the outcome of a perfectly normal labour.

I find it very difficult to estimate how much patients understand what you are telling them, even if you ask them directly if they understand. Often days or even weeks later if you meet them they begin asking questions which you know you have already explained. I know that pregnancy and delivery and the post natal period are a very emotional time, but it is very upsetting for midwives who have taken time and patience to explain things to patients and partners and then receive a letter of complaint a few months later about staff attitudes.

Even in the antenatal period there are potential problems, it seems. The need to balance giving out information so as to enable informed decision making without inducing fear is a tightrope which those involved in Parentcraft must walk:

The clients themselves are setting unrealistic goals. We ask them to make a birth plan; many go into detail which they have barely researched, and come up with what is their ideal plan. Unfortunately I have never yet seen a labour or delivery that went to plan...I know of one colleague who was censured for telling a Preparation for Parenthood class at a labour talk that they would experience excruciating pain. Is this the right approach? We leave ourselves wide open for criticism.

There is clearly a need for practitioners to be sensitive to the needs of patients, especially when something has gone wrong.

The next question asked about communication and rapport between doctor and midwife in the same circumstances. It will be seen that the doctors consistently had a higher opinion of such staff relationships than did the midwives:

Figure 11.1

How would you rate communication and rapport between doctors and midwives in your unit generally?

<table>
<thead>
<tr>
<th></th>
<th>%age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very good</td>
<td>Doctors</td>
</tr>
<tr>
<td>Good</td>
<td></td>
</tr>
<tr>
<td>Fair</td>
<td></td>
</tr>
<tr>
<td>Poor</td>
<td></td>
</tr>
<tr>
<td>Terrible</td>
<td></td>
</tr>
</tbody>
</table>

257
Figure 11.2

How would you rate communication and rapport between doctors and midwives in your unit when something has gone wrong?

<table>
<thead>
<tr>
<th>%age</th>
<th>Very good</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Terrible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>[Graph]</td>
<td>[Graph]</td>
<td>[Graph]</td>
<td>[Graph]</td>
<td>[Graph]</td>
</tr>
<tr>
<td>Midwives</td>
<td>[Graph]</td>
<td>[Graph]</td>
<td>[Graph]</td>
<td>[Graph]</td>
<td>[Graph]</td>
</tr>
</tbody>
</table>

Why midwives should be of the opinion that staff relationships are so much worse than doctors is not clear. Over half the midwives described such relationships at best as Fair when things go wrong. There were statistically significant differences in the Scottish-English midwifery matched pairs trial, with the English group more likely to answer Very Good/Good both generally (p<.01) and when something has gone wrong (p<.001). There was correspondingly a statistically significant difference in the proportion answering either 'Poor' or 'Terrible' when something had gone wrong (p<.01). These differences were not replicated in the obstetric survey.

Table 11.3 Scottish-English midwives' matched pairs: How would you rate communication and rapport between midwife and doctor in your unit:

<table>
<thead>
<tr>
<th></th>
<th>Very good / Good</th>
<th>Fair</th>
<th>Poor / Terrible</th>
</tr>
</thead>
<tbody>
<tr>
<td>generally</td>
<td>Eng 148</td>
<td>22</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sco 124</td>
<td>41</td>
<td>5</td>
</tr>
<tr>
<td>when something</td>
<td>Eng 104</td>
<td>49</td>
<td>17</td>
</tr>
<tr>
<td>has gone wrong</td>
<td>Sco 69</td>
<td>65</td>
<td>35</td>
</tr>
</tbody>
</table>

This difference in the midwife-doctor relationship appears very stark: one explanation is the theory of a more imposing Scottish medical establishment, referred to here by one midwife who has worked in both England and Scotland:

I think Scotland's medical establishment does not recognise the potential of midwives and therefore we as a profession do not stand up against this due to fear of confrontation...

Experience in this area clearly varies, since a seventh of all respondents cited 'Poor / Terrible' for when things go wrong. The question did not specify obstetricians only.
and one respondent, while mentioning obstetricians, also added this comment about other doctors:

Communication between obstetricians and midwives is generally non-existent when problems arise. Paediatricians are too quick to blame the labour / delivery without really knowing about the details. I personally feel that in our unit they cause more problems because they are very quick to apportion blame to the midwives / obstetricians if a baby is ill or traumatised.

This doesn't sound like a unit where relationships are good; and midwives from several other units made similar comments:

(There is) antagonism between midwives and doctors...leading to a lack of teamwork, witch hunting when things go wrong. We don't work together no matter how hard people say they try.

Doctors dissociate themselves from midwives when something goes wrong.

Medical staff will never back midwives in the event of difficulties. I work constantly in fear of litigation from clients, and also from pressure from medical staff. I feel the attitude in my unit is "Cover your back" at all times.

There were also comments about how poor relationships can cause anguish:

SHOs and registrars can be off putting when asked to see a client, and you are left to reassure client on what is happening, and left watching fetal distress until finally they do a LSCS.

For one respondent problems could occur according to the level of experience of the doctor:

Better rapport between midwives and senior medical staff than with SHOs, especially if new to obstetrics - medical arrogance persisting in "I'm doctor, you nurse" attitude - takes time to overcome this.

Once again there was the expressed feeling that doctors will close ranks in the event of something going wrong:

The medical staff tend to 'close ranks', and give the doctor the support he requires. Not so the midwife. It's as if there is something in-built, that we must find someone to blame, therefore the midwife is somewhat solitary.

Not all comments were completely adverse, however:

We are encouraged by managers to attend weekly meetings with the doctor - audit and perinatal. We discuss complimentary therapy with them - the doctors can be cynical but open to listening. On Labour Ward the doctors are supportive and if you say you don't want / need their involvement they will not enter the room at all.

We meet regularly with our consultant to discuss cases - very supportive - occasionally he can be arrogant / judgemental in his assessment, but he is approachable to challenge and eager that we challenge his ideas.
It is worrying that so many practitioners view these matters so pessimistically, for good staff relationships are essential for effective care. A better appreciation of eachother's role would be one way to overcome some of the misunderstandings and communication failures which seem quite prevalent; to do this a new member of staff (midwife or doctor) would spend a set amount of time 'shadowing' the other, observing what (s)he does, when and how. Other possibilities include semi-formal meetings in which grievances can be aired 'without prejudice' - so that staff are assured that there will be no come-back.

Counselling procedures

'De-briefing' was mentioned in Chapter 8. Moves towards establishing counselling procedures for patients has received some publicity (Charles and Curtis 1994), but it is unclear how prevalent such facilities are. Respondents were asked about formal counselling procedures for patients when there has been an adverse outcome to the pregnancy.

62% of the midwives said there were formal procedures within their unit, indicating fairly widespread implementation; however this could be skewed by answers from the larger units (which did show a higher than average 'Yes' response). Least likely to say 'Yes' were those from the smaller units: 31% from units of up to 100 deliveries, and 46% from units with 100-999 deliveries. This is perhaps surprising, given the image of smaller units being more personal places. Almost two thirds of doctors (63%) claimed their unit has such a facility, with a quarter (and half the GPs) saying it does not. Size of unit had no effect on answers.

However, knowledge of their existence in units where some respondents claimed they do exist was scarcely universal: in only four out of the remaining 28 units could all the obstetric respondents agree that such procedures were available. Even among consultants there was a surprising lack of agreement: in only ten out of 24 units could all the consultants agree that such procedures exist.

The importance of counselling was stressed by several respondents:

I have had a degree of interest in de-briefing patients postnatally, sometimes up to three years later, when the woman is contemplating another pregnancy....(in) most instances anxiety, unhappiness, and sheer terror of her experience has resulted from a doctor usually, but sometimes a midwife, failing to 'communicate', i.e. examined her or carried out a procedure without explanation or even introducing themselves....in several instances the women feel that sheer rudeness has offended them and left them with very bad feelings about their experience.
I have heard it said that the whole story only comes out in court. So hopefully more open and honest discussion with clients would reduce the incidence of litigation if clients feel they have not been given a full explanation.

A debrief session the day following delivery has helped a lot of women to clarify events which happened during their labour.

However not all appeared to feel that there is enough support. One who said there were counselling procedures in her unit added that they were "very poor". Another common complaint was that in many units there are no procedures for counselling staff involved either in legal action or in a clinical case which has had a poor outcome. A rather plaintive appeal from one midwife was "Where is the counselling for staff?" Another commented:

No proper counselling from within Health Service for patients or staff (in obstetrics). Counselling usually available from voluntary organisations. Staff obtain support by discussing problems with each other. Very seldom any support from management.

This expression of a perceived gulf between midwives and managers was a recurring theme:

I do not feel midwives get enough support or counselling from their midwifery managers or charge nurses (sic).

Generally there is distrust between midwives and managers.

This last comment relates back to the discussion above about complaints made about staff, and specifically how managers deal with these:

Management taking too heavy a hand in disciplinary procedures encouraging staff to be defensive and doubt their ability. Encourages poor morale.

The patient is always right, no matter what. Once a complaint is made the damage is done.

However it is not just managers who are criticised: some of the comments above have indicated a lack of team support, and this is echoed by the respondent who claims:

I do feel conscious that if there was personal litigation you would be pretty much on your own on an accountability level.

As autonomous practitioners each individual must be prepared to be accountable for what (s)he does (and does not do) in the course of duty, but there appears to be a perception among some that should an individual be involved in litigation or a complaint then she would receive no support from colleagues at all. It is to be hoped
that this would not be the case, but the statement made by one midwife personally involved in litigation, that "I wanted to form a support group for midwives who had been in that position. I wanted to be there for them, because I felt no one was there for me" indicates that this may not be so.

The format of such procedures will vary from one unit to another; in medico-legal terms the emphasis is on answering questions openly and honestly in an attempt to avoid those legal claims which are made on the basis of a misunderstanding. Anaesthetists have instigated such review procedures for patients, especially those who have had epidural or spinal anaesthesia; given that events during caesarean section are frequently the subject of complaints and claims, such procedures by obstetricians may also be beneficial. Perinatal outcomes analysis, which has been introduced in at least one area which formed part of this survey, aims to identify all poor outcomes, and initiate a full examination to establish whether the outcome was preventable and if so, which staff may be involved in subsequent investigations. This management of potential claims endeavours to shorten and simplify the huge task of investigating events which occurred perhaps several years ago, it not being uncommon for claims to take several years to come to light. With all the staff involved clearly identified, and with these staff all making full records of what happened, when and why, the decision whether or not to defend a claim can be made much more easily. In theory this will reduce legal costs, lessen the stresses of retrospective investigation on staff, and ensure quicker compensation for those patients who have a genuine case.
Summary

Complaints made against respondents varied: 41% of the doctors, but only 17% of the midwives admitted that they had been the subject of a complaint. As the discussion in Chapter 8 noted, there is no way of knowing which complaints might be taken further and made more formally legal, but it seems clear that an insensitively handled complaint is more likely to end up this way.

Communication and rapport between patient and practitioner were generally held to be good, but there was a distinct downward shift in perceptions when things go wrong, especially among midwives. Paradoxically this is when such features must be at their best. The midwives also tended to be more pessimistic about the doctor-midwife relationship, particularly when things have gone wrong, and this was especially so among the Scottish midwives. Such perceptions are difficult to quantify, but for so many practitioners to characterise their work relationships in such a poor light indicates that there is a great deal of room for improvement. If clinicians cannot relate effectively with one another, the prospects for good care and for effective communication with patients is questionable. The lack of consistency in answers concerning counselling procedures for patients also indicates that a good deal of room exists for such innovations within maternity units; quite apart from being an effective way of empowering patients, they constitute a potential bulwark against legal complaints which are made on the basis of a misunderstanding.
Part IV Conclusion

This research targeted obstetricians and midwives in all the areas for which an analysis of legal files took place. All those believed to be practising obstetrics in Scotland and in two identified English areas were approached, and with a 63% return rate reasonable reliability about obstetricians' attitudes in these areas can be assumed, for the Scottish-based obstetricians at least; the English sub-sample is small and the views of these respondents may not be typical. The survey similarly targeted all full RCM members in Scotland, and used RCM membership to target midwives in one of the two identified English areas (for the other English area the hospital management supplied a [coded] list of midwives). Again, reasonable reliability can be assumed for the Scottish respondents, but the English-based sub-sample was much smaller, and so these responses should be treated with more caution. The midwifery matched pairs trial allowed for Scottish and English responses to be compared directly, and there is no particular reason to feel that the English-based midwives were not typical of English midwives generally. The English obstetric sub-sample was too small to allow for a matched pairs trial in the obstetric survey.

The survey found that a large majority of both doctors and midwives believe litigation in obstetrics / midwifery has increased over the last ten years. In large part this is put down to an increase in expectations and awareness on the part of the public generally, and of patients specifically. Whereas few midwives had been personally involved in legal actions relating to alleged negligence, almost half the obstetricians had been involved at least once or twice, and 13% had been involved at least three times. While it was clear that litigation is seen by most as a threat, there were a few who felt it to have positive aspects too. The view was expressed that having to deal with the possibility of litigation meant that midwives had started to develop support systems to cope with the stresses and responsibilities of their role, and that the way information is given to patients is now much more sensitive (and hopefully effective).

A third of those doctors who thought litigation had not increased, or who were unsure, had themselves been involved once or twice, and almost half of those who thought litigation had increased had not themselves been personally involved, so perceptions about this issue cannot be put down to personal experience alone.

All of the English doctors agreed that litigation has increased, and they were much more likely to discuss both personal involvement and the possibility of being sued
than their Scottish counterparts. 65% of the English doctors had been involved in litigation compared to 52% of the Scottish hospital doctors (and only 11% of the GPs). The English hospitals had a higher than average (for this research) rate of litigation when the incidence was at its height (1988-91; see Chapter 4), and this may be reflected in these obstetricians' responses.

For obstetricians increasing length of experience was positively associated with legal involvement; initially this appears to suggest that an obstetrician will become involved if only he/she is clinically involved for long enough. However, analysis of the consultants' responses (they were the group most often involved in legal actions) showed this not to be the case: those consultants who had never been involved, or who had been involved only once or twice, had practised for just as long as those who were involved more often. They also worked in units of comparable size, and undertook almost as many deliveries.

Despite such a large majority believing litigation to have increased, less than half the doctors said they had changed their clinical practice as a result of the fear of litigation. The English doctors generally were much more likely to say they had changed practice in some way (76% compared with 42% of Scottish hospital doctors). It does seem that litigation awareness (as measured by discussing legal matters and altering practice to try and avoid legal entanglement) is much higher in England, from this survey at least.

For doctors the most commonly cited example both of altering personal practice, and of a belief in obstetric practice generally becoming defensive, was an increase in the number of caesarean sections. This reflects the very natural fear of being accused of not proceeding quickly enough (or at all) to caesarean in the presence of either fetal acidosis or a recognised and serious fetal heart rate abnormality when the end result is a brain damaged child. Measures to reduce the caesarean section rate have been instigated, but these will have to fight against the public's apparent assumption of an automatic causal connection between intrapartum events and brain damage. Doctors in this survey were on the whole aware of the likelihood of causation between intrapartum events and cerebral palsy; midwives in their survey were much less so, and there is a need to improve this perception amongst midwives if the public's apparent misperception is to be corrected.

The most commonly cited instance of changing personal practice among the midwives was an improvement in documentation; this was cited by 41% of all
respondents. This is a difficult area to quantify: much has been written on the need for thorough and accurate documentation, not least to avoid medico-legal pitfalls (Dornan, 1990; Rosenberger, 1995), but the literature reveals no studies assessing the quality of record keeping. It is one area, however, which may be amenable to audit (Hughes and Goldstone, 1989). Other changes in personal practice were obtaining permission for all procedures, and obtaining medical advice more quickly: while the former example surely constitutes no more than good practice, the latter may cause dismay to those who advocate minimal intervention in maternity care.

A belief that practice generally is becoming defensive was popular among both obstetricians and midwives, the principal examples being more caesareans, more investigations, and quicker interventions. All of these have implications for the delivery of health care, since they impinge on the autonomy of patient and practitioner alike, and constitute a questionable drain on resources.

5% of the doctors said they had considered leaving the speciality because of the fear of litigation, and a further 27% knew of a colleague who had considered this. A similar proportion of midwives (5% and 22% respectively, but with a degree of overlap between the two groups) claimed the same. Eight of the doctors who had considered leaving were consultants, the other three being a registrar, a staff grade, and one SHO.

Some midwives mentioned that they had considered leaving clinical practice, citing the fear of litigation as a significant factor. While it is presumed that all of these (still being full members of the RCM and citing a place of work) have not left, it is not known how many midwives may have already left practice because of a fear of litigation. While this fear may be at a higher level than is warranted by actual occurrence or personal experience, this does not reduce the importance or effect of the fear.

Considering leaving and actually leaving may be miles apart, but the fact that practitioners are even considering this is a matter for concern: disenchanted or frightened clinicians may not be as committed to their work. This feature of legal side effects may be countered to a degree by continuing education: if a clinician's practice can be judged as safe and competent by a body of co-professionals, there is nothing to fear in terms of being found to have acted negligently.

'The media' came in for some criticism both for its perceived tendency to raise expectations among the public and for its lurid and sensationalist reporting of a
handful of probably atypical cases. Certainly the media have a significant role to play in educating pregnant women; the concern is that, in the interests of selling newspapers or obtaining high viewing figures, either the truth will be distorted or isolated instances used to portray rare occurrences as commonplace. The possibility that people may get paid large sums of money for their story also alarms some practitioners, as there may be a temptation to exaggerate in order to make the story more dramatic, a temptation possibly fuelled by the 'lottery culture' which presents the possibility of large payouts by the courts if a negligence action succeeds.

Reactions to the claim that interprofessional relationships in the delivery room are being poisoned by the fear of litigation were mixed. Junior grade doctors, who probably spend more time in the delivery room than most of their senior colleagues, were more likely to agree. On the whole slightly more midwives than doctors agreed with the view as well, and again it was the more junior (E and F grade) midwives, who work most often in direct contact with patients and junior doctors, who were most likely to agree. If these feelings are as widespread as they appear amongst junior clinical staff, then again a teaching programme which educates clinicians about the law as it affects clinical practice would seem to be essential. Deteriorating doctor-midwife relationships in an area as critical as the delivery room is surely a recipe for disaster, with practitioners developing a tendency to point the finger of blame whenever outcomes are less than optimal. Scottish hospital doctors were more likely to agree or strongly agree than their English counterparts (36% compared with 24%).

Inadequate supervision of patients and junior staff has already been described as a feature of perinatal litigation (Ennis and Vincent, 1990), and this research has borne this out (Chapter 6). Very few doctors felt supervision of patients to be frequently inadequate within their unit, although two fifths claimed this occurred occasionally. However, of the eleven doctors who did say it is frequently inadequate, it was very striking that eight came from just three units (with delivery rates of 3,500 - 5,000). Larger units face the probability of poorer continuity of carer, and when supervision breaks down altogether, dissatisfaction rates are likely to be very high.

The midwifery survey found a much higher proportion claiming that supervision of patients is frequently inadequate. Midwives are in theory in a better position to judge whether this may be so, since they are the ones who actually give most of the one-to-one care, whereas doctors are responsible for covering perhaps several wards, including the Labour Ward. One Post Natal ward sister had claimed that 'Patients (in
labour) state that they felt abandoned.' This inevitably leads to lowered satisfaction levels, and should the outcome be suboptimal, may well lead to inferences of substandard care or even negligence. While midwifery staffing levels are the concern of midwifery managers, obstetricians must be aware if the standard of care the patients receive declines because of lowered staff numbers, whether this be due to sickness or other factors. The possible legal fallout from such a situation is, sadly, easy to imagine.

Supervision of junior staff brought some notable differences of opinion: 27% of SHOs said this was frequently inadequate, compared to just 5% of consultants. One does not have to be a statistician to realise that such a discrepancy has implications for the confidence and reliability of many junior obstetricians. If these SHOs feel their supervision to be so inadequate, whether this be the responsibility of the consultant or the registrar, then their standard of work may be questioned. Legal implications, again, are all too easy to imagine.

That the relationship between junior staff and consultants is sometimes less than satisfactory was also shown by the answers to the question about how well staff felt they could rely on one another (consultants to junior staff and vice versa). Only one consultant out of 91 said he could always rely on junior staff to deal with potential or actual problems on the Labour Ward, and 27 out of 107 junior grade staff said they could always rely on their consultant in such a situation. Since the majority of legal cases originate from incidents in the Labour Ward or Theatre areas, this does seem to be an area which ought to be addressed. Given these views it was surprising that the idea of a permanent consultant presence on the Labour Ward was more popular with consultants than with SHOs.

CTG monitoring is another feature of perinatal litigation which has been described in the literature (Ennis and Vincent, 1990), and again the legal files analysed here found this to be a significant factor. Few respondents felt this procedure to be underused (37% said it is overused within their unit). A larger proportion of the Scottish doctors answered this way, mirroring the results of the midwifery survey. Claimed ability to diagnose fetal distress in an intrapartum CTG varied, with midwives rather less modest about their perceived ability than the obstetricians. Given that, in units where this procedure is used, midwives report suspected abnormalities to a doctor, this situation is anomalous.
The level of training in CTG interpretation apparently varies in its effectiveness: 82% of SHOs felt this to be insufficient compared to 36% of consultants. The SHOs are usually the first doctors to be called by a midwife who suspects that an abnormality is present; for so many SHOs to feel obviously unprepared for this responsibility is clearly worrying. Also a matter of concern is the fact that 65% of consultants felt that training of midwives in this skill is insufficient. Results from the midwifery survey showed that of those midwives based on the Labour Ward, only 14% said they had had regular updates, less than a quarter had been on a study day, 8% said their level of training had been minimal, and 5% said they had had none at all. Given the widespread use of the procedure, it would seem imperative that staff are well trained in its interpretation.

A related point about CTG use was under which circumstances (if any) a respondent would insist upon its use despite the clear wishes of the patient that it not be used (this question stemmed from an actual legal case); the question of autonomy for the pregnant woman has been discussed in Chapters 2 and 6. A clear difference in answer depending on grade was noted, with both junior doctors and junior midwives much more likely to say they would insist. It may be that a lack of experience will predispose to this; over reliance on the reliability and validity of CTG machines may be more common among junior staff. However, as one obstetrician (and many midwives) pointed out, insisting on a procedure such as this carries potential dangers, one of which is a possible charge of trespass or even assault. Even if this does not arise, the dissatisfaction engendered may well predispose to complaints being brought against staff. While these are unlikely on their own to initiate legal proceedings, insensitive handling of such complaints has been known to promote further disputes between patients and staff (Case 538 [TH]; see Chapter 8).

While, broadly speaking, attitudes towards communication and rapport between doctors and midwives showed similar overall responses from the two professions, many midwives were far less generous about the nature of their relationships with doctors than the doctors were about their relationships with midwives. Over half the midwives described these as Fair at best when things were deemed to have gone wrong (almost 15% described them as Poor or Terrible), which does not indicate harmony in the workplace.

Communication and rapport between practitioners and patients were generally felt by doctors to be good; even when things go wrong doctors appear to feel that relations do not deteriorate to an unacceptable level. Midwives once again were more
pessimistic in their outlook. If such relationships are poor at a time when empathetic communication and sympathy are essential, then the incidence of complaints and legal claims may be expected to rise. Many midwives pointed out in their survey that the government has given to patients the right (some would say the encouragement) to complain, and undoubtedly many are taking advantage of the procedures which are publicised in the Patients' Charter.

Claims management aims to ensure that complaints are dealt with in such a way as to deflect frivolous claims while acknowledging the nature of genuine complaints, and offering apology and, where necessary (and after due legal advice), compensation.

The actual incidence of complaints appears fairly high: 41% of doctors said they had been the subject of a complaint. This was much higher than the 17% of midwives who admitted that they had been the subject of one. While it is unclear what the relationship is between initial complaint and possible legal action, examples of litigation following on from a complaint have been discussed in Chapter 8. It would be foolish to dismiss the apparent rising tide of complaints as being no more than a fashion induced by the Patients' Charter.

The presence of formal review / counselling procedures for patients who have had an adverse outcome to their pregnancy or labour appears to be fairly widespread: in only three (all GP units) of the 31 units surveyed, did no respondent claim that such procedures existed. However, staff from the same unit were often not of the same opinion regarding the existence of such procedures.

Given the importance being attached to risk management strategies, a similar investment in claims management would seem in order. This could effect a large reduction in the number of actively pursued complaints and claims which come in and which are the result of dissatisfaction or disappointment at a less than optimal outcome rather than a genuine belief that negligence has occurred. Such claims must still be investigated, and if the initial complaint is not made for months or even years (as is commonplace) the complicated process of enquiry can take a long time, inducing much stress and anxiety among the staff concerned. Formal review procedures available soon after the event ought, in theory, to head off those claims which are made on the basis of a misunderstanding, and ought to pre-empt the tortuous retrospective enquiry process which is so often required at present.

Some of those midwives who had experienced litigation had harrowing tales to tell; frequently there was a perception that managers were not supportive, and that they
felt isolated even from their colleagues. The antagonisms which arise in such situations can be addressed at least in part by sensitive case management: one area at least has instigated a perinatal outcomes analysis project which aims to clarify the issues involved in such situations, identifying the relevant staff and getting them to document clearly their involvement in the events which have led to a poor outcome. Until such developments become widespread, there will always be the possibility that staff will become isolated when complaints come in, particularly when the complaint is in the form of a formal legal action, as frequently happens.

Several respondents mentioned their concern at the apparent lack of protection of the rights of the unborn child when attempting to allow the woman autonomy and decision making. The fear that the woman's decisions may not be adequately informed, and that she may in consequence contribute to a poor outcome, is evident from the fact that almost two thirds of respondents said they would monitor a woman in labour using electronic equipment even when she had specifically refused this. Such a dilemma cannot be easily resolved; continuing education, both of midwives and the women under their care, will help to reduce such instances occurring, but it would be naive to think that resolution will be speedy or without acrimony.
Part V

The implications for risk management
This thesis began by noting that there has been a perception that medical negligence litigation, and especially perinatal litigation, has increased sharply over recent years. The evidence for the latter assertion in Scotland and two English areas has been considered by analysing several hundred legal files, and the nature of such litigation discussed at some length. There has also been a concern that litigation may have several side-effects on the delivery of health care, either through an exodus of clinicians or a spiralling of tests and procedures which divert money away from essential patient care. Large scale surveys of obstetricians and midwives allowed these claims to be assessed.

It became apparent that nothing existed in the literature which adequately described the complex nature of litigation in this (or any other) area of medicine. Access to legal files has traditionally been restricted, and indeed it was a frequently-expressed view that I would not obtain permission to see many (if any) files. Despite this pessimism, a detailed and comprehensive analysis has been possible: in all areas access was granted, almost always with no more than a straightforward guarantee of confidentiality. The almost complete lack of an existing theoretical structure with which to approach the analysis of files effectively left me with as open an approach as I cared to take, and with this leeway I have described legal files from a number of different angles. I was fortunate in being able to read through over 400 legal files, as well as obtaining essential data on over 200 more from the CLO computer database, and for all their co-operation and forbearance I am deeply indebted to the legal department staff at the CLO and in the two English areas.

Access to clinical staff, while administratively quite complex because of the numbers involved (especially in the midwifery survey) was not methodologically difficult, but would have been impossible without the assistance of the staff of the Edinburgh office of the RCM. Obtaining the views of almost 1800 midwives and over 200 obstetricians allows for some fairly firm conclusions to be drawn on the attitudes and reactions to litigation of clinical staff, in Scotland at least. Since the clinicians came from the same areas in which legal file analysis took place, the results of both strands of the research can be compared.

In applying to individual health managers for access to legal files, the possibility which the analysis of files might have for improving risk and claims management strategies was stressed, and throughout the thesis the possible policy implications of the incidence, nature and apparent effects of litigation have been considered. There
are concerns in this area for clinicians, managers and patients alike, and such a
topical and essential area requires a degree of open debate and analysis. Given the
limited scope for wholesale legal reform, the onus of responsibility for perinatal
litigation lies with the health service, and I have tried to present suggestions for ways
forward. In concluding the thesis in Chapter 12 the research questions are addressed
and answered, and suggestions for improving the situation are brought together in an
attempt to present the information gathered in as helpful a manner as possible. Areas
for possible further research are also identified.
Chapter 12
Conclusions and Proposals

As shown in Chapter 2, commentators seemed to agree that litigation was on the increase, and that this constituted a serious potential threat to the delivery of health care. The limited data available also showed obstetrics to be the principal area attracting legal claims, as well as the area most heavily implicated in rising levels of damages. While this may have been so at the time that these claims were made (mostly the late 1980s) this could not be verified due to the lack of available data on the incidence of litigation. The true scale of the problem remained hidden.

While it is not known how much information is informally (or perhaps formally but secretly) available to health managers, it seemed odd that policy could be formulated without information about the substance of these fears and claims being in the public arena. Health is still a public issue, even if recent changes within the National Health Service have done little to promote the notion of public accountability. This research set out to identify the extent of perinatal litigation in Scotland and in two English areas, and to examine its nature. In this it has succeeded: in Chapter 4 detailed figures were given which show how much perinatal litigation there has been since 1980, and in Chapter 5 the principal heads of claim were described.

In Parts II and III of the thesis the nature of litigation was analysed in some depth. The restricted information on the types of claim made in the literature provided a limited platform from which to begin this analysis. However the scope of access to files, and of this thesis, meant that a far broader and deeper study of the nature of litigation could be undertaken. The time available and the lack of constraint (from either gatekeepers or funders) allowed for a wealth of information to be gathered. This was used to deepen the analysis of the context in which legal claims are made.

Securing the views of clinicians was an essential tool in assessing whether, and if so, how litigation was having a practical effect. Allegations had been made about the fears felt by those working in the clinical area, yet such reports were largely anecdotal, with nothing being done to quantify the (apparent) problem in any meaningful way. Part IV reported two large scale surveys of clinical practitioners, which further the debate about the perceived effects of litigation.
The research questions are now considered, areas for further research are suggested, and the implications for risk and claims management examined.

The research questions

1: How much litigation is there?

That litigation was increasing sharply was so much the accepted wisdom of the available literature that the obvious, and very dramatic, drop in incidence since 1993 was surprising. A caveat which needs to be inserted here is that the claims made in the literature relate to England, since no data about Scotland have been available for scrutiny. However, from the Tables in Chapter 4 it is apparent that the English hospitals studied here experienced a fall in litigation since 1991 at least as dramatic as that in Scotland, and while it is possible that these English hospitals are atypical, there is no particular reason to think that this is so.

It is acknowledged that the figures for 1993 onwards are incomplete (given the usual time lag between event and legal notification), but even so the scale of the drop is difficult to explain. The upsurge in claims from 1990 to 1992 may have been due in part to changes in eligibility for Legal Aid which may have hastened a number of cases which otherwise would have taken longer to surface. If so, the effect of this change in eligibility ought soon to have run its course. While it is outwith the scope of this thesis, it may be possible in future years to state whether the dramatic drop in claims made in 1994 and 1995 represent a 'blip' or the start of a clear downward trend in litigation. Unfortunately information about Legal Aid was only available in a minority of cases, and so it cannot be concluded with certainty what effect the changes in eligibility have had.

While litigation certainly increased sharply throughout the 1980s, the picture appears rather different in the 1990s (if the caveat noted above is accepted). This may have serious financial implications for those Trust hospitals which are now signing up with the Clinical Negligence Scheme for Trusts (CNST) in an attempt to ensure that sufficient resources exist for large damages payments. Committing large sums in insurance premiums inevitably drains resources away from the patient care budget. Each Trust can choose the level (of damages payments) at which it enters the scheme: for example some may choose to remain liable for all payments up to £25,000, while others may choose to enter the scheme at a much higher level (one Trust studied here entered at £100,000). Claims which are concluded for a sum smaller than the level at which a Trust enters the scheme are still notified, and so the
CNST will know of successfully defended legal claims. However claims which are successfully repudiated and incur no damages payments may not feature on the CNST assessment of the extent of litigation.

Given that in England each Trust employs a firm of independent solicitors to act on its behalf in negligence actions, and is not required to notify legal claims to any central body, it will be difficult to monitor the overall incidence of English litigation. In Scotland the situation is more fortunate, in that the CLO retains the effective monopoly of defending health service actions. In theory Trusts can nominate a different firm of solicitors, but in practice this is unlikely to happen often, if at all, given the much higher cost of independent solicitors: the CLO has a profit 'ceiling' of 5%, which minimises costs to the health service; it also has many years' experience in this field. It ought, therefore, to be possible to track the future trend of litigation in Scotland.

Publicising the rate or incidence of litigation and its trend should help to clarify the debate about the perceived effects of litigation, and in particular establish whether these are justified. If the 'litigation crisis' has indeed passed, some of the features of defensive practice may be criticised with more justification.

A large majority of respondents to the obstetric and midwifery questionnaires believed litigation to have increased sharply in recent years (the question asked about the previous ten years, since it was felt that many junior practitioners might feel unable to provide an answer for a longer period). Such a belief did not correspond directly to personal involvement - a third of those doctors who thought litigation had not increased, or who were unsure, had themselves been involved once or twice, and personal involvement among midwives was rare.

The perceived cause among clinicians for such an upsurge in litigation was attributed mainly to an increase in awareness and expectations on the part of the general public, although many other reasons were suggested. A belief in high expectations regarding pregnancy would seem to be reinforced by the high proportion of primigravid litigants noted in Chapter 5. However, these opinions are difficult to quantify, since many were couched in rather vague terms. Nevertheless, a strongly held view was put forward by a number of respondents that litigation is increasingly a 'fact of life', not just in relation to childbirth, or, more generally, to health care. Because of the salience of health issues, with maternity care being especially prominent, it may be that perinatal litigation has become the epitome of this
phenomenon. This, too, is impossible to confirm, since figures for litigation in other areas are, as with the existing figures for litigation in this area, piecemeal.

No respondents thought that the incidence of litigation had decreased, although it is apparent from the data presented in Chapter 4 that this is so. This may seem odd, not least because the clinicians who were surveyed and the legal cases came from the same areas. However, it should be remembered that not every area studied has seen a reduction in the rate of litigation, and neither is the experience of litigation something which occurs in neatly-contained time intervals: many cases take several years to conclude - one midwife commented that she had been kept in suspense for five years. While there has evidently been an overall drop in incidence, there are other variables which may mean that this is not the start of a downward trend in litigation. The (anecdotal) increase in the number of complaints since the introduction of the Patient's Charter may have contributed to a decline in the number of formal legal claims, and in due course the effect of this Charter may wear off somewhat; given that the length of time from event to legal notification has dropped steadily since 1980, the notion of a more litigious society would seem to be reinforced.

While it is essential to obtain overall figures in order to understand the trend of litigation, most health managers could be excused for being less concerned with what is happening generally and more concerned with the likelihood of their own Trust being the subject of a major legal action. As Fenn and Dingwall (1995) noted, the figures for individual Trusts become much harder to predict, and this inevitably complicates the decision about joining the CNST insurance scheme. A cautious manager may prefer to write off a certain part of the budget in insurance premiums and buy the financial peace of mind which belonging to the scheme promises, while a more adventurous colleague may believe the risk of a large damages payment to be too remote to justify setting aside money which could otherwise go towards direct patient care. In today's financially-driven health service, both of these strategies may be criticised, depending on the outcome. Even with a decreasing incidence of litigation, there is the potential for one large damages award to wreak financial havoc within a Trust.

The data presented in Chapter 4 on the rate of litigation by hospital show large variations within the same time period, and the picture is further complicated by a rapidly changing overall incidence. Clearly predictions are difficult to make. It was interesting to note the much higher rate of litigation in certain hospitals compared
with the figures released for some US obstetricians by Baldwin et al (1991). The perception that the USA is far more litigious in this area could be called into question by these figures.

Litigation rose sharply during the 1980s and appears to have fallen during the 1990s, although the rising MPS subscription levels for obstetrics indicate that this defence organisation at least believes the financial outlay for this specialty is increasing. This may reflect rising compensation awards rather than a rise in the number of claims. The best that can be said is that the incidence of litigation is unpredictable, with large variations seen between different areas, and in the same area over a period of time. This may be of little comfort to those trying to steer a financial course for the health service in these budget-constrained days, but of more practical value in attempting to reduce the outlay in legal costs and damages is the identification of litigation-prone situations.

The restricted demographic data available concerning pursuers allowed for a limited profile of litigants to be constructed. While it is not possible to paint a picture of a typical pursuer, the superior success rate for those pursuers in the higher socio-economic groups was noticeable, and the prominence of primigravid litigants was also striking.

2: What is the nature of perinatal litigation?

Having identified obstetrics as the area most commonly associated with damages payments, the literature provided a limited understanding of the issues involved. Capstick and Edwards (1990) identified certain areas relating to obstetric mismanagement (including reactions to the presence of meconium, and the allegedly improper use of forceps); Ennis and Vincent (1990) highlighted complaints made about CTGs; and, from a risk management point of view, James (1991) stressed the importance of supervision and documentation. These provided a base from which to begin analysing legal files. However these studies concerned at most 100 files, and the scope offered by being able to study many more files in depth meant that a much broader and deeper picture of the nature of perinatal litigation could be constructed.

As James (1991) noted, claims made about brain-damaged babies are only one head of claim among several. This research found that there are many different reasons why people sue, and these were detailed in Chapter 5. A brain-damaged child was by far the most common reason for suing, but it only accounted for a quarter of claims: stillbirths, non-CNS birth injuries and neonatal deaths were all fairly common
reasons for suing on behalf of a baby, while for mothers perineal trauma was the most common reason. Caesarean sections also featured prominently, and allegations about retained products and epidural or spinal anaesthesia were not uncommon. Risk management must acknowledge the wide spectrum of heads of claim.

The success rates by head of claim which were detailed in Chapter 5 were not previously available in the literature. Given the low success rates for those suing under the CNS head of claim, it seems inappropriate that this head of claim has been cited as the prime reason for trying to reduce litigation (a logic largely driven by financial considerations). However the length of time some cases take to conclude (the unsuccessful CNS cases averaged over 33 months, the successful ones 65 months) is a concern: financially, because there are legal costs involved in keeping a case live, and in emotional terms, both for the staff and the family concerned. The information on the clinical details of CNS cases showed how cerebral palsy is often an unexpected outcome, and this constitutes a potential worry for all staff involved in perinatal care. When a clinical outcome is initially good but the child subsequently develops cerebral palsy, the devastation of this news for parents, and for staff of being called to account, is difficult to imagine.

One way of reducing the time gap between event and legal notification is the implementation of targeted 'de-briefing' sessions, which aim to give patients an opportunity to air grievances or ask questions about the care they have received. It may be argued that this focus might encourage some legal claims, but it is more likely that it will divert a greater number. Initiating this process will also help to clarify the events in question, so that if a retrospective legal enquiry is needed, all the relevant documents have been identified, and all relevant staff required to submit explanatory accounts; such a proposal is also the aim of perinatal outcomes analysis. This approach ought to reduce significantly the time currently taken to investigate and decide cases, something which would benefit all sides.

There are of course good practical reasons for trying to reduce the incidence of litigation, but the wide variation seen in the different heads of claim initially makes risk management appear daunting. For this reason Chapter 6 took legal claims and examined them in the context of the clinical setting. The influence of protocols, policies and supervision levels cannot be gleaned from merely listing the heads of claim, and tackling the issues arising from the clinical context allows for a more informed approach to risk management. There was evidence from the analysis of legal files of an intricate interplay of clinical, administrative and personal factors.
Poor outcomes are not always preventable, and will continue to occur, despite improved risk management. Supervision was indeed a problem, and not only when the unit in question was busy. To an extent the problems and mistakes encountered are an inevitable feature of an environment in which students and junior-grade staff gain much of their experience through minimally supervised contact with patients. The ramifications for managers are both financial and organisational: adequate staff must be present to cope with the clinical requirements (despite maternity care often being rather unpredictable in terms of workload) and this has implications for the unit or departmental budget.

CTGs were identified as a critical feature in several actions; in the staff surveys there were disagreements as to their applicability and reliability, and levels of training were frequently claimed to be low. Certainly this is one area which could be targeted.

Ensuring that the standard of work corresponds to accepted good practice involves the use of protocols and policies. While they inevitably constrain autonomous practice to a degree, they are seen as providing a bulwark against allegations of substandard care: 86% of the obstetricians agreed that protocols and policies could minimise the risk of mistakes or actual negligence. The apparently rapid growth of these instruments indicates that employers are now keen to define a standard of competence which, it may be presumed, will help in any defence against allegations of negligence. Certainly, some of the cases cited in Chapter 6 showed that this argument has been used in the past.

Such policies must be sensitively implemented, however; they must take into account the professed autonomy of the pregnant woman. Denying women the right to make decisions or exercise choice is exactly the wrong signal to send out if communication and rapport between patient and clinician are to be at their best.

The nature of perinatal litigation, however, is so diffuse that simple targeted strategies are unlikely to be comprehensive enough to reduce substantially the likelihood of litigation. The broader picture demands that communication between patient and clinician needs to be improved, but although easy to prescribe, this is more difficult to achieve in practice. The discussion of 'Talking to patients' in Chapter 8 identified examples of communication failure (including the inappropriate use of jargon), and explored the possibility of pre-empting litigation through a policy of full and frank explanation when things are deemed to have gone wrong.
Such improved communication relies upon a co-ordinated interprofessional approach, in which midwives and doctors communicate effectively with one another. However, tensions between the two groups of professionals were identified in Part IV, and these must be of concern to health managers, for if clinicians do not relate well to each other, the prospect for effective communication and rapport with patients may be seriously undermined.

Improved communication with patients, including giving explanations and apologies, would surely reduce the number of cases which are initiated on the basis of a misunderstanding or misperception, and help to avoid the complicating feature of the distortion of memory over time. Poor recollections can of course apply to staff as well as pursuers, the 'aide-mémoire' role of case notes notwithstanding.

Chapter 8 also attempted to explore some of the possible motives pursuers had for litigation; in no sense was this an attempt to criticise those who sought legal advice, nor was it within the scope of this thesis to provide a detailed explanation of this phenomenon. A number of legal cases began as simple complaints, but for one reason or another they became legal actions after a time. In one instance this was explicitly stated to be due to the flippancy of staff in dealing with the complaint, and this is inexcusable. As noted earlier, risk management can never completely avert poor outcomes; when complaints or claims arise, sensitive claims management is an absolute requirement. This applies even when the complaint or claim is made many years after the event.

Several of the clinicians believed that the need for money was a reason for suing, and while this was undoubtedly true in cases of cerebral palsy it was less obviously so for most other cases. 'Greed' and the 'lottery culture' were blamed by some respondents for an increase in litigation, but given the limited potential for damages in the majority of (non-CNS) cases, this is questionable.

One of the most problematic features of legal actions is the length of time they take. Addressing delays in initiating an action is beyond the scope of health managers, and, as noted in Chapter 4, there has been a steady reduction in the time it takes to initiate an action (both CNS and non-CNS). Some of the delays which occur during the course of an action are similarly outwith the control of health managers: the low level of competence displayed by some solicitors is best addressed by further training within the legal profession, and by ensuring that pursuers select appropriately experienced legal representatives.
Delays due to poor record keeping and administration within the health service were, unfortunately, commonplace. These can all be targeted by continuing education for staff regarding documentation, including those records relating to staff whereabouts, and by ensuring that the storage of records (and CTG traces were a particular problem) is improved. This may make a significant difference to the investigation of a legal claim. Many midwives claimed now to have improved (or at least increased) their documentation, although objective evidence for this was, sadly, unavailable. These organisational features are essential in establishing a level of trust between a patient and the hospital concerned: in cases in which case records are untraceable, the damage to such relationships is immeasurable.

It is possible that the shorter time it has taken to conclude successful and unsuccessful actions since the mid-1980s indicates that legal departments are becoming more efficient, but pursuers still have to be patient and resolute. Delays in legal actions occurred for several reasons, an extreme example being (according to the legal department) an exceptional degree of incompetence on the part of the pursuer's solicitor. This CNS action was initiated fourteen years ago, but still has not been concluded, despite the facts of the case being quite clear. Reform of the present adversarial legal system is one way in which many of these delays could be avoided, but it remains to be seen what the practical effects of the reforms suggested by Lord Woolf will be.

Some of the law's anomalies were described in Chapter 7, among them the problematic notion of establishing causation, and the fact that similar degrees of negligence could result in widely differing amounts of damages. Many of the legal features could be better understood by pursuers and defenders alike; continuing education within the health service can aim to achieve this for clinicians, but the responsibility for educating the general public is much more problematic.

Root and branch reform of the law is unlikely, although Lord Woolf's recommendations include the adoption of a less adversarial procedure for dispute resolution, and the earlier involvement of Procedural Judges to direct the conduct of a case. This is intended to help clarify the legal issues, determine the appropriate procedure for the exchange of evidence, and set realistic timetables (Dewhurst 1996).
3: What are the effects of negligence on clinical practice?

A number of side effects of litigation have been mentioned. Within the literature there were claims of an increase in defensive clinical practice, and of a possible exodus of clinicians from perinatal care. From the surveys reported here, it is apparent that clinicians believe that more investigations and operations are being conducted as a direct consequence of the fear of litigation. The term 'exodus' is clearly an exaggeration, but despite few practitioners admitting that they had themselves considered leaving, many claimed to know of one or more colleagues who had apparently done so.

A large number of midwives claimed to have improved their standard of documentation, and many also said they now obtained permission from a patient before carrying out any procedure. It is difficult to argue that these constitute anything other than improvements in clinical care, but some of the other instances of defensive practice which were cited were more worrying. A reduction in the midwife's autonomy is inherent in the claims made that medical staff are now involved more quickly in a woman's care; and several of the midwives noted that involving doctors almost always leads to a higher incidence of investigation and intervention, not all of it necessary. This intervention - in terms of more instrumental and operative deliveries - is at odds both with an apparent 'consumer' demand for more natural childbirth, and the stated aim of obstetricians (in the Scottish Caesarean Section Audit) to reduce the number of caesareans.

A realistic awareness of the extent of litigation, and of the circumstances of litigation-prone situations, will help clinicians to see this issue in context, and may also help to minimise some over-reactions to the prospect of litigation. Such an improvement in clinical care may be achieved through on-going education of staff by management.

More CTG use is another example of defensive practice, and one which carries an increased likelihood of intervention during labour and a corresponding rise in morbidity. It was worrying to note the high prevalence of staff who thought that training in this art is insufficient - 65% of consultant obstetricians thought that training for midwives was inadequate, and 82% of SHOs felt insufficiently prepared. Midwives, interestingly, and despite a number acknowledging the level of training they had received to be inadequate, were much more likely to profess an ability to interpret CTG traces accurately than were the doctors. Several midwives said they
had requested further training in CTG interpretation, and it seems that hospitals, knowing the vital importance of this art (not least in the event of litigation), are now encouraging staff to attend lectures and practical sessions.

The perceived need to carry out this procedure led to the surprising admission by two thirds of the midwives that they would insist on CTG monitoring in certain circumstances, even when the woman concerned had specifically said she did not want this. A smaller proportion of doctors admitted this, but it was noticeable that it was the junior grades of both doctor and midwife who were much more likely to do so. It seems likely that this stance reflects the fear of being criticised for not ensuring that adequate monitoring is carried out, but this over-ruling of a woman's wishes is a matter for uneasiness at least. A lack of confidence may be blamed for this, something which can only be ameliorated through improved education and adequately supervised experience.

The claim by Acheson (1991) that litigation and the fear of litigation were starting to poison interprofessional relationships in the delivery room produced some interesting responses. Junior grade doctors and midwives were more likely to agree than their senior colleagues, and Scottish respondents more likely to agree than their English counterparts. This comparative pessimism in the Scottish respondents was echoed in the views expressed about communication and rapport between doctor and midwife, particularly when things go wrong. This was an interesting difference of opinion, not least because the English respondents (both obstetric and midwifery) had a greater direct experience of litigation. For such a crucial area in clinical care to be apparently so prone to poor relationships should be a matter of concern for health managers, since effective communication and rapport are especially important when things go wrong. Channels for improving communication with patients have already been discussed in this chapter.

It was interesting that the views of respondents about defensive clinical practice (including the consideration of leaving the specialty) were not positively associated with a direct experience of litigation. It might have been thought that such an experience would predispose a clinician to become more wary or disenchanted, but this did not appear to be the case. This finding lends little weight to the theory that increasing litigation (itself shown to be questionable in light of the fall in incidence since 1993, at least in the geographical areas studied here) will lead to a haemorrhaging of clinicians from the specialty, although of course it is not known how many potential obstetricians or midwives (particularly the former) may be put
off entering this area of clinical care by the perceived risk of litigation. The RCOG has surveyed its fellows and members to determine their attitudes towards litigation; similar research with medical students and junior doctors concerning their intended medical specialty might, if conducted longitudinally, provide evidence about changing attitudes towards litigation.

It is intriguing to note the high degree of awareness of litigation among practitioners. While less than 5% of the midwifery respondents had been involved in a legal action, 86% thought litigation had increased, 44% claimed to know of a midwifery colleague who had been involved, and 32% had discussed litigation often with colleagues. For the obstetric respondents personal involvement (at 49%) was much higher; but compared with the much larger figure reported by Saunders (1992) in which 85% of fellows and members in an RCOG study said they were either currently involved in litigation, or had been so in the previous ten years, this appears relatively modest. Given the comparatively small numbers involved, the significance of a higher involvement among English respondents (65%) is not known, but the consequence of so many practitioners (77% of doctors and 59% of midwives) saying they thought clinical practice generally is becoming defensive, is worth consideration. While a smaller proportion of each group (45% and 53% respectively) admitted that they personally had changed clinical practice, it appears that a majority see the apparent effects of litigation around them.

The wider context of this research
Because of a varying rate of litigation between different hospitals and in the same hospital over time, predictions about possible future rates cannot be made with any certainty, and clinical practitioners are left to consider the potential for legal action in their workplace with very little accurate data to hand. While it may be argued that an obstetrician may expect to be sued at some stage in his/her clinical career, this may happen no more than once in ten or twenty years, and while undoubtedly traumatic, it is possible that the sense of perspective (i.e. all the other patients in that time not suing) is lost. Such figures are not plucked at random: on average the English doctors in the survey delivered about 120 babies a year; the Scottish hospital doctors just under 100. Of the 57% of midwifery respondents who said they delivered babies, the average annual figure was 50. For 1991-95, the average number of deliveries per legal file (see Table 4.1d) for small hospitals was 1223 (median 1220); for medium hospitals 2364 (median 2100); and for large hospitals 3071 (median 2799). While not all cases concern the actual delivery, the bulk do; and so it may be seen that the likelihood of becoming involved in a legal action is
comparatively remote. Given the low rate of success for pursuers in this field (25%), the chances of being found guilty of negligence appear even more remote.

The fear of litigation
While in no way attempting to diminish the significance of legal actions for those involved - the emotional trauma was clear from many of the questionnaires, and is being personally examined further in on-going research - it may be that the prominence of litigation has been exaggerated from a statistical point of view beyond its worth. If this is so, then it is pertinent to ask how this has come about, and what interests might be served by such a situation, which might be termed (within its own clinically-delineated confines) a 'moral panic' (cf. Cohen 1987). A possible subject for comparison is the fear of crime: fear of mugging is greatest among elderly women; but those most likely to be mugged are young men (Hough and Mayhew 1985). Shapland and Vagg (1988) note that advertising crime figures can make some people over-react, just as some practitioners may be over-reacting to reports of litigation. In such situations perceptions and reality may not coincide, but this does not diminish the impact of the relevant fear.

Concerning litigation, Daniels (1989) provides one answer in the American context: for him this is a consequence of the 'agenda-building' of certain groups, including the insurance industry and the medical profession. Their aim, he claims, is to reform the fault-based legal system because it works against their (mainly financial) interests. Quite where the argument starts, however, is not so clear: in Chapter 2 it was seen that the limited data provided by the MDOs in Britain depicted a sharp rise in both the number of claims referred to them, and the expense of litigation. The cost implications in this field are such that even one large case may wreak financial havoc within a Trust. The realisation of these two 'facts' may have combined in some minds to produce an unjustifiably increased fear of litigation. While the MDOs were up to 1990 in a comparable position to the American medical insurers, and the data produced by them (see Figure 2.1) pointed towards a seemingly inexorable rise in the costs of litigation, the paucity of hard data concerning legal files has deprived clinicians of a detailed context within which to judge such figures.

Practitioners, even those who have never been involved in litigation, sometimes point to the frequency and prominence of articles within clinical journals as a justification for believing that litigation has increased (personal data; on-going research for the Iolanthe Trust). In this thesis it was noticeable that some practitioners felt directly affected by the fear of litigation, despite not knowing of
anyone who had been involved. There has also been in the last few years an increase in the number of seminars and study days concerning the legal responsibilities of the clinical practitioner; and several books and booklets have been published which highlight the same area (Chamberlain 1992; Mason and Edwards 1993; Dimond 1994; Dimond and Walters 1997).

The deterrence principle
Given the improbability of substantial change to the principle of a fault-based system for determining medical cases, despite pressure from the medical profession in both Britain (BMA 1987) and the USA (Daniels 1989), who may benefit from such a situation? It was noted in Chapter 2 that the fear of litigation may encourage clinicians to be safer in their practice, and that in order to avoid the situations believed to make litigation more likely hospitals may employ more staff (Fenn and Whelan 1989). However there appears to be little empirical evidence for the first assertion. Shapiro et al (1989) found a great divergence in some of the perceived reasons for litigation when comparing the responses of suing patients and non-sued physicians: 11% of the former, but 75% of the latter, thought physician-patient personal conflicts were a cause of litigation. This indicates that the greater vigilance supposedly induced by the fear of litigation may not in fact deter many cases. Hupert et al's study (1996) suggests that, far from taking positive lessons from litigation, physicians may actually subvert the intended educational / deterrence signal from legal actions.

As stated, on-going research aims to explore the views of non-sued and sued practitioners, and compare their views with others involved in the legal process (lawyers, patient group representatives, and hospital managers). The responses presented in Chapter 9 need to be seen in context: although practitioners were clearly aware of litigation and most believed it had increased, only about half of each group (doctors and midwives) admitted that they had changed their own clinical practice; and of those midwives who said they had changed their own clinical practice more than half (526 out of 940) only cited an increase in documentation as an example of this. If this reason is excluded (not being strictly clinical), then the proportion of midwives admitting to a change in clinical practice as a result of the fear of litigation is significantly reduced. While this does not alter the fact that a majority still feel clinical practice generally is becoming defensive, it suggests that the intended individual deterrence signal of a fault-based system is questionable.
It is suggested that perceptions of litigation - among midwives in particular - are sometimes rather vague, not being grounded in personal experience. Why a greater proportion of both obstetricians and midwives believed their colleagues to be more defensive than they were themselves is not known, and notions of patients being more aware of their right to sue, or of having greater expectations, are difficult to quantify in any meaningful sense. It may be that providing clinicians with accurate data on litigation, so helping to put its incidence and nature into perspective, may alter these perceptions. Certainly an investigation of these areas might be the basis of further qualitative research.

**Complaints**

Whereas 41% of the doctors reported that they had been the subject of a complaint from a patient, only 17% of midwives had had this experience. It is not known what proportion of complaints become legal actions, but that some have was shown in Chapter 8. It is alleged that the incidence of complaints is increasing rapidly: if so, it is possible that some of these complaints (made with the encouragement of the Patients' Charter) have taken the place of a number of claims which would otherwise have been legal in nature, and contributed to the decrease in legal claims since 1993. This is conjecture, but it may be that the publicity of these new complaints procedures (most Trusts now have a designated 'Complaints Officer' to whom complaints are addressed) has helped to defuse a proportion of claims which would otherwise have been made using a solicitor. If this is so, and the assumption is made that most of these complaints will have little legal merit in terms of being able to establish negligence, then the success rate of legal claims may be expected to rise. In Chapter 4 the overall success rate for pursuers was noted to be 25%, and less than 18% for those pursuing CNS cases; this is below the estimate for medical negligence generally (30-40%), and well below the average for most personal injury litigation (85%; Fenn and Dingwall 1989).

Complaints seem to be increasing. Partly in response to this many hospitals have initiated counselling procedures for patients who have experienced a poor outcome, although in the obstetric survey significant differences of opinion as to their existence were noted from respondents from the same unit. If counselling helps to clarify misconceptions, then few would argue that it is not worthwhile, given the large number of legal claims made on the basis of misunderstandings. Some of the pitfalls inherent in giving explanations and apologies were explored in Chapter 8, but this is surely a more enlightened approach than sweeping mistakes under the
carpet. This aspect of claims management will succeed or fail by its sensitivity, and there is great scope for the implementation of such facilities in maternity units.

The 'Fault' / 'Need' debate
Although research into personal injury litigation has at times criticised its operation and proposed alternatives, the fault-based principle of the law of negligence is unlikely to be changed in any substantial way in the foreseeable future. Investigation into this subject included a Royal Commission (Pearson 1978), which sat from 1972 to 1978, and which examined civil liability and personal injury compensation. Despite advocating reforms which included shifting the emphasis away from establishing fault in certain instances (such as road traffic accidents), its findings, according to Mansell (1997: 226), "have been almost completely ignored by the legislature."

There has been a suggestion that the requirements of funding bodies may impede the freedom of researchers, something Hillyard and Sim (1997: 67), with reference to socio-legal studies generally, refer to as the "monetarisation of intellectual labour." Despite this view, others are more optimistic about the prospects for socio-legal research: Thomas (1997) claims that academic boundaries are constantly shifting, and that the possibilities for the contextual study of law and legal processes are good. He believes that in socio-legal studies we may be "experiencing...the emergence of a new legal paradigm" (ibid, 19). Nevertheless, proposed changes must take into account the political realities of the day, and in particular the willingness of the government to confront such a long-standing legal tradition.

The law of negligence, as set out in Chapter 2, appears straightforward: if the duty of care is breached and damage results from this, then negligence is established. Atiyah and Cane (1993) note the centrality of the concept of fault to this law, but criticise the need to establish fault in order to obtain compensation. If loss occurs as a result of fault, then compensation may be paid; but if it occurs and fault cannot be proven (as is often the case in medicine), then the victim must bear the burden without financial help. In New Zealand and Sweden the many apparent injustices of this system, including its administrative costs (Palmer 1994: 273), led to the introduction of specifically no-fault schemes.

Genn (1987) notes that the theoretical certainties of the law of tort / delict may often be overtaken by other factors: "this...lack of precision...creates...conditions of uncertainty under which claims are argued and resisted, and...contributes
substantially to the pressure on plaintiffs to avoid the risks of trial by compromising their claim." (ibid, 163). What might have been seen as a straightforward claim may be affected by several factors: a pursuer/plaintiff's solicitor may lack expertise in personal injury matters (ibid, 164), a finding which was at times echoed in this thesis. Although "neither plaintiff's nor defendant's lawyers, both acting for private parties, have any direct interest in facilitating the administration of civil justice" (ibid, 167), the requirements of the civil justice system demand that the vast majority of claims are settled before the court stage. This in turn is used by the insurance companies (who were the defendants in Genn's study) to put pressure on the claimants' solicitors to compromise the extent of the claim. This sort of compromise, according to Mansell (1997: 233) is very unseemly: "The striking of a bargain between lawyers as to the level of compensation after negotiations...resembles nothing so much as (in a greatly prolonged from) the haggling required before purchase in an Oriental market. The price settled upon in each case often has less to do with the quality of the claim...than with the quality of the bargaining skills of the (lawyers)."

The principle of tort/delict is that, providing fault is established, the injured party is compensated in full: "'restituto in integrum' implies full compensation for losses suffered" (Genn 1987: 168). However, the 'haggling' process is likely to reduce the eventual level of damages, despite the lack of any contingency fee for the lawyer, given the experience of the defender/defendant in this area of the law. Genn, referring to Galanter (1974), called the insurance companies in her study 'repeat players', a label which could accurately be used to describe hospitals in negligence cases. In addition, as Mansell (1997: 233) points out with reference to a 1994 Law Commission report, "notwithstanding the principle of full compensation most victims required significant unpaid care by parents, spouses, friends and neighbours."

However, as Atiyah and Cane (1993: 149) point out, there may be little correlation between a negligent action or omission and its consequences; this was referred to in Chapter 7. The theory of 'fault' as a moral principle is further reduced by insurance liability (which almost all practitioners have) and the vicarious liability of the employer. These features, together with the difficulty many pursuers have encountered in satisfying the Bolam / Hunter v Hanley test, have led to calls for compensation to be payable on the basis of need rather than fault. Advocated principally as a means of ensuring greater fairness for the victims of medical accidents, this would paradoxically sometimes work in favour of practitioners: in a
small number of cases claims have been settled out of court when there was little
evidence of any negligence, but when the case would be more expensive to defend
than to concede. When a case is conceded the inference is that the practitioner has
been guilty of negligence, but this is not always the case.

Atiyah and Cane (1993) also point out that payment under the law need not be
associated with moral culpability; and indeed moral culpability does not always
result in compensation. If compensation is to be on the basis of need rather than
fault, then the usual provision for this is some form of social security. The
comprehensive Swedish social welfare provisions were mentioned in Chapter 2: the
no-fault compensation is intended to 'top up' already existing benefits which are
generous by British standards. Finland introduced a drug insurance scheme in 1984,
and a statutory patients insurance scheme in 1987. Based on the Swedish model of
no-fault insurance, these measures were intended to reduce the burden on the
delictual system and ensure a fairer method of compensation: "The damages are
reduced by whatever other benefits the patient can claim from the state or his
employer so the scheme 'tops up' these benefits..." (Brahams 1988: 679). To be
comparable, benefits in Britain would need to be augmented significantly; an
improbable prospect at present. Adopting a top-up mechanism like that in Sweden or
Finland would be feasible, however: Atiyah and Cane (1993: 402) note that there are
already rules "which determine when and to what extent no-fault, first-party
insurance and social security benefits are to be set off against tort damages."

Interestingly, the Finnish Bar Association did not oppose the changes, seeing them in
the public interest (ibid, 678). This is in stark contrast to the view expressed by
Mansell (1997) concerning legal opposition to proposed changes to the fault-based
system in Britain; in a similar vein Atiyah and Cane (1993: 405) assert that "the
interests of a few hundred barristers cannot, in the long run, be allowed to determine
the shape of the law relating to compensation for personal injuries; law is a social
service, and in the long run the interests of the consumer and not the administrators
must prevail." In addition, Brahams (1988: 680) notes that in Finland payment is by
instalment and not lump sum, so that "the family of a compensated victim do not
gain by his untimely death." Instalments payments (known as structured settlements)
have sometimes been used in Britain, but this is not yet the norm, and the failure to
do this has caused problems (Calladine v Nottingham AHA - see footnote 23 in
Chapter 2).
If 'need' is to replace 'fault' as the basis for compensation, the argument may then turn to the rationale for distinguishing a disability which is caused by an accident (such as in the New Zealand scheme) from one which is not. Noting that there is a long legal tradition which requires that the victims of negligently-caused accidents be compensated, Mansell (1997: 229) points out that "In tort a single tortfeasor is called upon to make good the damage, and clearly the losses of those disabled otherwise are not similarly individually attributable...there is no long tradition of such compensation for those who have become ill."

Implications for legal reform
Any suggestions for reform must encompass the feasible. Citing Palmer (1994), Mansell (1997: 227) notes that in the New Zealand scheme "for a variety of reasons...attempts to broaden compensation provisions foundered politically." Opposition to any expansion of the New Zealand scheme largely centred around cost. However, extending the argument about the comprehensiveness of the provision of compensation, Stapleton (1994) questions why the disabled should be treated preferentially over victims of other misfortunes. The political background must of course be taken into account: it seems unlikely that the Labour Government elected in Britain in 1997 will increase levels of public expenditure in order to provide a significant boost for victims of medical accidents. Given this continuing political reality, Brahams (1988: 681) asks why a no-fault scheme should be restricted to medical accidents: "Accepting that we cannot change the whole world at once, then why not start with injured patients?" Atiyah and Cane (1993: 426) note that preferential treatment such as this is not necessarily wrong; but its proponents must be prepared to justify the reasons for making such distinctions. They claim that "the only way of eliminating causal issues entirely is to base entitlement to compensation solely on the need of the plaintiff for compensation" (ibid, 400).

It might be argued that certain cases ought to be treated as exceptions to the current system, or as the first to be included in any reform. Accepting the moral principle of need rather than fault, a good argument in favour of no-fault may be made for babies affected by central nervous system handicap (the 'CNS babies' discussed in Part II). In part this is due to the emotional trauma of such cases, given the length of time they typically take to be concluded, but it may also be argued on the basis of cost. Whelan (1988: 74) notes generally of medical negligence costs: "Cases take years to be determined, and for every £100 recovered, anywhere from £50 to £70 goes on legal costs. In the medical context, it is conceivable that one arm of the State via legal aid finances proceedings against another, a health authority, purely, cynics
might say, for the benefit of the lawyers." However, a note of caution is sounded by Bowles and Jones (1990) who warn against stumbling into a no-fault scheme in an attempt to avoid the perceived financial dangers of the current system. Despite such worries, and perhaps irrespective of the particular costs of the CNS cases (which, being lengthier and more complicated than most, are more expensive), a moral argument may be made for providing greater resources for such babies on the basis of need. This argument may be criticised for being emotive rather than rational, and to be consistent all babies who suffer brain damage, however caused, would have to be entitled to such compensation. However, if the cost of legal debate between lawyers about causation could be redirected to providing structured settlements (perhaps through an insurance system), then one of the more glaring deficiencies of the fault based system might be rectified.

Nevertheless, at present the extent of proposed reform is much more modest. Mediation, possible arbitration, the speeding up of the legal process so that smaller claims are dealt with more efficiently, and case management by judges (Woolf 1996), do not answer the fundamental criticisms of the tort / delict process. Mansell (1997: 236) notes rather ruefully that "While the academic arguments provided by research have been impressive and show how the position might at least be ameliorated, they have nevertheless been politically resistible at best and unsaleable at worst." For the time being the fault-based negligence system will continue to operate, notwithstanding the many criticisms of its anomalies and shortcomings. Such changes as are made must be introduced within its framework.

Risk Management proposals
In this discussion risk and claims management are considered together. Claims management - the sensitive handling of claims when they come in - is in effect a sub-set of risk management, since its aim is still to minimise the risk of a damaging outcome.

A possible conclusion to be drawn from the steadily decreasing time between event and legal notification noted in Chapter 4 is that society is becoming more litigious, although the overall drop in the incidence of litigation since 1993 would seem to question this. Nevertheless, the question of litigation and its side effects is a public one.

Publicising the incidence of litigation should settle the debate about how much there is, and will help to clarify what might be considered a reasonable response to the fear
or prospect of litigation. If the incidence of litigation continues to fall, or at least does not rise to its former heights, then the actual effects of defensive clinical practices may be criticised with increased justification. A public debate about this issue requires widely-available information. The health service can initiate this by disclosing data about how often people sue, and why.

It was shown in Chapter 4 that there are wide variations in the rate of litigation, both between different areas and over a period of time. The unpredictability of its incidence makes the matter complicated, but this reinforces the need for an open debate about this subject, particularly since large sums of public money are being directed, perhaps needlessly, into insurance schemes. While it would clearly be beneficial from a risk manager's point of view to know what a typical pursuer looks like, the limited demographic data presented in Chapter 5 do not allow this, although it seemed clear from the restricted data available that first time mothers are more likely to sue, and those in the higher socio-economic groups more likely to win. This cannot be used to conclude that the better off primigravidae are the 'ones to watch'.

Many of the features of perinatal litigation described in the literature were confirmed, and these can be used to target risk management. The question of supervision, both of patients and of junior staff, needs to be addressed by management. Flexibility within the staffing structure, including perhaps employing more staff at short notice, is required if the workload increases suddenly and dramatically. This may appear an expensive option for budget-constrained managers, but the dangers, in terms of poor clinical outcome, patient dissatisfaction, and possible litigation, make it a prudent one.

Documentation is another feature confirmed as a problem area. Inadequate case records were a distinct characteristic of several cases, and this can have done little to improve memory recall, especially when there was a considerable gap between event and legal notification. Staff can be taught the importance of full and detailed case notes through continuing education; other hospital records, such as those detailing staff whereabouts or the timing of drug administrations to particular patients, will also provide evidence of the course of events when a retrospective enquiry becomes necessary. Hospitals have a duty to ensure that all such records are stored safely, and are available for immediate retrieval when required. An effective record retrieval system is a crucial feature of risk management, and will do much to reduce the lengthy delays which were such a feature of many legal actions. Such delays benefit
no one, and indeed only serve to increase the stress suffered by pursuers and defenders alike, as well as increasing the financial cost of the claim.

Other areas highlighted in the literature include the reactions of staff to meconium staining, the allegedly improper use of forceps, and deficiencies in CTG interpretation. All of these can be targeted through continuing clinical education, and the sensitive implementation of protocols and policies. Many of the clinicians surveyed felt CTG interpretation to be of singular concern, and given its importance in legal matters, this area is one which could be targeted. Mandatory training sessions for those involved in antenatal or intrapartum care are an essential start; attendance at fire lectures and on 'lifting and handling' courses are already mandatory for certain staff. Protocols and policies may provide evidence of an adequate standard of clinical care, but must be sensitively implemented, with the views of the pregnant woman accorded weight; failure to do so promotes barriers to effective communication and rapport.

All of these aspects of risk management may help to improve the standard of clinical care, but as previously noted, poor clinical outcomes will still occur, and sometimes will not be apparent for some time after the birth in question. In particular cerebral palsy is frequently an unexpected outcome, and this constitutes a serious potential worry for clinical staff and managers alike. One way in which some of these cases may be ameliorated is through sensitive claims management, the staff concerned being required to be receptive to complaints or claims even years after the birth of the child. The possibility for a twin approach of targeted 'de-briefing' sessions and perinatal outcomes analysis when an outcome is known to be poor is another way forward, but this demands a degree of openness and a standard of communication between different clinicians and between clinician and patient which was evidently lacking in many of the legal cases examined. Explanations and apologies are not without their dangers, but represent an immense improvement on attempts to sweep problems under the carpet. The damage to the patient-clinician relationship when such problems are uncovered is immeasurable. Communication skills may be difficult to teach, but are essential if this approach is to be adopted.

All of these proposals aim to ensure that clinical care is at its best. However, the wide variety of heads of claim shown here represent a complex problem, and indicate that these suggestions cannot be easily transcribed into a cure for litigation-prone situations. The 'brain-damaged baby' case may be the most newsworthy of heads of claim, but represents only a minority of all actions. Staff can only be helped
by understanding the true nature of perinatal litigation; to do this risk management
must take on board the variety of heads of claim, and not concentrate exclusively on
those cases which may have the greatest financial imperatives.

Continuing education of staff could also include a better appreciation of the way in
which the law operates, so that they appreciate the importance of thorough
documentation and the possibility of having to provide statements when required.
Understanding the extent of litigation may help to create a better understanding of
the perceived need to adopt defensive clinical practices; in certain cases staff appear
to have over-reacted somewhat, with potentially serious implications for both patient
care and health service expenditure.

Postscript
Perinatal litigation is an unpredictable area, having first risen and then fallen since
1980. The multitude of reasons for suing in this area of health care make simple
descriptions and simplistic prescriptions inappropriate. Contrary to the view
expressed by one solicitor that obstetric cases are easy to spot because they have "a
£1m price tag on them", the majority of cases concern less tragic outcomes than a
brain damaged baby, and involve far less financial outlay.

The complex circumstances surrounding the clinical origins of many cases make risk
reduction problematic. However, this is not to say that attempts ought not be made to
reduce the likelihood of such events.

The fears clinicians have about the effects of litigation cannot be easily downplayed:
while there appear to be positive side-effects, such as improved documentation and
involving the pregnant woman more in decision making, many feel constrained to
intervene more quickly, and this is a matter for concern, since it reduces the scope
for clinical autonomy and patient choice, increases the risk of morbidity, and incurs
unnecessary expense for the health service. An improved understanding by patients
and clinicians of the benefits and drawbacks of intervention may help to reduce the
likelihood of events which have been seen in this research to be the origins of legal
actions; a better understanding of the nature of clinical negligence may also help to
clarify the appropriateness of particular courses of action for all concerned. At all
times an improvement in the quality of communication between patient and clinician
will lessen the risk of subsequent litigation.
Glossary, and explanation of initials and abbreviations

abruption .. partial or complete separation of placenta before birth of the baby
accoucheur (Fr) the person conducting a birth
AFE .. Amniotic Fluid Embolism - entry of liquor amnii (fluid filling the amniotic sac which surrounds the fetus) into maternal circulation, leading to haemorrhage
AIMS .. Association for Improvements in the Maternity Services
amniotomy .. artificial breaking of the amniotic sac to induce or augment labour
Anti-D immunoglobulin injection given postnatally to Rhesus negative women to prevent production of antibodies
anuria .. failure of kidneys to secrete urine; a complication of haemorrhage
Apgar score .. method of assessing condition of newborn baby
APH .. Ante Partum Haemorrhage - bleeding from the genital tract occurring between the age of viability (24 weeks gestation) and the onset of labour
ascites .. free fluid in the peritoneal cavity
auscultate .. listening (in this sense usually referring to the fetal heart rate)
coccydynia .. pain in the coccyx (base of the spine) region
CPD .. Cephalo Pelvic Disproportion - in which the baby's head is too large to pass through the maternal pelvis
CTG .. cardiotocography (see also EFM)
D+C .. Dilatation and Curettage - operation to ensure uterus is empty (in this case free of any retained products of conception)
decidua .. the endometrium (q.v.) of the pregnant uterus
dysmorphic .. abnormal appearance
dyspareunia .. difficult or painful coitus
EFM .. Electronic Fetal Monitoring (see also CTG)
endometrium .. mucous membrane lining the body of the uterus
episiotomy .. incision of the perineal body to accelerate delivery of the baby
FHR .. Fetal Heart Rate
haemostasis .. the arrest of bleeding
hypovolaemia .. abnormally low circulating blood volume
Intraventricular haemorrhage (IVH) bleeding into the ventricles of the brain

lochia .. discharge from uterus following childbirth or abortion
LSCS .. Lower Segment Caesarean Section
meconium .. contents of the fetal intestinal tract
MRU .. Midwife Run Unit
'paed' (abbrev.) .. paediatrician
Parentcraft .. organised teaching sessions (covering pregnancy, labour and the postnatal period) for parents-to-be
perineoplasty .. plastic surgery to repair the perineum
perineotomy .. incision of the perineum, usually to correct an existing postnatal perineal repair
peripartum .. surrounding the labour period
PET .. Pre-Eclamptic Toxaemia (aka pre-eclampsia) - the precursor of eclampsia - of which there are three typical signs: hypertension, oedema, and proteinuria
PIH .. Pregnancy Induced Hypertension
Pinard .. stethoscope for listening to (auscultating) the fetal heart rate
sagittal suture .. the junction of the two parietal bones in the fetal or newborn skull
shoulder dystocia .. difficulty with delivering the shoulders once the baby's head has been delivered
'show' .. the passing of a plug of mucus, often with a small amount of blood, from the cervical canal; may be a sign of early labour
Sonicaid .. Electronic device for listening to fetal heart rate
Staphylococcus aureus type of pyogenic bacteria
steristrip .. synthetic fabric alternative to stitches; used for closure of small wounds
Syntocinon .. drug given intravenously to induce or augment labour
Syntometrine .. drug given intramuscularly to help separation of placenta following birth of the baby
Ventouse .. method of instrumental delivery using suction
XYY .. abnormal chromosomal complement in a male (extra Y chromosome)
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Key:
ACOG American College of Obstetricians and Gynecologists
AIMS Association for Improvements in the Maternity Services
AJDC American Journal of Diseases in Childhood
AJOG American Journal of Obstetrics and Gynecology
AVMA Action for Victims of Medical Accidents
BJOG British Journal of Obstetrics and Gynaecology
BMJ British Medical Journal
JAMA Journal of the American Medical Association
JMDU Journal of the Medical Defence Union
JRCGP Journal of the Royal College of General Practitioners
NEJM New England Journal of Medicine
Appendix A

Hypothetical damages for the case of Geddes v Lothian Health Board

The court hearing was in September 1991. Claimed damages amounted to £664,130, with 7.5% interest since May 1984 to be added, therefore full claim was for £1,012,798. Figures given below are exclusive of interest.

Solatium (damages given by way of reparation for injury to feelings) agreed at £70,000.

1. The parties agreed on the following costs which had already been incurred:
   i. £1,400 - visits to Peto Institute in Hungary
   ii. £2,500 - visits to the Centre for Brain Injury, Rehabilitation and Development in Chester
   iii. £650 - adaptations to the home
   iv. £35 - disposable nappies
   v. £3,920 - “past care paid”
   vi. £42 - special car seat
   vii. £2,000 - towards a bigger car

   = £10,547

2. Agreed items on capital costs yet to be incurred:
   i. £750 - ortho-kinetics travel chair
   ii. £143 - “rollator”
   iii. £140 - special potty
   iv. £243 - shower chair
   v. £17,350 - computer equipment
   vi. £1,250 - adjustable bed (the defenders contested this item, but were overruled)

   = £19,526 (sub total for section 2)

   Replacement / maintenance of these items:
   i. iv. and v. - a multiplier of 15 was agreed on with respective costs of £150, £24, and £4,000 p.a.
   vi. - £50 claim with a multiplier of 15 for maintenance;
   - £125 p.a. with a multiplier of 15 for replacement of bed also made.

   This claim was resisted, and judge gives a single sum of £1,250 for this category.

   Grand total for section 2 = £64,610

3. £55,000 claim made for the costs of acquiring a bungalow (total cost £160,000).

   This claim is resisted by the defenders, who argue that this would constitute a “windfall benefit” for the pursuers. This counter claim is rejected by the judge, but he accepts a second counter claim that “the proper basis for such a claim is annualised cost. The problem which then arises is that there is no material in the evidence upon which, in my view, I can properly calculate an award on what I consider to be the
proper basis.” The defenders then agree to half the original sum claimed, so the award under this head would have been £27,500.

4. Agreed items for ongoing extra costs:
   - £600 - telephone
   - £416 - laundry
   - £375 - clothing
   - £12,000 - holiday costs
   - £3,200 - speech therapy
   - £5,906 - “care provided by the pursuers”
   = £22,497

The defenders disputed a claim for £40,965 (£2731 with a multiplier of 15) for the costs of extra transport. This was based on 5,000 extra miles annually applied to AA mileage costs. The judge felt there were shortcomings in the pursuers’ evidence here, and £15,000 (£1,000 with a multiplier of 15) was the agreed sum.

The defenders also disputed a claim of £25,000 (£5,000 x 15) for future visits to the Peto Institute. It was claimed that although past visits had been made in good faith and therefore should be paid for, no real benefit had been gained from the visits and so they should stop. The judge allowed £10,000 for this claim.

Care to be purchased by the pursuers:
   until their son is aged 18 - 20: £7,497 x multiplier of 11.5 ( = £86215.5)
   for care thereafter in an institution: £15,000 x multiplier of 3.5 ( = £52,500)
Total costs under section 4 items = £186,212.5


   The multiplier under this head of claim was reduced to 11.5, as it was felt that there was some duplication of this claim and the cost of care by others. The agreed multiplicand under this head of claim was based on average non-manual earnings.

   Therefore £126,727 would have been awarded.

Total claim made was for £664,130 with 7.5% interest backdated to 1984; had the pursuers succeeded Lord Milligan would have awarded £505,072 with 7.5% interest = £770,234.8

Appendix A. ii
Appendix B
Cerebral Palsy

As noted in the Literature Review, cerebral palsy has been a much cited instance in perinatal litigation, and it was seen in Chapter 5 that it is indeed the single most common reason for suing in this field of health care. A brief description of the condition is now given.

Huntingford (1990: 678) notes that it is not a diagnosis, but a term implying a non-progressive condition of mental and/or physical handicap which becomes apparent soon after birth. Nelson (1988: 572) follows the same line, describing it as a category of disability involving patients with one kind of problem - a chronic non-progressive disorder of movement or posture of early onset.

The condition was first described by Little, an orthopaedic practitioner in London (Little 1862). He did in fact stress the relevance of prematurity in cases of cerebral palsy, but it is his connection between the condition and birth trauma / birth asphyxia which has been remarkably enduring, and which accounts, at least in part, for some of the litigation in the field of obstetrics and midwifery.

The link with 'birth asphyxia' is problematic because the term 'birth asphyxia' is one which, while frequently used, is defined in many different ways. There is no way of measuring asphyxia directly (i.e. measuring oxygen levels on the brain at cellular level). In most clinical settings, indirect measures or markers are used, such as FHR changes, fetal or cord blood pH, or a baby's condition at birth (assessed by the Apgar score) or neurological status in the first few days of life. Paneth (1993: 97) points out that "The several asphyxial markers do not identify the same infants (so) it is difficult to choose any particular clinical variable as truly representing birth asphyxia...it is a research laboratory concept, not yet translatable into a clinical measure." Because of the difficulties in reaching a comprehensive definition. Blair (1993: 449) recommends that "the term be dropped in clinical practice in favour of terms referring to clinically observable events." This view has been endorsed by the American College of Obstetricians and Gynecologists (ACOG, 1991).

Hensleigh et al (1986) note that "the incidence of cerebral palsy in developed countries is about 1.5 to 2.5 per 1000. Comparisons between countries show no correlation with the prevailing perinatal mortality rate." In other words, intrapartum monitoring measures which were designed to reduce perinatal mortality will have little impact on the incidence of cerebral palsy, since the factors leading to the two outcomes are different. Stanley (1994: 236) notes that obstetric technology has done
nothing to reduce the incidence of cerebral palsy - indeed, this has increased slightly, a factor attributed to the survival of low birth weight babies who would not have survived twenty or thirty years ago.

The markers generally used to assess fetal or neonatal compromise have been listed above. Many follow up studies have been carried out to investigate these markers: Neutra et al (1978) and Haverkamp et al (1979) examined the relationship of CTGs to outcome; Mulligan et al (1980), Paneth and Stark (1983), Low et al (1984), and Perlman et al (1989) examined asphyxiated babies; Nelson and Ellenberg (1981) studied the Apgar score as a predictor of chronic neurologic disability; and Dennis and Chalmers (1982), Derham et al (1985), and Minchom et al (1987) looked at babies who had had seizures. A brief summary of these various markers is given here.

The Apgar score

The origins of the Apgar score go back to the early 1950s (Apgar 1953), since when it has become the almost universal method of assessing the condition of the newborn baby. It has, however, not been without its critics (Marlow 1992).

<table>
<thead>
<tr>
<th>Signs</th>
<th>0</th>
<th>1</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colour</td>
<td>Blue; pale</td>
<td>Body pink; limbs blue</td>
<td>Completely pink</td>
</tr>
<tr>
<td>Respiratory effort</td>
<td>Absent</td>
<td>Slow, irregular; weak cry</td>
<td>Strong cry</td>
</tr>
<tr>
<td>Heart beat</td>
<td>Absent</td>
<td>Less than 100</td>
<td>Over 100</td>
</tr>
<tr>
<td>Muscle tone</td>
<td>Limp</td>
<td>Some flexion of limbs</td>
<td>Active movement</td>
</tr>
<tr>
<td>Reflex response</td>
<td>Absent</td>
<td>Facial grimace</td>
<td>Crying</td>
</tr>
</tbody>
</table>

Henderson-Smart (1991: 576) notes that "More children with cerebral palsy had low Apgar scores, and children with low Apgar scores more often developed cerebral palsy. However this association is statistically rather than clinically important." Grant (1987: 107) notes that the 1960s American Collaborative Perinatal Project found that the 4% of babies with an Apgar score of less than 7 at five minutes contained 25% of subsequent cases of cerebral palsy (a relative risk of between 8 and 9). On the other hand, 98% of babies with an Apgar of less than 7 at five minutes did not develop...
cerebral palsy. Goodwin et al (1992: 1506) claim that even in cases where severe acidosis exists, "the Apgar score is not highly predictive of asphyxial complications... Our findings suggest that even in the pH range below 7.0 a 5-minute Apgar score ≤3 has only moderate predictive value for HIE." HIE (Hypoxic Ischaemic Encephalopathy) is discussed below.

Ruth and Raivio's study (1988) found that 81% of those babies defined as at risk because of a low Apgar score will be normal at follow up. Levene et al (1986: 68) conclude that "The failing of the Apgar score is that it describes the condition of the infant at a particular time; it may not reflect how long the infant suffered intrapartum asphyxia. In addition a low Apgar score may be due to sedation of the infant by drugs given to the mother."

**Blood analysis**

Samples of blood may be taken from the fetal scalp during labour, and also from the cord after delivery. Measuring the pH levels should identify an existing acidosis. Goodwin et al (1992: 1506) claim that population-derived statistical lower limits of normal umbilical artery pH range from 7.1 to 7.2, but go on to claim that "an umbilical artery pH below these levels is not highly correlated with Apgar score or with evidence of short and long term end-organ asphyxial sequelae."

Henderson-Smart (1991: 577) notes that "scalp pH values of less than 7.2 have been considered evidence of significant acidosis necessitating delivery, and levels of 7.2-7.25 as pre-acidosis indicating the need for continued close surveillance. However, although pH values correlate with altered adaptation immediately after delivery, they are not related to long term neurological outcome." The study by Dennis et al (1989: 213) found several babies with very low Apgar scores but no acidosis, and they speculate that "the ability of the fetus to produce an acidosis in response to the stress of labour may be beneficial to long term outcome...the absence of an acidotic shift may be a sign of a compromised fetus." However they note that many units aim to deliver babies with no acidosis, and in this pursuit, some now routinely assess the cord blood pH values and record these in the notes, even when there has been no clinical sign that fetal compromise has existed.

**Neonatal seizures**

Seizures may be one manifestation of a baby with cerebral dysfunction; they are a feature of hypoxic-ischaemic encephalopathy (HIE), but not its only feature. HIE describes the condition of a baby who has become hypoxic at some stage, and who has developed neurological signs which indicate short and/or long-lasting cerebral damage. HIE is usually described as being mild, moderate or severe, and one of its
most striking features is the presence of seizures. Others are irritability, diminished or absent reflexes, and hypotonia.

It has been claimed that seizures in the neonatal period are a much better means of predicting later neurological problems: Johnson (1991) claims that with these there is a 50 to 70-fold increase in the risk of cerebral palsy. Grant (1987: 108) notes that the Dublin trial of EFM found that the group who had continuous monitoring had less than half the rate of seizures as the group who were intermittently monitored. From this it may be concluded that more intensive monitoring could help to prevent seizures and so reduce the incidence of cerebral palsy, but this view is disputed. One author (Anon, 1989: 1252) claims that "while more intensive forms of fetal monitoring can prevent seizures, this protective effect does not appear to apply to babies whose seizures reflect aetiologies that are subsequently manifested in cerebral palsy. Seen another way, the seizures in some children with cerebral palsy were not manifestations of preventable intrapartum asphyxia", a point accepted by Grant in his paper. The cerebral palsy rates for the two groups in the Dublin trial were the same at four years of age.

Of HIE generally, Hull and Dod (1991: 953) [see Paneth] note that 40% of the babies they studied with this condition had normal deliveries, and 45% of these had no evidence of fetal distress or asphyxia at birth. Henderson-Smart (1991: 577) claims that 80% of babies with moderate HIE, and even 20% of those with severe HIE, develop normally.

**Prematurity**

While all the individual markers which may indicate that the fetus is, or has been, compromised have been shown to be poor predictors of later handicap, it has also been claimed that their presence in the preterm fetus or neonate is more significant (Low et al 1992: 60). This argument however is also complicated: while it is acknowledged that the ability of a preterm fetus to withstand the stresses of labour is less than that of a term fetus, it is debatable whether the onset of premature labour is itself an indication of a fetus who is already compromised. If this is the case, then it is self-evident that the preterm fetus will not fare as well.

Stanley and Blair (1991: 623) note that despite the huge increase in obstetric interventions seen in the last thirty years, the incidence of cerebral palsy has not fallen, but has in fact increased slightly: this rise, they claim, is "coincident with increases in the neonatal survival of low birthweight babies". This view is echoed by Paneth (1993: 95): "Premature delivery is the single most important antecedent of
cerebral palsy, and the increase in survival of very small infants resulting from newborn intensive care may augment this contribution in the future."

However, while the rate of cerebral palsy is much higher in those babies born prematurely, Mann (1986: 6) points out that two thirds of all babies with cerebral palsy are not in fact born prematurely, so while this variable is probably the most common single factor in the aetiology of cerebral palsy, it can help to explain less than half its occurrence.

Cerebral palsy, then, is a complex condition, and one whose aetiology is at best only partially understood, although aetiological studies have been attempted (Naeye et al 1989; Laisram et al 1992). Acheson (1991: 158) points out that cerebral palsy "results from damage to a brain while it is in the process of development"; this can be "as early as the first three months of pregnancy or as late as early infancy."

The assumed link between cerebral palsy and birth asphyxia is one which Nelson (1988: 572) challenges: to ask what proportion of cerebral palsy is related to birth asphyxia is, he says, just as pertinent as to ask "What proportion of mental retardation is caused by Down's syndrome?" The American Collaborative Perinatal Project found 21% of children with cerebral palsy had at least one marker of serious intrapartum asphyxia, but a third of these also had a major non-central nervous system malfunction. It found that more than half the children with cerebral palsy and a marker of serious asphyxia also had an indication that the cerebral palsy may have stemmed from pre-labour problems. This issue has been crucial in recent court cases.

Blair and Stanley (1988: 516) found that there was an association between the clinically observed signs of birth asphyxia and spastic cerebral palsy: they concluded that in only 8% of children with spastic cerebral palsy was intrapartum asphyxia a possible cause.

<table>
<thead>
<tr>
<th>Table B.2: Relationship of intrapartum asphyxia to cerebral palsy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definitely not - 85.2%; Most unlikely - 6.6%; Possible - 3.3%; Definitely - 4.9%</td>
</tr>
</tbody>
</table>

There is now, they claim, a questioning of the 'conventional wisdom' that cerebral palsy and birth asphyxia are linked (Stanley [1994] later notes that courts may be catching up with this belief); they admit there is a weak association, but claim a stronger one between cerebral palsy and 'adverse ante-natal events'. For instance, low birth weight is a major confounding factor, since it is associated with both
cerebral palsy and birth asphyxia; Acheson (1991: 163) notes that as well as prenatal factors, babies of very low birth weight (less than 1500g) are prone to brain damage due to low blood pressure in the first few days of life. Blair and Stanley (1988: 519) claim there is no absolute link either way between birth asphyxia and abnormal neonatal neurological signs: severe asphyxia may not lead to seizures, and seizures may occur when there has been no severe asphyxia. They further claim that since the research suggests that few children with cerebral palsy are damaged during birth, efforts to reduce further the incidence or likelihood of birth asphyxia may have little effect on the incidence of cerebral palsy. Asphyxia, they say, may be an early sign of cerebral palsy, “the effect of ante-natal brain anomaly rather than a cause” (ibid).

Freeman and Nelson (1988: 240) state that “to attribute cerebral palsy to prior asphyxia with reasonable certainty, there must be evidence that a substantial hypoxic injury occurred and that a sequence of events ensued which would prove the clinical impact of that hypoxic insult. Few cases of cerebral palsy meet these criteria.” The assumption seems to have been that if evidence of fetal distress could be proved, then that would indicate a cause of an ensuing cerebral palsy; one such sign of fetal distress is the staining of the amniotic fluid with meconium, which is observable once the membranes have ruptured. They claim from their study that 99.6% of infants whose birth weight was above 2500g and who had shown meconium staining of the liquor during labour did not go on to develop cerebral palsy. Paneth (1993: 96) estimates that meconium passage occurs in 20% of labours, yet the incidence of cerebral palsy is 0.2 - 0.25%.

The weight of recent evidence, then, is heavily against an automatic link between cerebral palsy and birth asphyxia.

Il lingworth (1985: 123) notes that a common feature associated with cerebral palsy is relative infertility of the parents, and that a third of cerebral palsy infants were of low birth weight (less than 2500g). He says: “The high incidence of congenital anomalies found in children with mental subnormality or cerebral palsy is a strong indication of a prenatal origin for many so-called ‘brain damaged’ children,” and notes studies which have suggested that an underlying brain defect predisposes to perinatal problems, especially hypoxia. He states: “It is simplistic to ascribe ‘brain damage’ to single factors, such as breech delivery, or hypoxia at birth, without considering the antecedent causes of those factors,” and in a later article (Il lingworth 1987: 15) goes on to say “An implicit pointer to possible prenatal factors in cerebral palsy, rather than perinatal ones, is...that despite sophisticated intensive care and fetal monitoring in the last decade or two, and a considerable increase in caesarean sections, the
incidence of cerebral palsy has remained steady or has increased, in contrast to the striking reduction in perinatal and infant mortality."

Towbin (1986: 932), a pathologist, highlights the role played by “latent prenatal sub-acute lesions...(caused by) maternal complications during pregnancy.” He claims that the baby with acute cerebral damage stays depressed for a long time, even weeks; the baby with old cerebral lesions is delivered depressed but “usually responds to attention in the delivery room and is soon alert and active with spontaneous respirations.”

The relationship between cerebral palsy and intrapartum events is a problematic one; this lack of evidence of causation leads to difficulties in establishing the causal link necessary to prove negligence in law.
Appendix C: Midwifery questionnaire

ID

Perinatal Litigation Questionnaire

All responses will be treated in strict confidence

What is your grade? _____ How many hours a week do you normally work? _____

For how long have you been practising? _____ Years _____ Months (if applicable)

How many deliveries are there in your unit each year? _____

How many deliveries do you undertake each year (on average)? _____

Where do you normally work?
(tick one box)

Consultant unit .. ☐
Community .. ☐
Midwife-run unit .. ☐
Independent practice .. ☐
GP Unit .. ☐
Other (state) .. ☐

In which area do you normally work?
(tick one box)

Ante natal .. ☐
Post natal .. ☐
Clinics .. ☐
Labour Ward .. ☐
Community .. ☐
Neonatal unit .. ☐
Team (most or all of these) .. ☐
Float (eg 'Bank') .. ☐
Education .. ☐
Other (state) .. ☐

Litigation generally

1 Do you feel that there has been a rise in litigation in obstetrics / midwifery in the last 10 years? Yes .. ☐

• If you think there has been a rise in its incidence, what in your opinion has it been caused by? (please state) __________________________

Appendix C: i
2. Have you discussed with your colleagues at work the possibility of being sued?  
- Often  
- Once or twice  
- Never  

3. Do you know of any colleagues who have been involved in a legal case relating to alleged negligence?  
- Yes  
- No  
- If yes, was it  
  - a midwifery colleague  
  - a medical colleague  
  - yourself  
  - another (state)  

4. Do you agree with the view that the number of medical accidents has risen sharply over the last 10-15 years?  
- Strongly agree  
- Agree  
- Neither agree nor disagree  
- Disagree  
- Strongly disagree  

5. Have you changed your clinical practice at all as a result of the fear of possible litigation in the last five years?  
- Yes  
- No  
- If so, in what way(s)?  

6. Do you think that clinical practice is becoming “defensive”?  
- Yes  
- No  
- Don't know  
- If so, in what way(s)?  

"Defensive" practice is said to occur when practitioners carry out investigations or tests, or intervene sooner than they would otherwise, as a result of the fear of being sued.

7. Have you ever known anyone to leave (or consider leaving) midwifery because of litigation or the fear of litigation?  
- Yes - myself  
- Yes - someone else  
- No  
- Don't know  

Appendix C: ii
8 Do you agree with the view that litigation and the fear of it is starting to poison interprofessional relationships in the delivery room?

- If yes, was litigation

<table>
<thead>
<tr>
<th>The sole reason</th>
<th>One reason among others</th>
</tr>
</thead>
</table>

- If so, why?

- If not, why not?

9a) For midwives not working in a midwife-run unit:

Would you happily work in a midwife-run unit, taking full responsibility (in conjunction with your team colleagues) for a woman’s care?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

- If so, why?

- If not, why not?

9b) For midwives already working in a midwife-run unit:

Are you completely comfortable with the increased level of responsibility/accountability your job entails?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

Other (please state)
## Pregnancy / At risk

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Do you believe that women who have an adverse outcome to their pregnancy at term can be identified well before term?</td>
<td>Yes - always, Yes - usually, Rarely, Never, Don't know</td>
<td>□</td>
</tr>
<tr>
<td>11 Is the prenatal diagnosis of &quot;at risk&quot; sufficient?</td>
<td>Yes, No, Don't know</td>
<td>□</td>
</tr>
<tr>
<td>12 Have you ever had a woman refuse a procedure which was routine hospital policy?</td>
<td>Yes, No, Don't know</td>
<td>□</td>
</tr>
<tr>
<td>• If yes, which one(s)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13 Is it the case that routine hospital treatments are given often in opposition to the stated views of patients?</td>
<td>Yes, No, Don't know</td>
<td>□</td>
</tr>
<tr>
<td>14 Do you agree with the view that women may be putting their babies at risk by refusing routine interventions?</td>
<td>Agree strongly, Agree, Neither agree nor disagree, Disagree, Disagree strongly</td>
<td>□</td>
</tr>
<tr>
<td>15 Do you agree that invasive obstetric technology is at a too high level: - in your unit?</td>
<td>Yes, No, Don't know</td>
<td>□</td>
</tr>
<tr>
<td>- in Britain as a whole?</td>
<td>Yes, No, Don't know</td>
<td>□</td>
</tr>
<tr>
<td>• If so, can you give some examples?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 Do you feel that antenatal ultrasound is completely safe?</td>
<td>Yes, No, Don't know</td>
<td>□</td>
</tr>
</tbody>
</table>

Appendix C: iv
17 In an uncomplicated first pregnancy, what in your opinion should be the number of routine antenatal ultrasound scans? (please state)

<table>
<thead>
<tr>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Don't know</td>
</tr>
</tbody>
</table>

18 Do you agree with the view that obstetric medicine has given the impression that it can ensure more than it actually can?

- If so, has the image of midwives been damaged by this?

<table>
<thead>
<tr>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Don't know</td>
</tr>
</tbody>
</table>

The labour period

19 Is supervision in your unit inadequate

- i) of patients/clients? Frequently

- ii) of junior staff? Frequently

20 In your unit, do you believe that women are often left completely alone for long periods during labour?

<table>
<thead>
<tr>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequently</td>
</tr>
<tr>
<td>Occasionally</td>
</tr>
<tr>
<td>Very rarely</td>
</tr>
<tr>
<td>Never</td>
</tr>
</tbody>
</table>

21 What do you feel about CTG monitoring in your unit?

<table>
<thead>
<tr>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overused</td>
</tr>
<tr>
<td>Underused</td>
</tr>
<tr>
<td>About right</td>
</tr>
<tr>
<td>Not applicable</td>
</tr>
</tbody>
</table>

22 What do you feel about Fetal Blood Sampling in your unit?

<table>
<thead>
<tr>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overused</td>
</tr>
<tr>
<td>Underused</td>
</tr>
<tr>
<td>About right</td>
</tr>
<tr>
<td>Not applicable</td>
</tr>
</tbody>
</table>

23 In general, it is desirable to have a woman continuously monitored in labour?

<table>
<thead>
<tr>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td>Don't know</td>
</tr>
</tbody>
</table>

Appendix C: v
24 Do you believe that Electronic Fetal Monitoring is completely safe (i.e. has no adverse sequelae)?
   - Yes
   - No
   - Don't know

25 How would you rate the probability that you could accurately assess fetal distress in an intrapartum CTG?
   - 50%
   - 55%
   - 60%
   - 65%
   - 70%
   - 75%
   - 80%
   - 85%
   - 90%
   - 95%
   - 100%

26 What level of training have you had in CTG interpretation?
   - While training
   - Since qualifying

27 Do you believe that hospital birth is usually safer than home birth?
   - Yes
   - No
   - Don't know

28 Is it the case that midwives in your unit are given full responsibility when managing the labour of a woman deemed to be low risk?
   - Yes - always
   - Yes - usually
   - Yes - occasionally
   - Rarely
   - Never

29 If a woman indicated that she did not have want to have electronic fetal monitoring during her labour, are there any circumstances in which you would insist?
   - Yes
   - No
   - Don't know

Appendix C: vi
30 If a woman indicated that she did not want an episiotomy, are there any circumstances in which you would perform one?  
- If so, what are these? 

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

31 What would you estimate to be the episiotomy rate 
   i) - for the women you personally deliver?  
   ii) - in your unit?  

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>i)</td>
<td></td>
</tr>
<tr>
<td>ii</td>
<td></td>
</tr>
</tbody>
</table>

(NB: ii will include forceps and vaginal breech deliveries)

32 Do you believe that episiotomy may assist in the prevention of pelvic floor prolapse in later years?  

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

33 'Brain damage' is a commonly cited reason for litigation; very often this is used synonymously with 'cerebral palsy'. What percentage of cases of cerebral palsy would you estimate is caused by birth asphyxia / trauma?  

<p>| | |</p>
<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
</table>

34 Are midwives consistent when giving an Apgar score?  

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

35 Do midwives score the same as paediatricians when giving an Apgar score?  

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

36 Do you print your name when making entries in the case notes / kardex?  

<table>
<thead>
<tr>
<th></th>
<th>Yes - always</th>
<th>Yes - sometimes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>a)</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
## Communication / Counselling / Consumer groups

### 7. Do you agree with the statement that "no pregnancy or birth is normal except in retrospect"?

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

### 8. Do you believe there is co-operation between providers of maternity services in your area and user groups / consumer groups?

<table>
<thead>
<tr>
<th>Yes - often</th>
<th>Yes - occasionally</th>
<th>Rarely</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 9. Is consumer group (not commercial interest) literature allowed into the maternity unit in which you work?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*If so, can you name any groups which are allowed to publicise themselves in your unit?*

---

It has been claimed that parents have frequently complained about the attitudes of staff. Has this ever happened:

a) in relation to you personally?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

b) in relation to anyone you have worked with?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

Do you agree with the statement that "women have lost their trust in the medical and midwifery professions"?

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you feel that in the last 10 years there has been a breakdown of trust between providers and patients/clients?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Appendix C: viii
<table>
<thead>
<tr>
<th>Question</th>
<th>Response Options</th>
<th>Ticks</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you rate communication and rapport between client / patient</td>
<td>Very good</td>
<td>☐</td>
</tr>
<tr>
<td>and practitioner (midwives and doctors) in your unit?</td>
<td>Good</td>
<td>☐</td>
</tr>
<tr>
<td>i) - generally</td>
<td>Fair</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Terrible</td>
<td>☐</td>
</tr>
<tr>
<td>ii) - when something has gone wrong</td>
<td>Very good</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Fair</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Terrible</td>
<td>☐</td>
</tr>
<tr>
<td>How would you rate communication and rapport between midwives and</td>
<td>Very good</td>
<td>☐</td>
</tr>
<tr>
<td>doctors in your unit?</td>
<td>Good</td>
<td>☐</td>
</tr>
<tr>
<td>i) - generally</td>
<td>Fair</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Terrible</td>
<td>☐</td>
</tr>
<tr>
<td>ii) - when something has gone wrong</td>
<td>Very good</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Good</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Fair</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Poor</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Terrible</td>
<td>☐</td>
</tr>
<tr>
<td>Are there any formal procedures in your unit for counselling a patient</td>
<td>Yes</td>
<td>☐</td>
</tr>
<tr>
<td>/ client when there is an adverse outcome to a pregnancy or labour?</td>
<td>No</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Don't know</td>
<td>☐</td>
</tr>
<tr>
<td>How many times in the last five years have you attended clinical update</td>
<td>Never</td>
<td>☐</td>
</tr>
<tr>
<td>courses apart from statutory refresher courses?</td>
<td>Once or twice</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Three to five times</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>More than five times</td>
<td>☐</td>
</tr>
</tbody>
</table>

A very small selection of respondents will be contacted at a later stage to arrange a follow up interview. If you do not wish to be contacted, tick this box ☐.

Please use the final page if you wish to add any further comments about this subject.
Thank you for your time and effort in completing this questionnaire.

Please feel free to make any comments you wish about any aspects of litigation and/or its effects on obstetric/midwifery practice.

No individual will be identified or identifiable in any report based on this survey.

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Appendix C: x
Appendix D: Obstetricians' questionnaire

Perinatal Litigation Questionnaire

ALL RESPONSES WILL BE TREATED IN STRICT CONFIDENCE

What is your grade?

- Consultant
- Senior Registrar
- Staff Grade
- Registrar
- Senior House Officer
- Other (state)

If you are recently retired, please indicate, and specify the last post you held. Where appropriate, please answer the questionnaire as if you were still in that post.

How many hours a week do you normally work? _____

For how long have you been practising? _____ Years _____ Months (if applicable)

How many deliveries are there in your unit each year (on average)? ______

How many deliveries do you personally conduct each year (on average)? ______

Could you give an approximate estimate of the number of the following types of delivery which you personally conduct each year?

- Caesarean Section
- Forceps
- Ventouse
- S.V.D.
- Vaginal Breech

Litigation generally

1. Do you feel that there has been a rise in litigation in obstetrics / midwifery in the last 10 years? Yes No Don't know

• If so, what in your opinion has it been caused by? (please state)

2. Have you discussed personal involvement in litigation with colleagues at work? Often Once or twice Never
• Have you discussed with colleagues the possibility of being sued?
  
  Often .. .. .. □
  Once or twice .. .. □
  Never .. .. .. □

I would stress again that all responses will be treated in strict confidence.

3 How many times in the last fifteen years have you been personally involved in perinatal litigation concerning alleged negligence?
  Never .. .. .. □
  Once or twice .. .. □
  3 to 5 times .. .. □
  6 to 10 times .. .. □
  More than 10 times .. .. □

4 How many times in the last five years have you acted as an expert witness in obstetric litigation?
  Never .. .. .. □
  Once or twice .. .. □
  3 to 5 times .. .. □
  6 to 10 times .. .. □
  More than 10 times .. .. □

5 Have you changed your clinical practice at all as a result of the fear of possible litigation in the last five years?
  Yes .. .. .. □
  No .. .. .. □

  • If so, in what way(s)?

6 Do you agree with the view that the number of medical accidents has risen sharply over the last 10-15 years?
  Strongly agree .. .. □
  Agree .. .. .. □
  Neither agree nor disagree .. .. □
  Disagree .. .. .. □
  Strongly disagree .. .. □

7 Do you believe that financial pressures in the NHS may affect clinical practice to the extent that it becomes less safe?
  Yes .. .. .. □
  No .. .. .. □
  Don't know .. .. □

"Defensive" practice is said to occur when practitioners carry out investigations or tests, or intervene sooner than they would otherwise, as a result of the fear of being sued.

8 Do you think that obstetric clinical practice generally is becoming "defensive"?
  Yes .. .. .. □
  No .. .. .. □
  Don't know .. .. □

  • If so, in what way(s)?

Appendix D: ii
9 | Have you ever known anyone to leave or retire from obstetrics because of litigation? (tick all which apply) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes - myself</td>
<td>❑</td>
</tr>
<tr>
<td>Yes - someone else</td>
<td>❑</td>
</tr>
<tr>
<td>No</td>
<td>❑</td>
</tr>
<tr>
<td>Don't know</td>
<td>❑</td>
</tr>
</tbody>
</table>

| Have you known any one to consider leaving or retiring because of litigation or the fear of litigation? (tick all which apply) |
|---|---|
| Yes - myself |  ❑ |
| Yes - someone else |  ❑ |
| No |  ❑ |
| Don't know |  ❑ |

10 | Do you agree with the view that litigation and the fear of it is starting to "poison interprofessional relationships in the delivery room"? (Acheson, 1990) |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Agree strongly</td>
<td>❑</td>
</tr>
<tr>
<td>Agree</td>
<td>❑</td>
</tr>
<tr>
<td>Neither agree nor disagree</td>
<td>❑</td>
</tr>
<tr>
<td>Disagree</td>
<td>❑</td>
</tr>
<tr>
<td>Strongly disagree</td>
<td>❑</td>
</tr>
</tbody>
</table>

11 | Would you prefer obstetrics to be covered by a no-fault scheme for compensation? |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>❑</td>
</tr>
<tr>
<td>No</td>
<td>❑</td>
</tr>
<tr>
<td>Don't know</td>
<td>❑</td>
</tr>
</tbody>
</table>

12a) For Consultant grade staff only:

| Do you feel in general that you can rely on your junior colleagues to deal with potential or actual problems in the Labour Ward? |
|---|---|
| Yes - always |  ❑ |
| Yes - usually |  ❑ |
| Some of the time |  ❑ |
| Rarely |  ❑ |
| Hardly ever |  ❑ |

12b) For all grades below Consultant:

| Do you feel in general that you can rely on your consultant to provide adequate support in order to deal with potential or actual problems in the Labour Ward? |
|---|---|
| Yes - always |  ❑ |
| Yes - usually |  ❑ |
| Some of the time |  ❑ |
| Rarely |  ❑ |
| Hardly ever |  ❑ |

13a) Do you feel there should always be a consultant presence on the Labour Ward? |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>❑</td>
</tr>
<tr>
<td>No</td>
<td>❑</td>
</tr>
<tr>
<td>Don't know</td>
<td>❑</td>
</tr>
</tbody>
</table>

13b) Do you feel that agreed policies in your unit would help to minimise the risk of clinical mistakes or actual negligence? |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>❑</td>
</tr>
<tr>
<td>No</td>
<td>❑</td>
</tr>
<tr>
<td>Don't know</td>
<td>❑</td>
</tr>
</tbody>
</table>
## Pregnancy / At risk

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you believe that women who have an adverse outcome to their pregnancy at term can be identified well before term?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the prenatal diagnosis of &quot;at risk&quot; sufficient?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever had a woman refuse a procedure which was standard policy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If yes, which one(s)?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is it the case that routine (i.e. standard) hospital treatments are given often in opposition to the stated views of patients?</td>
<td>Yes</td>
<td>No</td>
<td>Don't know</td>
<td></td>
</tr>
<tr>
<td>Do you agree with the view that women may be putting their babies at risk by refusing routine interventions?</td>
<td>Agree strongly</td>
<td>Agree</td>
<td>Neither agree nor disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>Do you agree that invasive obstetric technology is at a too high level:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- in your unit?</td>
<td>Yes</td>
<td>No</td>
<td>Don't know</td>
<td></td>
</tr>
<tr>
<td>- in Britain as a whole?</td>
<td>Yes</td>
<td>No</td>
<td>Don't know</td>
<td></td>
</tr>
<tr>
<td>If so, can you give some examples?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you agree with the view that obstetric medicine has given the impression that it can ensure more than it actually can?</td>
<td>Yes</td>
<td>No</td>
<td>Don't know</td>
<td></td>
</tr>
</tbody>
</table>
If so, has the image of obstetricians been damaged by this?
- Yes
- No
- Don't know

Again if so, has the image of midwives been similarly damaged?
- Yes
- No
- Don't know

**The labour period**

21 Is supervision in your unit *inadequate*
- i) of patients/clients?
  - Frequently
  - Occasionally
  - Very rarely
  - Never

- ii) of junior staff?
  - (obstetricians and / or midwives)
  - Frequently
  - Occasionally
  - Very rarely
  - Never

22 In your unit, do you believe that women are often left completely alone for long periods during labour?
- Frequently
- Occasionally
- Very rarely
- Never

23 What do you feel about CTG monitoring in your unit?
- Overused
- Underused
- About right

24 What do you feel about Fetal Blood Sampling in your unit?
- Overused
- Underused
- About right

25 In general, it is desirable to have a woman continuously monitored in labour?
- Yes
- No
- Don't know

• Any comments? ____________________________

Appendix D: v
26 Do you believe that Electronic Fetal Monitoring is completely safe?  
Yes ..., No ..., Don't know ...

27 How would you rate the probability that you could accurately assess fetal distress in an intrapartum CTG?  
50% ..., 55% ..., 60% ..., 65% ..., 70% ..., 75% ..., 80% ..., 85% ..., 90% ..., 95% ..., 100% ...

28a) Do you feel that there is sufficient training of junior obstetric staff in CTG interpretation?  
Yes, sufficient ..., No, insufficient ..., Don't know ...

28b) Do you feel that there is sufficient training of midwifery staff in CTG interpretation?  
Yes, sufficient ..., No, insufficient ..., Don't know ...

29 Do you believe that hospital birth is usually safer than home birth?  
Yes ..., No ..., Don't know ...

• If yes, what are some of the dangers of home birth which a hospital birth should avoid?  

• If not, what are some of the dangers of hospital birth which a home birth would not have?  

30 Is it the case that midwives in your unit are given full responsibility when managing the labour of a woman deemed to be low risk?  
Yes - always ..., Yes - usually ..., Yes - occasionally ..., Rarely ..., Never ...

31 If a woman indicated that she did not have want to have electronic fetal monitoring during her labour, are there any circumstances in which you would insist?  
Yes ..., No ..., Don't know ...

• If so, what are these?
'Brain damage' is a commonly cited reason for litigation; very often this is used synonymously with 'cerebral palsy'. What percentage of cases of cerebral palsy would you estimate is caused by birth asphyxia / trauma? ____% 

33 Do you print your name when making entries in the case notes? 
Yes - always ... ... □
Yes - sometimes ... ... □
No ... ... ... □ 

Communication / Counselling / Consumer groups

34 Do you agree with the statement that "no pregnancy or birth is normal except in retrospect"? 
Strongly agree ... ... □
Agree ... ... ... □
Neither agree nor disagree □
Disagree ... ... □
Strongly disagree □

35 Is consumer group literature allowed into the maternity unit in which you work? 
Yes ... ... ... □
No ... ... ... □
Don't know ... ... □

* If so, can you name any groups which are allowed to publicise themselves in your unit? 

Again, I must stress that all replies in this study will be anonymised in any report 

36 It has been claimed that parents have frequently complained about the attitudes of staff. Has this ever happened: 
No ... ... ... □
Yes ... ... ... □

a) in relation to you personally? 

b) in relation to anyone you have worked with? 

No ... ... ... □
Yes ... ... ... □
Don't know ... ... □

37 Do you agree with the statement that "women have lost their trust in the medical and midwifery professions"? 
Strongly agree ... ... □
Agree ... ... ... □
Neither agree nor disagree □
Disagree ... ... □
Strongly disagree □
38 How would you rate communication and rapport between client / patient and practitioner (doctors and midwives) in your unit?

i) - generally
- Very good
- Good
- Fair
- Poor
- Terrible

ii) - when something has gone wrong
- Very good
- Good
- Fair
- Poor
- Terrible

39 How would you rate communication and rapport between doctors and midwives in your unit?

i) - generally
- Very good
- Good
- Fair
- Poor
- Terrible

ii) - when something has gone wrong
- Very good
- Good
- Fair
- Poor
- Terrible

40 Are there any formal procedures in your unit for counselling a patient / client when there is an adverse outcome to a pregnancy or labour?

- Yes
- No
- Don't know

A very small selection of respondents will be contacted at a later stage to arrange a follow up interview. If you do not wish to be contacted, tick this box.

Thank you for your time and effort in completing this questionnaire. An analysis will be sent in due course to all respondents.

Reference
Acheson D (former Chief Medical Officer) (1991) Are obstetrics and midwifery doomed? Midwives Chronicle 104; No. 1,241, June
Appendix E
Characteristics of the respondents

Characteristics of midwifery respondents
Each midwife was asked for her grade, length of experience, number of deliveries carried out on average each year, and place of work. These are shown in Tables E.1a-1d. Not all figures add up to the total number of returned questionnaires because many respondents left certain parts of the form blank. This also applies to all of the questions. This information allowed responses to be analysed (using cross tabulation in Microsoft Excel) by grade, size of unit in which practising, length of experience, and, where appropriate, by area of work.

It is not possible to draw a rural/urban distinction based on a respondent's stated size of unit, or area of work: some Community staff belonging to principally or wholly urban RCM branches cited the delivery rate of their local consultant unit, while others estimated what was presumably the delivery rate for Community staff in their area. Most RCM branches also have both rural and urban based members, and so branch membership alone cannot be used to draw this distinction; the situation is made more complicated because some respondents based in midwife-run units (MRUs) gave the annual delivery rate for the MRU (always less than a thousand), while others gave the delivery rate for the attached consultant unit.

The numbers of respondents in each of these categories is shown here.

<table>
<thead>
<tr>
<th>Tables E.1a - 1d: Characteristics of midwifery respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grade</td>
</tr>
<tr>
<td>-------</td>
</tr>
<tr>
<td>D</td>
</tr>
<tr>
<td>E</td>
</tr>
<tr>
<td>F</td>
</tr>
<tr>
<td>G</td>
</tr>
<tr>
<td>H</td>
</tr>
<tr>
<td>I</td>
</tr>
<tr>
<td>Manager</td>
</tr>
<tr>
<td>Independent</td>
</tr>
<tr>
<td>Lecturer</td>
</tr>
<tr>
<td>Unspecified</td>
</tr>
</tbody>
</table>
For ease of reading in this discussion the length of experience categories are 'rounded up': the 3-5.9 years group is referred to as the 3-6 years group, the 6-8.9 group as the 6-9 group, etc.

Length of experience of respondents working in different areas and in different sized units was analysed to note any variation which might influence answers. In fact there were some significant differences found, as the following Table shows:

Table E.2: Length of experience (in years): by size of unit and area of work

<table>
<thead>
<tr>
<th>Size of Unit</th>
<th>mean</th>
<th>SD</th>
<th>Area of Work</th>
<th>mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 100</td>
<td>14.12</td>
<td>8.27</td>
<td>Antenatal / Postnatal</td>
<td>10.89</td>
<td>8.18</td>
</tr>
<tr>
<td>100-999</td>
<td>13.94</td>
<td>8.58</td>
<td>/ Clinics</td>
<td>14.52</td>
<td>7.79</td>
</tr>
<tr>
<td>1000-1999</td>
<td>12.38</td>
<td>7.79</td>
<td>Community</td>
<td>10.83</td>
<td>7.55</td>
</tr>
<tr>
<td>2000-2999</td>
<td>10.97</td>
<td>7.89</td>
<td>Labour Ward</td>
<td>11.38</td>
<td>7.27</td>
</tr>
<tr>
<td>3000-3999</td>
<td>9.66</td>
<td>7.25</td>
<td>Neonatal Unit</td>
<td>9.24</td>
<td>7.42</td>
</tr>
<tr>
<td>4000-4999</td>
<td>11.26</td>
<td>7.35</td>
<td>Team / Rotation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5000 or more</td>
<td>10.03</td>
<td>7.61</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

It can be seen that the mean length of experience differs especially between the smallest units (less than 100 deliveries a year) and those with 3000-3999 deliveries a year, and between those working on the Community and those in Team / Rotation schemes. However F-tests using Microsoft Excel showed the variance to be statistically significant between those working in units of 100-999 deliveries a year and those in units of 3000-3999 ($F=0.033$); it will be seen that the standard deviation (and therefore the variance) is greater in these units than in the smallest units.

Analysis of variance (Anova) tests (also using Microsoft Excel) showed both Tables to be statistically significant, indicating that the populations of each sub-group are not identical, when analysed by length of experience at least. This should be borne in mind when responses by area of work and size of unit are shown in this report, since length of experience can be a confounding variable.
Characteristics of obstetric respondents

211 obstetricians responded; 21 from the three English hospitals, 190 from Scotland.

Table E.3 Grade of obstetric respondents

<table>
<thead>
<tr>
<th>Grade</th>
<th>England</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant</td>
<td>10</td>
<td>82</td>
</tr>
<tr>
<td>Senior Registrar</td>
<td>3</td>
<td>24</td>
</tr>
<tr>
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<td>9</td>
</tr>
<tr>
<td>Research etc.</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>GP</td>
<td>-</td>
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</table>

The GPs were based in three towns in mainland Scotland away from the central belt, and in three towns on the Scottish islands. The SHOs were those who were identified either by the RCOG or their respective hospitals as being 'career obstetricians' - i.e. were not GP trainees. 21 respondents came from the three English hospitals.

Comparisons between the various sub-groups was carried out using Anova in Microsoft Excel and Chi-square tests. Given the relatively small sizes of these sub-groups, only one statistically significant difference in their background data was found in their characteristics.

English staff claimed on average to work 55 hours a week; Scottish hospital staff 61 hours (p>0.1); Scottish GPs claimed to work 63 hours a week. Comparing all staff in the English and Scottish consultant units, there is no significant difference in length of experience, the averages being 11.5 and 14 years respectively (p>0.1). For the 10 English and 81 Scottish consultants, there is no significant difference in their length of experience (18 and 21.5 years respectively; p>0.1). The English staff claimed on average to deliver 119 babies a year, compared with 97 for Scottish consultant unit staff (p>0.1). The Scottish GPs gave estimated personal delivery rates of between 0 and 50, with an average of 15.

The English staff came from three units with estimated annual delivery rates of about 1400, 3100 and 6400 (average for English respondents 4230); the Scottish hospital-based staff (with the exception of a small DGH with a delivery rate of 450) came from units with estimated rates of between 1200 and 5600 (average for Scottish respondents 3328). This produced the one statistically significant result (p<.05), which may be notable in terms of a respondent's likelihood of becoming involved - however peripherally - in litigation, if it is taken that a larger unit is more likely to attract legal complaints (this association, however, was not borne out by the data presented in Chapter 4). This does not of course mean that an individual is necessarily more likely to
be involved personally, only that the unit in which they work may be more likely to be the target of a complaint.
Appendix F
Midwifery questionnaire:
Scottish-English sub-sample

231 respondents comprised the English sample, but in 24 of these cases background data was partially missing and so matching could not be done. Of the remaining 207, exact matches in terms of grade, length of experience, size of unit and area of work was possible in 139 cases (65% of the total sample); further matches were made possible by allowing some leeway in terms of grade, since it was evident that certain differences were present in the two respective samples, as shown below.

It appears that grading structures have not been identical within the two countries: while for the E grades there was little difference, for F and G grades length of experience was significantly shorter in England (calculation by Anova):

Table F.1: Comparison of length of experience of different grades

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<th>Scotland</th>
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<tr>
<td></td>
<td>mean (years)</td>
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<td>8.87</td>
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<td>G grades</td>
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<td>13.07</td>
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<tr>
<td></td>
<td>n= 438</td>
<td>n= 90</td>
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Given these differences, a difference of one grade (e.g. F to G) was allowed in seeking a match for an English respondent when an exact match was not possible. Similarly, some difference in terms of length of experience was allowed: for between 5 and 10 years, a difference of up to three years was allowed (e.g. 5 compared with 8); for 10 to 15 years a difference of up to 4 years; and above 15 years a difference of up to 6 years.

This meant that pairing was possible in 172 cases in all, 74.5% of the total English sample, or for 83% of those who provided the necessary background data.
Appendix G

Perinatal cases by hospital for four time periods

The four time periods, as in the thesis, are 1980-83; 1984-87; 1988-91; 1992-95. Decisions of closed cases are given.

Table G.1  Perinatal cases (decisions of closed cases) by hospital 1980-83

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<td>Non-CNS</td>
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Table G.4  Perinatal cases (decisions of closed cases) by hospital 1992-95

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Appendix G: iv
Appendix H

Correlation between size of unit and litigation rate by
Scottish health board / English area

These four figures indicate the lack of correlation between an increasing unit size and an increase in the rate of litigation: i.e. the larger units, despite attracting more deliveries and more high risk cases, do not have a higher rate of being sued than smaller units. If increasing unit size were positively correlated with the litigation rate, the increase in 'Dels (4 years)' line would be matched by a corresponding decrease in the 'Dels per case' line.

Figure H.1

Correlation between number of deliveries and 'deliveries per legal file': 1980-83

Figure H.2

Correlation between number of deliveries and 'deliveries per legal file': 1984-87
Figure H.3

Correlation between number of deliveries and 'deliveries per legal file': 1988-91

Figure H.4

Correlation between number of deliveries and 'deliveries per legal file': 1992-95

Appendix H: ii
Appendix I

Success rates for CNS and non-CNS cases

The following table shows the success rates of, respectively, CNS and non-CNS cases by year action initiated.

Table I.1  Success rates for CNS and non-CNS cases by year 1980-95

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Appendix J:
Further details on the perinatal cases illustrated in Figure 5.1

The intention here is to illustrate what sort of case is included under the heads of claim shown in Figure 5.1, and explain briefly the reason for going to litigation. It will be seen that while all of these cases are perinatal, not all of them are obstetric; while obstetricians might breathe a sigh of relief at being excluded from some of these legal actions, midwives (and, increasingly, nurses) involved in neonatal care, particularly of the premature baby, are still very much involved. Anaesthetists are not exempt either, as will be seen. The existence of several specialties makes this area somewhat complicated, and less amenable to focused targeted improvements.

Baby cases

Stillbirth / intrauterine death (IUD)
Pursuers argue that more surveillance would have recognised a compromised fetus, or that signs of compromise were not acted upon. One case which was settled by the defenders concerned a woman who had had two previous premature stillbirths, both due to placental abruption. Despite being hospitalised for much of her pregnancy, and an abruption being diagnosed quickly, another stillbirth occurred. With hindsight it was felt that elective caesarean section ought to have been carried out as soon as the fetal lungs were thought to be mature, at around 36 weeks (i.e. when neonatal respiratory distress was unlikely); as it was induction at 38 weeks was planned, but the abruption occurred before this.

Examples of unsuccessful actions often relate to completely unexplained IUDs, when a woman presents with a history of feeling no fetal movements for some time. Delivery of a macerated stillborn baby indicates that the death has occurred at least one or two days earlier, and so no blame for the death can be apportioned to staff.

Non-CNS birth injury
Successful actions under this head of claim include fractures to a baby’s arm during a breech delivery, and brachial plexus injury in an apparently normal delivery; that the defenders concede indicates an acceptance that excessive force has been used. This head of claim has a relatively low success rate, however: either the injury is thought to be a recognised and frequently unavoidable occurrence, such as Erb’s palsy following shoulder dystocia, or the claimed injury is in fact a congenital condition; an example of this is cutis aplasia, a patchy hairless area on the baby’s head which the pursuer alleges is due to forceps blades or fetal scalp electrode.
CNS damage

This was the most common head of claim, and the circumstances surrounding this type of claim have been discussed fully in Chapter 5. The allegation is made that a child's cerebral condition (and here 'brain damage' and 'cerebral palsy' are to all intents and purposes interchangeable) is due to staff negligence, either in failing to detect signs of fetal compromise, or in failing to act on such signs. From the discussions on cerebral palsy in Chapter 2 and Appendix B it will be remembered that there is a poorly understood but complex aetiology to cerebral palsy.

Even where the brain damage is thought to have originated in the labour period, negligence is not an automatic assumption: in one case a student midwife delivers the baby's head, then finds the cord tightly around the baby's neck; the cord is clamped and cut, and then shoulder dystocia is diagnosed, and there is a delay in delivering the baby's body. The baby shows signs of neurological damage at 36 hours of age, and subsequently develops cerebral palsy. This case was unsuccessful because it was held that the staff acted appropriately in the circumstances: nothing they did (or failed to do) could be construed as negligent.

In another case in which fetal compromise is suspected, a doctor allegedly states "The baby would be better out than in." The pursuer's solicitors claim that: "No action was taken until many hours later." Although not conclusive proof, this version of events is held to make the defenders very vulnerable, and the case is conceded.

Neonatal death

Such actions are very similar to the 'Stillbirth/IUD' and 'CNS damage' heads of claim, in that it is asserted that better surveillance would have led to earlier intervention either before or during labour, and that the baby would have survived as a result. Least likely to be successful under this head of claim are those cases which concern very premature infants: one such case concerned a baby born by the breech at 25 weeks, the woman being admitted in advanced labour. The one case concerning a premature infant which did succeed turned on the neonatal management - it was felt that treatment was not aggressive enough when infection was suspected. More likely to succeed are cases concerning a term baby where the death apparently results from mismanagement of labour. In one instance a junior doctor used oxytocic drugs when the woman had already had uterine and cervical surgery, and also had epidural anaesthesia in place, and in which there was already evidence of fetal compromise; the uterus ruptured, and the baby was born severely asphyxiated and died several days later.
Failure to diagnose / treat (baby)
Out of ten cases under this head of claim, six related to a failure to diagnose congenital dislocation of the hips; others related to different congenital conditions such as cataracts or microcephaly. While failing to diagnose something may represent a poor standard of care (the congenital cataract for instance should have been picked up on routine neonatal examination by a doctor), the legal requirement that, to establish negligence, harm should result from the breach of a duty of care, means such cases do not succeed, the condition being congenital.

Neonatal injury
Six claims were noted here: in three cases these related to tissue injuries in the baby caused by venous or arterial lines. In one case the baby lost a lower arm after gangrene set in, but the case was unsuccessful because it was held that this was however tragic - unavoidable in the circumstances; in another a relatively minor degree of injury to the baby's arm resulted in damages for the pursuers. Injuries have been allegedly caused by an overdose of drugs; where harm results, such cases are difficult to defend.

Baby infection
In three cases allegations concerned neonatal infection; these related to meningitis (twice) and a septic osteitis. None succeeded.

Retinopathy of prematurity
Two cases (from the early to mid-1980s) concerned this condition, previously known as Retrolental Fibroplasia. The allegation is that over-oxygenation of the newborn (usually premature) baby causes blindness; neither of these two cases succeeded.

Other (baby)
These cases related to a baby allegedly born addicted to opiates because his mother had been over-prescribed drugs during her pregnancy, and a baby with a gastro-oesophageal reflux. The first case is still open; the second was unsuccessful.
Maternal cases

Failure to diagnose / treat (mother)
Such claims usually relate to a failure to detect conditions during pregnancy, which may be seen as reflecting high expectations in society. Unusual fetal cerebral or genetic conditions formed the basis of unsuccessful claims, as did the incorrect diagnosis of Down's syndrome, and a failure to detect placenta praevia. Failure to detect spina bifida on ultrasound accounted for three cases, the time in question being after twenty weeks gestation (the cut off point for this research). Successful actions included parents being told incorrectly that their baby had died in utero, the mistake only being realised 24 hours later, and the failure to detect rhesus antibodies during pregnancy (Rhesus negative women ought to be screened routinely throughout pregnancy). A study by Tucker et al (1996) found a high prevalence of this failure in women receiving community-led care (given by GPs and midwives) compared with hospital-based care, indicating that moves to reduce routine obstetric surveillance in hospitals must be accompanied by careful anticipation of possible risks.

Non-perineal trauma
Many of the claims in this section relate to injury allegedly sustained at delivery; these include damage to bladder or urethra from forceps, or apparent fracture of sacrum or coccyx at normal or instrumental delivery. Few of this type succeed, it being difficult to prove that the injury was caused by a standard of care amounting to negligence. Certain features, such as coccydynia or symphysis pain, may occur after a straightforward normal delivery. Other unsuccessful actions concerned caesarean scar dehiscence and haemorrhage from gynaecological surgery following subsequent normal delivery.
Examples of successful claims include burns from a hot water bottle given by midwifery staff, chemical burns from improper skin preparation in Theatre, and allergic reaction from adhesive strapping despite this known allergy being documented prominently in the woman's case notes.

Perineal trauma
This head of claim proved to be the most common of the maternal cases, accounting for 19% of them. Several claims included allegations of an over-tight repair which caused unnecessary pain, or a repair which either broke down and required resuturing or became infected; others concerned prolonged postnatal discomfort and eventual
refashioning of the perineum. However the success rate under this head of claim is not high (22%): successful claims tended to concern anal sphincter involvement and faecal incontinence, although some concerned simple evidence of poor repair technique. The concern to avoid extensive tearing at delivery underpinned the soaring episiotomy rate in the 1970s. Less common as a head of claim in the early 1980s, its prevalence remained fairly steady at 12-14% of all claims for 1984-91, but there has been a slight falling off since then.

Epidural / Spinal
Like some of the neonatal claims noted above, this head of claim concerns obstetricians less directly. Three distinct features were noted: analgesia in labour or at instrumental delivery was claimed to be inadequate, which relates to how midwives, obstetricians and anaesthetists respond to the woman's assertion that she is experiencing pain; anaesthesia at caesarean section was claimed to be inadequate, which relates to how anaesthetists respond to the same claim; and after-effects of the epidural or spinal are claimed to be causing pain and suffering.

All of these have a low success rate in terms of litigation: one out of seven, one out of nine, and two out of twelve settled cases respectively. It is clearly difficult to establish that staff were negligent in not ensuring adequate pain relief. One which did succeed concerned a caesarean which proceeded with apparently good anaesthesia until just before the baby was born, at which point the mother became very distressed; a 'top-up' of the epidural had no effect, and a general anaesthetic was required.

Allegations concerning 'epidural sequelae' have been commented upon (Bick and MacArthur 1995 [BJM 3: 27-31]). In one case a woman claimed the epidural fractured a small bone in her back; however an antenatal X-Ray pelvimetry (because of breech presentation) was claimed to show the spinal condition which the pursuer alleged was caused at delivery.

Analgesia / Anaesthesia (other)
These usually relate to claims of inadequate pain relief in either the Labour Ward or Theatre; of the five settled cases, the only one to succeed concerned the labour ward, with the claim made that midwives failed to monitor the woman's labour adequately. One unsuccessful claim concerned an anaesthetic catastrophe, with the woman suffering a cardiac arrest and dying after severe bronchospasm. At post mortem a "peculiar laryngo-tracheal anatomy" was found, which it is thought contributed to the disaster.

Appendix J: v
Infection
Seven of the ten cases concerned infection following caesarean section, the other three after vaginal delivery. This head of claim may reflect a lack of acceptance that infections will occur in hospital. As a recognised complication, particularly post-surgery, the presence of infection is not evidence of negligence, and none of the closed claims succeeded (although one is still on-going).

Retained products
Allegations of retained products of conception were fairly common, but were not very successful from the pursuer's point of view. These cases contained the claim that staff failed to ensure that all of the placenta and membranes had been delivered following the baby's birth. In many cases the claim seemed to arise out of a belief that any postpartum haemorrhage (PPH) must be due to retained products. This is not the case: at dilatation and curettage (performed for PPH) frequently the only finding is of endometrial tissue; even where there is evidence of placental or membranous tissue, negligence has not necessarily occurred.

Of the six cases which concerned caesarean section delivery, five failed; in the one which succeeded "considerable quantities of placental tissues and membranes" were found at dilatation and curettage; although the placenta was thought to be complete at the time of delivery, the surgeon clearly had not checked the uterine cavity thoroughly before closing.

Retained placenta
One case concerned a retained placenta (a recognised occurrence after vaginal delivery). An initial attempt to remove it proved unsuccessful, and a considerable wait then ensued because both on-call anaesthetists were occupied elsewhere. It was removed almost five hours after the delivery under a general anaesthetic, but no negligence was established and the claim failed.

Retained swabs
This head of claim, by contrast, is almost universally successful; this type of case is often cited as an example of the legal doctrine 'res ipsa loquitur' - the thing speaks for itself; the inference being that only through negligence could a swab be left inside a patient. In fact of the 24 closed cases studied here one did fail: towards the end of a caesarean section the obstetrician was informed by Theatre staff that the swab count was incorrect; apparently he then released a suture which he had almost finished inserting, quickly retrieved the swab, and closed up. It was held that the swab had not been truly 'retained', and no harm had been caused.
In other cases, however, swabs have been found inside patients even when the Theatre swab count is apparently correct; such cases are indefensible and are settled quickly.

Retained (other)
Three cases concerned part of a stitching needle which broke and was retained at perineal repair; one case is still on-going, one was successfully defended (no harm was found to have resulted), and the third was won by the pursuer: she developed complications, and so harm was seen to have been caused. A fourth case concerned a needle which broke during caesarean section and was retained. This case was unsuccessful: the situation was explained to the patient, fortnightly X-Rays kept track of the needle fragment, and it was successfully retrieved ten weeks later; staff were held to have responded appropriately to a known possible complication.

Other (maternal)
This term covered a wide range of heads of claim, from assertions that the wrong drug had been given in pregnancy or labour, to complaints about the attitudes of staff and of being prematurely discharged from hospital. Staff 'failures' figured prominently: a failure to send an ambulance, leading to the baby being born at home; failing to diagnose a bicornuate uterus at caesarean section; failing to remove an intra-uterine contraceptive device following childbirth; and failing to diagnose a cerebro-vascular accident in a mother, leading to delay in remedial treatment. None of these cases were successful. Two maternal deaths were also included here (both cases are still open).

Another head of claim was psychological trauma, which can concern the mother, the father, or the child. In one case it was claimed that the mother was traumatised by being given the wrong baby to feed during the night; as a result she developed a severe anxiety reaction with associated guilt at not recognising that the baby was not hers. In another (which concerned a retained swab which presented as a lump) psychological trauma was claimed to have been caused because of a family history of cancer. The solicitors involved here wrote that "The only evidence that we will be able to lead in such a matter would be that of the client and her husband and family, which we can assure you will be most graphic."

In another case in which obstetric events subsequently led to sterilisation, damages were claimed for the psychological distress of not being able to have more children. Whether or not one believes in a universal right to have children, this case poses interesting questions on how the degree of harm is assessed: in this case the debate turns to whether suffering in this way is affected by certain religious or cultural
beliefs. Many of these debates centre on the question of quantum, which was examined in Chapters 5 and 7.

In cases where a delivery has been traumatic, psychological distress may be caused by the thought of further pregnancies: in one case in which a woman has a third degree perineal tear she subsequently has a termination of pregnancy because she is terrified of the thought of another delivery.

Claims about psychological damage in the father of the child are more rare, but do occur. In one case in which both parents claim for psychological distress related to a traumatic delivery, the defenders retort that the patient's husband was not in fact present at the time, and so his claims to "wake up at night sweating with the memory of the trauma" are false. In this Sheriff Court action the sheriff dismissed the action raised by the husband, and awarded costs against him. In another similar case concerning a traumatic delivery the husband claimed damages for psychiatric illness / depression induced by the trauma of the delivery, and in this he succeeded.

Psychological damage relating to the child usually refers to a condition which might give rise to the child being teased or bullied; such cases were covered in the 'non-CNS injury' head of claim above.
Appendix K

Publications from this research

Midwives and Litigation: 'Introduction' and 'Allegations of clinical error'

Midwives and Litigation: 'Supervision'
Midwives and litigation: an introduction

Midwives and litigation' will be a series of articles which looks at perinatal legal files concerning events since 1980. The examination of these cases, which concern allegations of negligence, constitutes part of doctoral research based in the Social Policy Department at the University of Edinburgh, begun in 1993 and due to finish in 1997. The thesis details the incidence and nature of perinatal litigation in Scotland and two English areas since 1980, and further publication of this data, particularly on the incidence of litigation, is anticipated.

Funding, without which the research could not have taken place, came from the National Board for Nursing, Midwifery and Health Visiting for Scotland (NBS), and the Iolanthe Research Fellowship. Study time allowed by the Perth and Kinross Healthcare NHS Trust was invaluable.

Although two English areas were researched (one a large health authority, the other a city hospital), because most of the cases detailed in this series are Scottish, where appropriate, Scottish legal terminology is used. The terms 'pursuer' and 'plaintiff' are synonymous, as are 'defender' and 'defendant'; 'delict' is the Scottish term for the English law of 'tort' — the civil law of wrongs.

The law of medical negligence applies in the cases described here; a full discussion of this law can be found in Dimond (1994), and a synopsis is given in an earlier article in this journal (Symon, 1994). Briefly put, to succeed a pursuer must show that a duty of care existed between clinician and patient, that this duty was breached, and that damage resulted from that breach. The exact test for establishing clinical negligence in Scotland is found in the judgement of Hunter v Hanley [1955] (or Bolam v Friern Hospital Management Committee [1957] for England and Wales).

The series seeks to highlight various aspects of perinatal litigation, including consent and choice, the importance of cardiotocographs, supervision, and problems of communication. Focusing on litigation in this way indicates the many ways in which staff may become involved in a legal action, and suggests ways by which staff may avoid this.

The first article, appearing in this issue introduces cases under the general title 'Allegations of clinical error'; this aims to highlight the many different aspects of clinical care which have been the subject of formal litigation in maternity care since 1980. Subsequent articles in the series will examine cases under more specific headings.

To help preclude identification of those involved in particular cases, the term 'legal department' is used in each case to describe the actions or reports of the defence solicitors. In Scotland this is the Central Legal Office of the Scottish Health Service, which is based in Edinburgh; in England it is the relevant local health service legal office.

Although the series is entitled 'Midwives and litigation', many of the cases refer to the actions of obstetricians. No attempt has been made to distinguish cases specifically relating to midwives since this is frequently impossible in the multidisciplinary field of maternity care.

It is not possible to include a full summary of each case; certain features are identified which help to illustrate particular points. It is not intended that the success (or otherwise) of a legal action can be deduced from these brief summaries. Furthermore, to prevent identification of the people involved, in all relevant cases I have substituted initials for names, the initial in question not being the first letter of that person's name. Where relevant, times have also been altered, although the length of time between specific events is accurate.

Andrew Symon
Part-time Staff Midwife
Perth Royal Infirmary
PhD Student, University of Edinburgh

My thanks go to my supervisors Professor Mike Adler and Professor Rush Merja of the University of Edinburgh for their help and encouragement throughout this research, and for their constructive criticism of various drafts of the thesis from which this series of articles is taken.

Bolam v Friern Hospital Management Committee [1957], Queen's Bench Division, 2 All England Reports 118
Hunter v Hanley [1955] Session Cases 200
Midwives and litigation: allegations of clinical error

Andrew Symon

In the civil law, negligence may be established on the basis of actions or failures to act. There are many aspects of maternity care which have become the subject of allegations of clinical negligence; this introductory article will give an idea of the type of situation which may form the basis of a complaint and subsequent legal action.

Later articles in this series will focus on more specific headings such as supervision and the importance of cardiotocographs (CTGs), but I start with a selected overview which will describe some of the common pitfalls, and explain how staff may become involved in litigation despite maintaining a good standard of clinical care. The intrapartum period is the relevant time for most, but by no means all, legal actions, and what this overview does is show that allegations about substandard care may be made at any stage. Data about success rates for specific heads of claim may be published following completion of the thesis.

Antenatal

Anecdotally there is a popular perception that a failure to diagnose something is evidence of negligence, but this is not necessarily so: Case: At 24 weeks a woman goes into premature labour; a diagnosis of urinary tract infection is made.

Pursuers do not accept that the symptoms may be so similar that they can be confused, i.e. do not accept that the staff could have honestly not diagnosed premature labour. The baby is born alive, but subsequently dies.

Although this case was apparently dropped, the pursuer is clearly disgusted with the standard of care she believes she has received, and in her next pregnancy she refuses to book with any hospital within the same health board.

In another quite extraordinary case, legal action is brought because of a failure to diagnose two pregnancies in the same woman: Case: A woman had been taking the contraceptive pill right up until the 34th week of pregnancy; she had gone to her GP complaining of swollen ankles at 32 weeks and been referred to a consultant. Her GP had diagnosed a stomach growth which would have to be removed. The consultant then diagnosed pregnancy.

Four years later she went to her GP complaining of abdominal pains; he diagnosed 'stomach problems' and referred her to a consultant, who diagnosed fibroids — she said she was still having monthly periods.

It turns out that she was 18-20 weeks pregnant at this stage.

Presumably the fact that the woman said she was still menstruating (apparently ruling out the possibility that she might be pregnant) explains why this case was unsuccessful. Failing to diagnose something is not evidence of negligence, but the failure to take steps to diagnose in certain circumstances may be. For example, failing to examine the colour of amniotic fluid in labour following rupture of the membranes.

Failure to instigate adequate monitoring is another complaint which can form the basis of claims: Case: A stillbirth occurred at 32 weeks. The pursuer claimed that the midwives who attended her at home (because of her raised blood pressure) did not predict the intrauterine death. The community midwife referred her to hospital with a history of no fetal movements. Although there was only mild hypertension, extensive placental infarction occurred.

Claim is that although on three occasions she was seen by midwives and complained of lack of fetal movement, no extra monitoring was carried out.

The expert report notes that little was done to identify the problem, which was particularly severe as it developed between 28 and 31 weeks; it goes on to claim that had they done so, fetal compromise would have been noted and steps taken to deliver the baby.

Unsurprisingly the midwives are held to have acted negligently, and this case is conceded by the defence.
A further criticism of staff actions relates to delays in treatment. An example of this concerns CTG interpretation (the importance of CTGs is discussed more fully in another article in this series):

Case: A patient was admitted at 34 weeks. She was seen by the midwife and CTG showed a clear abnormality. Thirty minutes later she called a senior house officer who didn’t attend until 75 minutes later; another 75 minutes on, the senior registrar appeared (3 hours after the admission). The CTG remained grossly abnormal; by the next morning (almost 12 hours after admission) there was virtually no variability. The consultant was informed, and a caesarean was carried out (after a further delay because the patient was given breast milk).

Expert report stated that such a grossly abnormal CTG should have led to a quicker delivery.

While this case concerned the CTG recording, the real criticism made against staff was the collective failure to realize the severity of the case and to expedite delivery. Particular criticism accords to the doctors, although it is arguable that a more assertive stance by the midwifery staff may have involved the consultant more quickly.

Intrapartum

As stated, a large number of cases originate in the intrapartum period. The following is a very brief selection.

In this case a baby is stillborn when the presence of meconium is apparently detected, but not acted upon:

Case: The admitting midwife recorded ‘no SRM’, but also a ‘black substance in the vagina’—now presumed to be meconium.

The expert report stated:

‘The finding of meconium can only be made once the membranes have ruptured; every midwife must know this basic information. However this particular midwife seems to have been happy to record two mutually exclusive statements in her admission note.’

This claim appears indefensible, and is to be settled. Clearly the midwife’s contradictory reports could not be held to constitute a satisfactory level of practice.

This next case concerned the response of a midwife to a difficult delivery:

Case: According to the consultant obstetrician:

‘This was a case of shoulder dystocia which was not predictable and the midwife acted in the most appropriate way, and indeed had there been much more delay it might well have been that the baby would have suffered from rather more severe damage than it did in fact experience.’

In this case the midwife appears to have acted appropriately, although the claim is still ongoing, and has yet to be decided.

In similar circumstances to the previous case, midwives were criticized for not calling a doctor:

Case: During a normal delivery the baby’s head was delivered by a student midwife, the cord was tightly around the neck, and so was clamped and cut. Then shoulder dystocia occurred: a midwifery sister is called and she delivers the shoulders.

In this case, although the child developed cerebral palsy, the expert report stated that staff did all that could be expected.

Midwives have a duty to call a doctor in the presence of abnormalities, leaving aside the debate about how ‘normality’ is defined. In cases where a sudden emergency occurs, no medical help may be immediately available. In such circumstances midwives must cope with the resources to hand, and it is arguable that an experienced midwife would cope more effectively with shoulder dystocia than would an inexperienced junior obstetrician. The midwives’ actions in this case do appear defensible.

It is unusual for several pursuers to have cause to sue for the same reason at the same time, but this did occur several years ago when the same mistake was repeated with three patients. Each had surgery on the morning in question, and each sustained chemical burns due to the wrong skin preparation being used in theatre. It appears that the hospital pharmacy had supplied a similar preparation to the one normally used, but that this had caused burning of the skin which was made much worse in one case when diathermy was used to control bleeding. Not checking that the solution was the correct one was held to be negligent, and all three claims were conceded.

Postnatal

The failure to detect an incomplete placenta and abnormally high blood loss postnatally led to critical illness in another case:

Case: A patient collapses following recurrent postnatal vaginal bleeding. Haemoglobin was found to be 7.7 g/dl. In theatre, a ‘substantial piece of placental tissue’ was removed. The placenta had been thought initially to be donut-shaped, then said to be complete (pathology received a piece of placenta 10 x 6 x 4 cm...
Hypovolaemia leads to severe adult respiratory distress. The patient was admitted to intensive care.

Expert report states that the midwives should really have brought to the attention of the doctors more strenuously the question of persistent postnatal blood loss. It seems the amount was seriously underestimated: haemoglobin fell by over 10 g/dlitre, indicating over 1000 ml blood loss.

According to the expert midwifery report: 'I think all concerned (both midwifery and medical) showed a lack of initiative in how blood loss may be measured...'

This case was conceded, and settled out of court.

In this case, the failure on the part of both hospital and community staff to recognize urinary retention with a distended bladder proved catastrophic for the patient:

Case: After delivery more than 24 hours were allowed to lapse before the patient was catheterized; 1800 ml were drained. The catheter was left in situ for 48 hours; thereafter the patient managed to urinate once (100 ml was passed). At her request the patient was allowed to go home but was readmitted 2 days later.

The patient had been seen by the community midwife and GP at home, but neither diagnosed a full bladder (found to have 1.5–2 litres urine).

It is likely that she has now suffered permanent denervation, and is only able to void urine spontaneously by straining; this could cause problems later on with stress incontinence and prolapse.

In this case the midwives do not appear to have realized that urinary retention is an abnormality, and one which, as in this case, can lead to serious debilitation. Given the evident damage caused by an apparent breach of the duty of care, it would be difficult in such circumstances to argue against a finding of negligence.

Conclusion

These cases illustrate the diverse nature of perinatal litigation. Practising midwives, wherever they work, must be under no illusion about their responsibilities, and must acknowledge that a finding of negligence can be made when the standard of care is such that the breach of the duty of care to a patient results in damage. An adequate standard of care, but with little or no documentary support, may also result in a finding of negligence in certain circumstances.

The articles to follow will examine perinatal litigation under a number of headings, including documentation; they will aim to increase awareness among practitioners about the types of situation which have in the past led to legal actions.
Abstract
Inadequate levels of supervision have been cited as an influence in suboptimal outcomes, and in the origin of legal actions against midwives and obstetricians. All staff have a duty to ensure that supervision, both of patients and of their junior colleagues, is of a satisfactory standard. Thorough documentation in the case notes help an investigator to establish the level of supervision a patient has received.

For many midwives the first reaction to the term 'supervision' may be to think of their relationship with their supervisor of midwives, and while this is an important issue, more pressing from a legal point of view is the matter of supervision as it relates to the level and standard of care received by pregnant women. Inadequate supervision, both of patients and of junior staff, has been cited as a feature of perinatal legal actions (Ennis and Vincent, 1990; Doherty and James, 1994), and may relate to both midwives and obstetricians. Because of the multidisciplinary nature of maternity care, the cases discussed here will refer to both.

The unpredictability of each day's workload in maternity care means that it can be difficult to guarantee that adequate numbers of staff are always available; busier units with high stress levels may be more susceptible to high staff sickness rates, ensuring that sufficient staff on duty can be problematic. However, even with a full complement of staff, adequate supervision of juniors may not always occur. This can lead to tragic outcomes.

Case
Without consulting a more senior colleague, a senior house officer (SHO) decided to use oxytocic drugs to speed up a labour, when there was already evidence of fetal compromise. The woman had had a caesarean section and cervical cryosurgery in the past, and had an epidural in situ. The uterus ruptured vertically through the cervix. The baby died 6 days later.

Unsurprisingly this case is settled by the defence. The question of supervision may be viewed in a number of lights: it may be argued that the SHO ought to have contacted a more senior colleague before taking this course of action, or that alternatively, the relevant registrar ought to have been keeping a closer eye on this junior member of staff. Protocols establishing a need to inform a senior obstetrician when such procedures are contemplated may help. Criticism may also be levelled at the midwifery staff who presumably did not query this course of action, or demand that a more senior obstetrician attend.

A similarly tragic case concerns a junior midwife (qualified for less than 6 months at the relevant time), who looked after a woman in the second stage of labour.

Case
The midwife documented a series of fetal heart rates, many of which would be considered suggestive of fetal compromise, but did not inform a more senior midwife or doctor for about an hour. Her records are shown in Table 1.

<table>
<thead>
<tr>
<th>Time</th>
<th>FHR</th>
<th>Change to left lateral position</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.30</td>
<td>140</td>
<td>13.15</td>
</tr>
<tr>
<td>13.33</td>
<td>145</td>
<td>13.20</td>
</tr>
<tr>
<td>13.35</td>
<td>100</td>
<td>13.35</td>
</tr>
<tr>
<td>13.45</td>
<td>110</td>
<td>13.24</td>
</tr>
<tr>
<td>13.49</td>
<td>110</td>
<td>13.30</td>
</tr>
<tr>
<td>13.52</td>
<td>100</td>
<td>13.33</td>
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<tr>
<td>13.56</td>
<td>100</td>
<td>13.40</td>
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<td>13.00</td>
<td>105</td>
<td>13.42</td>
</tr>
<tr>
<td>13.05</td>
<td>105</td>
<td>13.42</td>
</tr>
<tr>
<td>13.12</td>
<td>100</td>
<td>13.42</td>
</tr>
</tbody>
</table>

FHR = fetal heart rates
The midwife claimed that she asked for help at 13.55, saying she thought the woman needed forceps delivery. She was told by the sister that all the doctors were busy. She did not record this conversation, and seemed to have waited until 14.35, assuming that someone would come when they were free.

The fact that the midwife had entered an iteration in the woman’s position (to the left laterally) indicates that she suspected that some intervention was needed to address apparent problems, but her evident failure to take any further steps, or at any rate to document that she had done so, left her wide open to criticism, and in fact internal disciplinary action was taken against this midwife. It is a far more tragic result for the baby and the family, since the baby developed cerebral palsy.

While ensuring adequate supervision levels may be most difficult in the intrapartum period, it is clear that this aspect of the duty of care principle exists to patients throughout their contact with the maternity services. An example of inadequate supervision in the postnatal period concerns a woman who had a forceps delivery, having had a caesarean section in a previous pregnancy.

In this case

The expert report was critical of the SHOs who were called to examine the pursuer when she had severe abdominal pain on the second postnatal day. The expert felt that being so called was unusual, and so the two SHOs should in turn have called a senior colleague.

Instead of a prescribed intramuscular narcotics which only mask the pain. The uterus appeared and a hysterectomy was required.

Here there was explicit criticism of junior medical staff for not requesting additional support from a senior colleague, a criticism which could equally apply to a midwife in similar circumstances. The midwifery staff appear not only to have allowed, but to have assisted, a regrettable course of action to be pursued, since it is presumably a midwife who gave the injection. Most frequently, however, the question of inadequate supervision seems to occur when the unit in question is busy. That this is so is of little comfort to those parents who suffer a tragic outcome, as shown by this husband’s statement from another case:

‘There was only one midwife who was looking after (my wife) and she was also looking after someone else in the room next door. She was not with us all the time but kept popping in and out of the room...I would say that 90% of the time we were on our own.’

In this case, tragically the child developed cerebral palsy, allegedly because of the failure to carry out adequate monitoring in the second stage of labour. If staff are required to look after more than one woman in labour, documenting this in the relevant case notes will help to explain absences.

Just how staff are deployed when a unit, particularly a labour ward, becomes busy is a matter which must be decided by the senior staff member present. Decisions are made in the light of the best available knowledge about patients and their state of progress in labour; however, despite the best intentions, errors may be made or conditions may deteriorate suddenly when the necessary staff are elsewhere.
In investigating the circumstances which give rise to legal claims, the hospital may examine the ward or unit report books to see how busy the unit was, and to help account for the whereabouts of the staff on duty at the time.

Case
The baby was presenting by the breech; the woman had had a caesarean section already, and was for a 'repeat section' should she go into labour. At 38 weeks she went into labour and was in the labour ward for 6 hours contracting irregularly. Obstetricians were busy with other patients (one with twins); the pursuer was not felt to be in established labour and so the membranes were left intact so as not to exacerbate labour.

When she was operated upon, her baby was asphyxiated, having aspirated meconium. The baby developed epilepsy, a condition shared by the mother.

This case is still ongoing, and it is a matter of debate whether the child's problems are familial or as a result of intrapartum asphyxia. The matter of supervision is debatable: as the woman was not thought to be in established labour, it can be argued that constant supervision and/or monitoring was not required. With the benefit of hindsight this may be challenged, but as previously stated, staff will be allocated according to the knowledge available at the time.

In investigating the circumstances which give rise to legal claims, the hospital may examine the ward or unit report books to see how busy the unit was, and to help account for the whereabouts of the staff on duty at the time. Some will say that optimum staffing levels are never likely to be met, given cuts in budgets and a drive to reduce 'overstaffing'. Just how this can affect the treatment given to patients is shown in the following case (in which the relevant times have been altered).

Case
A caesarean section (for fetal distress) was delayed during the night as the duty anaesthetist was busy with an emergency and the second on-call anaesthetist had to come from home.

According to the operation note the patient was in theatre for 20 minutes before the arrival of the anaesthetic registrar.

The second on-call registrar anaesthetist was called at home at 04.38. He arrived at the hospital at 04.53, and was in theatre by 04.38. The infant was delivered at 05.06.

This situation is readily imaginable; once the second anaesthetist arrives there is no delay at all, but the damage appears to already have been done. Whether a second on call anaesthetist should be on site rather than allowed to go home when on call can be debated: a legal action can succeed when a unit fails negligently to provide an adequate service (Bull v Devon Health Authority [1993]).

CONCLUSION
It is clear that supervision is a critical feature of perinatal care, particularly in the intrapartum period. Qualified staff are required to ensure that women under their care are adequately supervised, and that students or more junior staff are not left in situations they have not been prepared for. Should the unit become very busy this may be difficult to guarantee; in such an event (as in so many others in midwifery) good documentation may save a clinician from conclusions, if not accusations of negligence.

The examination of legal files described here constituted part of research for a PhD undertaken at the University of Edinburgh, and was funded by the Economic and Social Research Council, the National Board for Nursing, Midwifery and Health Visiting for Scotland, and the Voluntary Research Fellowship. Study time allowed by the Perth and Kinross Healthcare NHS Trust is invaluable.

Bull v Devon Health Authority [1993] 4 Medi. Law Review 117

KEY POINTS
- Poor levels of supervision have been seen to contribute to poor outcomes and sometimes to patient litigation.
- Midwives must ensure that patients and junior staff for whom they are responsible are adequately supervised.
- Problems which have not been immediately flagged for discussion.
- Clear documentation in the event of a unit becoming very busy may help to explain why a good standard of supervision has not been maintained.
Midwives and Litigation

The importance of cardiotocographs

By Andrew Symon

Abstract
Cardiotocography is an aspect of clinical care which has attracted considerable attention in legal cases, particularly those concerning cerebral palsy. While its level of use may be debated, those midwives who use this form of monitoring must be adequately trained in its interpretation.

Cardiotocography (CTG), also known as electronic fetal monitoring (EFM), is one aspect of perinatal care which has been highlighted from the legal standpoint: Vincent et al (1991) claim that deficiencies in staff interpretation of CTGs have at times resulted in poor outcomes and subsequent litigation. However, the supposed benefits of EFM are not universally acknowledged. A study among high-risk patients by Haverkamp et al (1976) found that ‘the presumptive benefits of EFM for improving fetal outcome were not found.’

The large scale Dublin randomized-controlled trial of intrapartum fetal heart rate (FHR) monitoring (MacDonald et al, 1985) concluded that continuous monitoring was beneficial in reducing the incidence of neonatal seizures, but suggested this was due to shorter labours in the continuously monitored group. Murphy et al (1990) note that continuous CTG monitoring has become integral to obstetric practice ‘despite the fact that no clear evidence exists for its efficacy, especially in low risk pregnancy.’ Their study found a low degree of specificity (false-positives), i.e. staff diagnosing fetal compromise when it did not exist, and conclude that this is one of the main reasons for current dissatisfaction with this method of monitoring. They stressed the need to view CTG in conjunction with other assessments (such as fetal blood sampling [FBS]), and not as the sole indicator of the fetal condition. Despite this, the use of FBS varies enormously. Keegan et al (1985) also found a high degree of false-positives and false-negatives in CTG interpretation. Ennis (1990; unpublished paper from British Psychological Society conference) points to a high degree of over-confidence in the ability to interpret CTGs among practitioners.

Interpretation of CTGs has been shown to vary not only between individual practitioners, but also when the same practitioner examines the same trace twice (Nielsen et al, 1987). With such a low level of agreement about interpretation, it is perhaps surprising that the CTG still forms such an integral part of legal wranglings when the issue is a brain damaged baby. Grant et al (1989) looked at babies born with cerebral palsy in the Dublin trial, and concluded that:

‘intrapartum FHR patterns do not seem to correlate with later cerebral palsy...suboptimal intrapartum care, in particular failure to respond appropriately during labour to an abnormal FHR pattern, has been shown to be associated with about a 6-fold increase in the risk of very early (<48 hour) seizures but not with an increased risk of cerebral palsy; and...less than 10% of cases of cerebral palsy are likely to be related to intrapartum care.’

The whole topic of CTG is one which divides many practitioners and patients. Its importance in legal terms is hard to overstate, since it often provides a continuous record of one aspect of intrapartum fetal wellbeing, despite its poor predictive value for cerebral palsy. The following cases illustrate how midwives may become involved in legal arguments.

In one case, the midwives are criticised when a fetal scalp electrode (FSE) becomes disconnected some 5-10 minutes before delivery.

Case
There is meconium staining. The woman is transferred from the midwives’ unit to the consultant unit. The FSE falls off, but auscultation is carried out between then and delivery; this is recorded as satisfactory through-
out. The parents seize on the few minutes when the FSE is unattached to explain the child's subsequent condition (cerebral palsy).

The Writ states:
'The hint of meconium staining...ought to have alerted the...midwifery staff and registrar to the risk of fetal distress occurring. Accordingly continuous FHR recording ought to have commenced at that time.'

While this action is ongoing, it would appear from the various reports that the midwives did all they could have been expected to do; continuous FHR recording using an abdominal transducer may be very difficult immediately before delivery, and in this case the scalp electrode is unattached. As the midwives continue to monitor the FHR using intermittent auscultation and record that this is satisfactory, their actions appear to be defensible.

At times it may be difficult to use the CTG to record the FHR; in such instances good documentation is essential.

Case
A baby is born very asphyxiated. Pursuers claim that the monitor should not have been taken off. Staff document that it was very difficult to listen to the fetal heart as the patient moved and rocked a lot.

The midwife looking after her notes frequent loss of contact with the FHR on the CTG trace, and states:
'I made the decision to stop the print out from the monitor but kept the transducer and belt in situ, and I was continually listening to the fetal heart.'

The midwife's report indicate that the FHR was satisfactory at all times.

In this (ongoing) case the expert report backs up the midwife's actions. In other cases reports have criticised midwifery actions.

Case
Pursuers' solicitors claim that instead of diagnosing fetal distress in labour, staff assumed the 'heart rate coming and going' was due to a defective CTG machine. Only when the third machine (they claim) was showing the same sort of trace was the woman sent for caesarean section.

A placental abruption is discovered then. There is nothing documented to say the CTG machine was replaced at all. Eventually the CTG traces are found, and they reveal one change of machine, from an old to a new model.

There is a gap of 2.5 hours when the CTG is not on. There are six written recordings of a FHR in this time, at half-hourly intervals. The medical expert feels the midwives can be criticised for not having a fuller record of the FHR.

In fact despite the implicit criticism of the staff, the pursuer's solicitors do not pursue this case vigorously, and it would appear that the case is dropped. In another case the presence of apparent abnormalities is not acted upon.

Case
Persistent early FHR decelerations. The staff appeared to think these were benign, despite there being reduced variability and meconium staining.

The expert report states:
'There is a period of 90 minutes...when there was no CTG recording. This is an unacceptable situation where the patient has had a previous section, at 42 weeks, with meconium staining, with CTG abnormalities which are persistent and who was on oxytocin.'

This catalogue of at-risk factors does not appear to have alerted midwives to the need for extra vigilance. An interesting point is noted in a separate case where the question of whether the midwife can insist on carrying out such monitoring is raised. This question was put to midwives and obstetricians in further research, and produced considerable differences of opinion (Symon, 1997).

In other cases the lack of action by midwives has been criticised.

Case
The pursuer's solicitors claim:
'It would appear that a fetal monitor was incorrectly adjusted and, accordingly, the readings which it gave were not properly interpreted and significant abnormalities were disregarded.'

The CTG has 'wrong speed' written on it. It seems that different speeds were used at different times in labour, and no times are logged, so it's harder to interpret.

According to expert opinion:
'I do not recall having ever seen a trace with such a smooth line and almost complete lack of beat to beat variation...The nursing (sic) staff faithfully recorded the events but apparently failed to appreciate
KEY POINTS

- The level of cardiotocograph (CTG) use is a matter of debate, but despite misgivings it remains a commonly adopted form of technology within maternity units.
- The ability to interpret CTG traces varies between individuals and apparently when the same person examines the same trace twice. Hospitals have a duty to ensure that staff are properly trained in its use.
- In instances where the CTG is not used during labour, midwives must continue to monitor the fetal condition carefully and document their findings.
- Staff are well advised to document fetal heart rate recordings even when CTG monitoring is in progress, since paper and ink quality may deteriorate over the years. In such instances, the case notes may provide the only evidence of the fetal condition.

the significance of the flat trace and therefore did not report it to the medical staff.

This action is conceded by the defenders shortly before the court hearing is due. There are other cases in which the CTG has showed abnormalities which were ignored by staff. In one instance the expert reported:

'Is it difficult to see the point of fetal monitoring if no action is to be taken when there are obvious abnormalities in the recording.'

In another case there is a similar damning lack of awareness on the midwife's part about the CTG.

Case

The defence solicitor states:

'(The midwife) admitted quite freely that she spent many hours watching a fetal heart monitor which she was insufficiently trained to interpret or understand at the time. She has since been better trained and, looking back at the fetal heart traces during the period she was on duty, she sees them as being abnormal. In my opinion, quite a bit of liability must therefore attach to a system which asked midwives to watch a monitor which they are insufficiently trained to understand.'

CTGs will remain a critical part of intrapartum care in many units. The need to ensure that staff are properly trained in CTG interpretation is one step which employers can address, but it should be remembered that the UKCC's (1992) Code of Professional Conduct 'encourages (practitioners) to declare their incompetence in certain procedures rather than to try and undertake them.' Individual midwives also have a responsibility to ensure that they are adequately prepared for the duties entrusted to them.

DISCUSSION

Storage of CTG traces so that they survive and are readable is also a matter of concern to hospitals. The possibility for electronic storage has been mooted, since paper and ink quality can deteriorate over the years. In one case the CTG trace from the delivery survived, but was presented at a medical meeting: a registrar used a thick black felt tip pen to illustrate points he was making, effectively obscuring the trace. In another teaching hospital case the CTG trace could not be found at all. Many people were doing research, and it appears that the trace was borrowed for this reason. A central hospital register of research studies may be required so that records can be easily found.

It is hard to overemphasise the importance of CTGs in this area of the law, despite the many misgivings about its use. Adequate training of all staff members in its interpretation, together with efficient storage (and retrieval when required) are the minimum which hospitals must guarantee. Education of the public — as well as staff — as to the limitations of this technology will help to establish a more realistic understanding of its applicability.

As with every other sphere of midwifery practice, good documentation in this area is essential, and may well provide the midwife with her best defence. What these cases show is how a legal case may be decided by the actions of staff concerning the CTG. While its widespread application remains controversial, the CTG is not going to disappear, and midwives who work in units where it is employed must be competent in its use.

The examination of legal files described here constituted part of research for a PhD undertaken at the University of Edinburgh, and was funded by the Economic and Social Research Council, the National Board for Nursing, Midwifery and Health Visiting for Scotland, and the Trolanthe Research Fellowship. Study time allowed by the Perth and Kinross Healthcare NHS Trust was invaluable.

It is not intended that the success (or otherwise) of these cases may be deduced from the brief extract given.


Consent and choice: the rights of the patients

By Andrew Symon

Abstract

Consent and choice are critical features of modern maternity care, and consent in particular has distinct (but largely well understood) legal implications. Choice may be more problematic in the clinical setting, with practitioners sometimes divided on the question of how much a patient's wishes must be respected.

These two aspects are critical in modern health care, with an increasing emphasis on the rights of the patient, particularly in relation to decision making. Maternity care in particular has seen some of the most intense debate on this subject, with a growing body of opinion demanding minimal obstetric intervention (Tew, 1986). The belief on the one hand that pregnancy and labour are essentially normal life events, and the (rather clichéd) assertion that 'no pregnancy or labour is normal except in retrospect' on the other, define the battle lines from which this argument is fought. Of the belief that some cannot cope with the responsibility which comes with choice, Mander (1993) retorts 'this argument has a pathetically paternalistic ring to it.' There is a debate as to whether obstetricians ought to see women whose pregnancies are uncomplicated (James, 1995; Walker, 1995), with some claiming that the midwife is the practitioner best placed to deal with such pregnancies (Thomson, 1991).

INFORMED CONSENT

The requirement for consent is clear in legal terms: carrying out a procedure without consent can be construed as a trespass or an actual assault. The need for the woman's decision-making to be informed is clear because in pregnancy and labour those concerned are almost always both adult and competent. There has been a growth in the need for clinicians to demonstrate that they have given adequate information to the patient, since claims have been made on the basis that patients have not fully understood the nature or possible consequences of a procedure or operation.

Midwives today appear to be more aware that adequate information must be given to pregnant women, especially in labour, although, as Kirkham (1989) found out, the quality of this information can vary considerably. The research described here found that legal complaints about failing to obtain consent usually concerned obstetricians, but the principle applies equally to midwives.

Consent is required before any operation can be carried out (with a few exceptions in cases of extreme emergency). During an operation it may become apparent to the obstetrician that further action, beyond that which was anticipated, is needed. When the patient is unconscious consent clearly cannot be obtained; even when the patient has epidural or spinal anaesthesia, and is awake, it can be argued that informed consent is not possible, since there is no time for the patient to reflect on the situation before either agreeing or disagreeing.

Case

According to the pursuer's solicitors:

'Our client learnt that while she had been under general anaesthetic one of her ovaries and a piece of tube were removed.'

The standard consent form said:

'I hereby consent to the performance of any operation which may be considered necessary.'

The consultant claimed that after the operation the wife was almost hysterical, and so explained to the husband why one ovary which appeared malignant had been removed — although histology later showed it was benign. The impracticalities of trying to counsel a patient in difficult circumstances is explained by a hospital manager to the pursuer's solicitors in another case:

'(The consultant) does not consider it normal practice in an acute obstetric
emergency to counsel patients in detail on all the possible difficulties that might, very infrequently, arise."

In this case damage to the fallopian tubes was caused at caesarean section, leading to secondary infertility. In a different case the obstetrician noted, again at caesarean section, that a previous section scar had ruptured; the rupture was large, and he felt that a further pregnancy would almost certainly lead to uterine rupture and stillbirth and possibly even maternal death. To prevent further pregnancy he ligated the fallopian tubes, and was sued for an unauthorized sterilization. This is an ethical matter as well as a legal one, but in this instance the defence of necessity appeared to be sufficient.

In another case (not concerning allegations of clinical negligence) a patient complained when a photograph of her was taken while she was in labour and without her consent. An anaesthetist wanted a picture of a patient using 'Entonox' (a mixture of oxygen and nitrous oxide (NO2)) apparatus, but did not seek consent at an earlier time, and instead took the photograph while the woman was having a contraction. His explanation was:

"In view of the self-administration of the NO2 and the effects of the labour I assumed implied consent."

This took place in the early 1980s; such an assumption would hopefully not be made today. The emphasis is now very much on consent being informed rather than assumed. All this relates to the notion of the patient having a degree of choice in her care and treatment.

**CHOICE**

Choice is not as simple a matter as it might first seem; must a woman express her choice, or can she be expected to wait until someone asks her what her preferences are? Clinicians may sometimes forget that some patients are intimidated by hospitals and by professional staff, and that some view the hospital as foreign territory in which they are unlikely to assert themselves.

Clinicians may sometimes forget that some patients are intimidated by hospitals and by professional staff, and that some view the hospital as foreign territory in which they are unlikely to assert themselves.

"As a teaching hospital all the women are aware that medical students may be present during their labour and birth, and we rely upon them to tell us if they do not wish this to occur."

Here the presumption is that the onus lies with the woman. Such a view can be easily criticised, but legal claims are sometimes made because the woman's expressed preferences have not been overridden; in one instance the pursuers allege that an elective caesarean section ought to have been carried out, but it is well documented in the notes that the woman has made it quite clear that she wanted a normal delivery. Very occasionally it is the demands made by the woman's husband or partner which are adhered to; one case shows that a husband consistently refused that his pregnant wife be examined, and threatened violence against any staff who attempted this. The full tragedy of this case is that the woman developed serious complications, and subsequently died; it is not known whether this tragic outcome could have been prevented had the woman been examined sooner.

Several cases have been concerned with a situation where a woman has expressed a wish for minimal intervention but has suffered a damaged or dead baby. The argument will then usually turn on whether earlier intervention would have affected the outcome at all.

Several cases relate to a woman's desire for a normal delivery having already had at least one child by caesarean section. Given the recently vaunted scope for choice within maternity care, it is a matter of some debate whether treatment will be significantly altered in the light of such expressed wishes. In one such case a consultant obstetrician notes:

"It may be that this enthusiasm for a vaginal delivery as opposed to caesarean section in some way influenced her obstetric management."

When the outcome is poor it is very easy for clinicians to claim that their advice was ignored or given insufficient weight by the patient. It would appear to be tempting for some to pursue the 'I told you so' line, and use such outcomes to justify higher levels of surveillance in routine care in the future. While this may be so, these cases inevitably reflect a rather distorted picture, in that all the cases relate to an outcome which is sub-optimal; those instances where a patient has successfully had a normal delivery after having had an earlier caesarean section receive less attention.
It is not always the case that the woman’s expressed choice is for minimal technology and intervention; a number of cases have concerned the woman’s dissatisfaction that she was in fact persuaded to try for a normal labour and delivery when she wanted an elective caesarean. Such instances may be fairly rare, but it is a common perception among staff that demands by patients for either elective induction of labour or caesarean section are growing (Symon, 1997). It is difficult to justify conceding to a demand for such procedures when there are no clinical factors which would warrant this; it could be argued that in a fee-for-service situation a patient could justifiably claim this, but we are not yet in that situation in this country.

With much safer anaesthesia today than has been the case in the past there does appear to be a popular perception that operations are more or less risk-free. It is possible that patients may claim that they are only exercising the choice which various government and local charters say is now theirs when they make such demands; if so these ignore the fact that a caesarean section is still a major abdominal operation not without risks. Obstetricians may be caught on the horns of a dilemma when such requests are made, for current policy is to reduce the number of caesarean sections (which coincides with the demand for less intervention).

Consent is well enough understood by clinical staff for it to be only rarely the basis of a successful negligence action; choice, however, much vaunted in government charters, provides more of a potential dilemma. Whether or not a patient is deemed to be capable of understanding every item of information relating to a condition, or whether indeed the standard of consent ought to be ‘informed’ or ‘rational’, is a matter of debate. However, an inescapable reality of current health care is that pregnant women are being told that they have the right to make choices about their care. While most clinicians welcome this development, such moves are not seen favourably by all. Nevertheless it is the responsibility of all midwives to ensure that they give adequate information to the women under their care, and that this allows them to make informed choices.


KEY POINTS

- Consent and choice have clear legal implications. The debate about whether consent must be ‘informed’ or ‘rational’ remains unresolved.
- The question of choice can also be problematic. Most would agree that it must be informed, but it is difficult to define the level at which choice is recognizably ‘informed’ choice.
- A patient’s choice may be for minimal intervention despite known complications, or for intervention such as operative delivery when there are no clinical indications for this course of action.
- A fine line may exist between giving sufficient information to patients and their families to allow understanding of a clinical condition or a possible complication, and overburdening them with detail.

Contributions

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British Journal of Midwifery
Croxted Mews
286-288 Croxted Road
London SE24 9BY
Tel: 0181 671 7521. Fax: 0181 671 4454
Recollections of patients: visions of the truth

By Andrew Symon

The next three articles examine the theme of recollections and demonstrate the importance of adequate case notes. The investigations of allegations of negligence become unnecessarily time consuming and expensive when memories are poor and the case notes inadequate.

One of the most noticeable features of legal cases is the time they frequently take to arise. This is usually beyond the control of those who work in the health service, although it could be argued that a well-publicized facility for patients who wish to obtain information or express their dissatisfaction may have some effect. The debriefing/counselling sessions described by Charles and Curtis (1994) allow time to scrutinise in some way substandard to see their case notes and to air their feelings or grievances. The process of becoming formally legal may become accelerated in a proportion of these cases, and while this may not seem to be in the best interests of the health service, these sessions may in fact prevent a larger number of legal cases from being initiated. If any do become formal legal cases more quickly, then the deleterious effect of prolonged delay on the investigation of a case will be largely avoided.

It should be noted that most legal actions which concern the mother must be made within 3 years of the event in question; this 3-year limit is known as the triennium. Exceptions are cases in which the alleged injury is not immediately apparent; and cases which concern brain damaged children may be made effectively without time limit — Halle (1997) notes one such case which took 27 years to arise.

Memories can become distorted over time, and while those patients who experience a poor outcome should now in theory be given the chance to express their views (whatever they may be), all the good communication and targeted debriefing of patients may not be enough to convince some people that they have no justified cause for complaint.

Of course those who do have justification for their grievances are perfectly entitled to seek legal advice and, where appropriate, compensation. It should be noted, however, that the success rate for litigants in this area is much lower than that found in most personal injury litigation (Fenn and Dingwall, 1989); detailed success rates may be published following the conclusion of ongoing research (Symon, 1997).

The recollections of staff may be as inaccurate as those of patients, but in the case of staff they usually have case records to help jog their memories. Patients are unlikely, at the time when the initial allegation of negligence is made, to have contemporaneous accounts of the events in question, although having made such allegations their solicitors will usually secure access to copies of the relevant case notes. Statutory entitlement to access to health records is provided by the Data Protection Act 1984, the Access to Medical Reports Act 1988, and the Access to Health Records Act 1990.

The combination of an inadequate grasp of details at the relevant time and the effect of distorted memories over a period of time may produce some strange accounts. Many relate to the labour or delivery period, as in this case concerning a caesarean section:

Case
The writ stated that the pursuer ‘screamed throughout the operation’. The consultant obstetrician claimed this was not true: it would be ‘intolerable to the surgeons, anaesthetists and nursing staff’. He also asserted that, contrary to a claim in the writ, there was no general anaesthetic given.
Case records are not proof per se of what happened; just because something is written down does not mean that it is necessarily true, but in practice courts have relied heavily on such records, providing they are contemporaneous and consistent with the recollections of staff members and of other documents.

The registrar who operated says he knew the woman from her first pregnancy and thought they had a good rapport. He says it is absolutely untrue that she complained she was in pain at any stage during the operation. In fact the woman was given intravenous thalmonal, an analgesic, after the baby had been born.

It appears that this intravenous analgesia was so effective that the woman believed she had had a general anaesthetic. It is a distinct possibility that memory has had a confounding effect in this case, since it was almost 3 years before the complaint was made (just before the expiry of the triennium).

In another case the pursuer claimed that an unsupervised student performed an episiotomy and then repaired it without anaesthetic; the records show that a staff midwife carried out the episiotomy, that a midwifery sister was also present, and that a registrar repaired the perineum.

The presence of case records can do much to support the actions of staff; in one case the expert notes that:

'Mr P alleges that after his wife's waters broke...they were left alone again. This is not borne out by the case records...'  

Case records are not proof per se of what happened; just because something is written down does not mean that it is necessarily true, but in practice courts have relied heavily on such records, providing they are contemporaneous and consistent with the recollections of staff members and of other documents.

Case
The pursuer claimed that after an initial hospitalization she was discharged, but came back a week later and insisted on readmission, which took place. The case notes do not bear this out: as planned, she was seen two weeks later for a repeat ultrasound scan and readmission.

The pursuer went to see her GP 5 years after the events in question, and it was another 5 years before she consulted a solicitor. In this situation, it is small wonder that memories can be inaccurate. It is possible that the desire to find a cause for some distressing outcome may blunt one's memories. In one case a woman sued claiming that her dyspareunia was due to her episiotomy repair (claiming the stitching was too tight); in fact her case records note that she had presented with this condition 6 years before this, her first pregnancy.

Memories can become distorted over time, particularly when the outcome is tragic: in one case which unfortunately resulted in a stillbirth, a woman was admitted with a possible antepartum haemorrhage, which staff appeared to believe was just 'show':

Consultant: 'The records would suggest that her initial bleed had been of a minor nature and that there was no indication to keep her in hospital at that stage. However, on subsequent discussion she...described the bleeding as having been at least an egg cup full...on review some two months later her memory of the amount of the bleeding was vastly increased and she described this as having been pints of blood that soaked her bed clothes.'

The tragedy of losing her baby may have conspired to make the memories more vivid than the actual events. In another case a couple initiated a complaint 11 years after the child's birth; when the child was 4 months of age he was diagnosed as having seizures. The consultant paediatrician who saw the baby at this time noted:

'I saw the parents repeatedly and at no time subsequently did they describe to me what they now claim happened at the child's birth.'

A patient's recollections of the time of labour may be affected by several factors, including exhaustion, the effects of opiate or inhalational analgesia, and the outcome of the pregnancy. It is accepted that information given to labouring women must be tailored to take account of these factors; a consultant wrote in some exasperation of one patient:

'Mrs H complains that she was not kept fully informed, but very experienced and dedicated labour ward staff are well aware that during labour patients are not receptive to detailed information....'

Understandable distress at the turn of events may colour perceptions. In one case a pursuer claimed that she begged the obstetrician to section her once the fetal heart rate dropped. In fact it had stopped altogether and this was confirmed by scan, hence the consultant's refusal to carry out a caesarean section. The consultant asserted that he did not speak to the husband when he came in, so the husband's claim to have begged the consultant to section his wife was untrue. At no point was the fetal heart rate noted to be slow: it was present and normal at
the morning check, but not later that morning when further monitoring was attempted.

In another case in which a premature baby unfortunately developed cerebral palsy, the Summons stated:

'(The pursuer) felt the baby starting to be born. There was no doctor present at this time. A nurse arrived, and appeared to attempt to push the child's head back into the birth canal of the pursuer. The pursuer thereafter required to have her vagina incised in order to facilitate the birth of the baby.'

The contradictory nature of this claim appears to escape the pursuer's solicitors, for if the nurse (sic) was attempting to delay the delivery by 'pushing the child's head back into the birth canal', then an incision to facilitate the delivery would have been completely unnecessary, if not impossible. The consultant obstetrician points out that controlling the delivery of the head to prevent sudden decompression is routine, and that episiotomy in the case of premature delivery is commonplace. He added:

'Mrs N had received analgesia about two hours before the delivery which could have impaired her memory of events. I do not see how a ludicrous claim can be made that there was an attempt to push the child's head back into the birth canal. No one would contemplate such a manoeuvre — it could not be done.'

The recollection of lengths of time can vary when distress is present. One patient who, during the night, was given the wrong baby to breastfeed, told staff immediately that she had fed the baby for a minute. Once at home she found that the mother of the baby she inadvertently fed lived close by, and she developed an anxiety condition. In her claim she said that she fed the baby for ten minutes and not one.

The perceived reasons for what occurs in the delivery room can also affect recollections and may be used by pursuers to explain subsequent developments. In one tragic case in which the baby developed cerebral palsy, it was claimed that the midwife examined the woman internally and attached a fetal scalp electrode, and then ran to the sink 'heaving'. The patient was taken soon after to theatre for a caesarean. The pursuers appeared to believe that something occurred during the internal examination which caused the cerebral palsy, and which was so nauseating that it also caused the midwife to vomit. It is explained that, although the midwife has no memory of running to the sink 'heaving', she was herself pregnant at the time and suffering from nausea, and that this is the more likely reason.

Patient recollections at times may clearly be inaccurate, and may be affected by several factors. In labour the ability to comprehend detailed information is generally held to be reduced; extreme tiredness and the side-effects of analgesia make perception problematic. When the issue is complicated by interpreting events in the light of subsequent outcomes or the distorting effects of time on memory, the scene may be set for unfortunate confrontation.

One way of reducing this possibility is to offer 'debriefing' sessions to postnatal women and, where appropriate, their partners, particularly in cases where the outcome is known to be poor. Despite this precaution legal cases will continue to be initiated, sometimes many years after the events in question.

From this discussion it can be seen that a patient's recollections may be held to be inaccurate, and for a number of possible reasons. It ought not to be concluded that a patient's account of events will be treated automatically with suspicion, only that there is the possibility that certain confounding factors may distort perception and recall. Staff, too, are not immune to these factors.

Full and contemporaneous records will provide a good indication of the course of events, and are invaluable in helping those involved to recall situations. The matter of staff recollections is discussed in this next article in this series.


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It is not intended that the success (or otherwise) of these cases may be deduced from these brief extracts.

**KEY POINTS**

- Memory recall may be significantly affected by the passage of time, and by other features, such as pain levels, the effects of analgesia, and knowledge of the clinical outcome.
- A patient's memory may be aided by obtaining access to the case notes, but frequently this is not done by the time the initial allegation of negligence is made.
- A thorough investigation of an allegation of negligence requires that full and detailed contemporaneous records are available. Staff have a duty to ensure that their records meet this standard, and hospitals are obliged to guarantee the safekeeping and availability of such records.