Midwives Protection Program

Special Delivery

Volume 4, Issue 1 **Spring 2012**

A Risk Management Newsletter for Midwives' Protection Program Members

In this Issue:

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Welcome to Special Delivery

Welcome to the Winter/Spring 2012 Edition of *Special Delivery*. In this edition of *Special Delivery,* we announce the creation of a risk management committee to support the delivery of the Midwives Protection Program (MPP). Common interests often lead to a community of practice for the purposes of shared learning and knowledge. The development and sharing of resources within this forum can only enhance our ability to deliver services to you, the practicing midwives of BC.

Grant Warrington, our Senior Claims Examiner/ Legal Counsel, writes on the outcomes of perineal trauma and suturing techniques from a best-practices perspective. This article is the first in a 2 part series on maternal injury. Part 2, which will discuss maternal haemorrhage, will be published in our next edition of *Deliv*ery which is scheduled for summer/fall of 2012.

In this edition, we also outline for you some things you need to be aware of related to privileging. Understanding the scope and limitations of MPP coverage in matters related to privileging will be helpful should you ever have to navigate this area.

Finally, our Risk Answers responds to questions related to the increasing use of social media and how to best integrate this into your midwifery practice.

We hope you enjoy this issue of *Special Delivery* and find the articles helpful in your practice. As always, we welcome feedback or suggestions for future editions. Please contact us at MPP@gov.bc.ca.

Working Together to Manage Risks

It's amazing what can happen when a group of people with common interests put their heads together. When you widen that to include a greater number of stakeholders, the knowledge gained from the interaction only becomes more insightful. On March 24th, 2011, the Midwives Protection Program (MPP) created and hosted the first meeting of the MPP Risk Management Committee.

The Terms of Reference for the committee include input into the planning and management of the MPP. To ensure the coverage provided continues to meet the needs of its members it is essential for us to keep current on issues that affect midwifery practice. Changes in scope of practice, for example, may have coverage implications. Our understanding of the environment in which you operate, enhances our ability to deliver services to you.

At MPP we also recognize the importance of continuing education and ensuring new information is readily available. The impacts of new legislation, changing demographics, structure of the health care system, tort and case law – all have potential implications for those who operate in it. We strive to promote and encourage innovation in the delivery of education, communication and consultation/ advisory service available from our skilled team of consultants and legal counsel.

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Working Together (continued)

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Generally speaking, one of the things that risk management principles strive to correct is the tendency of people to work in silos, becoming focused on management of their own business without considering the myriad of interdependencies that exist. Taking the time to look around, to seek others who are facing similar challenges, to learn from them and incorporate or collaborate on solutions can be amazingly effective. By providing a forum for discussion, knowledge transfer and promotion of awareness of health care risk management issues, the MPP Risk Management Committee hopes to create connections between these silos.

Included on the Committee are representatives from MPP, the Midwives Association of BC (MABC) and external legal counsel providing defence to midwives. By invitation, we may include representatives from the College of Registered Midwives of BC (CRMBC) and the Ministry of Health (MOH). The first meeting was one of successful discovery and was built upon with a second meeting in the fall of 2011.

Privileging Issues and the Limitations of MPP Coverage

Midwives in British Columbia are provided with liability coverage for malpractice by the Midwives Protection Program (MPP). In addition, MPP provides legal assistance to a midwife who is called on to attend a Coroner's inquest as a result of an incident. MPP also extends coverage for the legal fees incurred by a midwife in responding to complaints to the College of Midwives, up to an annual limit of $50,000.

It is important for midwives to understand that one incident can result in a number of potential consequences, not all of which are covered by MPP. It can also be difficult, in dealing with an incident involving a midwifery client, to separate out all the potential consequences, some of which may be covered by MPP and some of which are not.

When an incident is reported to MPP and a lawyer is appointed to assist the midwife, there are some limitations on what that lawyer is able to help with. An important limitation relates to hospital privileging and credentialing issues.

The practical effect of this for midwives is that in dealing with a lawyer appointed by MPP, there are times when the lawyer will have to say that he or she is not able to discuss or advise the midwife on a particular aspect of the matter (unless the midwife makes a separate arrangement to retain and pay that lawyer to deal with that aspect).

The repercussions of a client incident often include an actual or threatened lawsuit, an actual or threatened complaint to the College, an investigation, inquiry or inquest by the Coroner, a complaint to a health authority under the Patient Care Quality Review Board Act, or an internal quality assurance review by a health authority. Many of these may go on at the same time.

The consequences of reports to the College, complaints to a health authority, or a quality assurance review may include recommendations to suspend or alter a midwife's hospital privileges and there is typically a detailed process in hospital bylaws relating to how privileges can be removed or altered. Health professionals, including midwives, whose privileges in a hospital are altered or removed are able to legally challenge this by appealing to the Hospital Appeal Tribunal.

The lawyer appointed by MPP will be able to help you with issues relating to actual or potential lawsuits, a complaint to the College or a Coroner's inquest, with the costs of that legal assistance being borne by MPP.

However, issues relating to a midwife's hospital privileges are not covered by MPP. The lawyer assisting you through MPP is therefore not able to advise you on matters related to hospital privileging even though the issue may arise in relation to an incident which is otherwise covered by MPP.

Having hospital privileges is necessary for a midwife to practice and is obviously an extremely important issue. If it is apparent that privileges may be reviewed as a result of an incident, the

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Privileging Issues (continued)

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midwife may well need legal advice but will have to fund the cost of this herself. The midwife can choose to hire her own lawyer separately to advise on privileging issues, or, if a lawyer has already been retained by MPP to deal with the covered aspects of the matter, can reach an agreement with that lawyer for the midwife to independently fund the costs of advice on privileging issues.

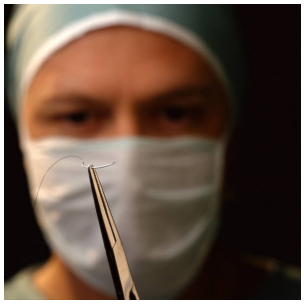
Because recommendations about privileges can result from internal hospital reviews, midwives who are concerned that an incident may result in a review of privileges should consider getting legal advice at an early stage. Midwives are also encouraged to report to MPP if they become aware of a quality assurance review involving their care, as such a review may precipitate a complaint to the College.

Privileging issues arise rarely and only in the case of serious incidents, serious lapses in care, or where there is a pattern of problems in a midwife's practice.

Apart from privileging issues, another matter which may arise is organization of a midwifery practice and business issues. Again, these issues may require legal advice, but the midwife will have to retain the lawyer and pay those costs herself as MPP does not respond.

Robin J. Harper
Robin Harper has been practicing law in British Columbia since 1982, with a focus on medical malpractice defense litigation and health law. She has considerable experience in obstetrical litigation and frequently acts for midwives on both discipline and potential litigation matters. In addition, she has expertise in dealing with hospital privileging issues and Hospital Appeal Board matters arising from hospital privileging matters.

Perineal Injury – Assessment, suturing techniques and reducing the risk of claims or complaints



In previous articles written for Special Delivery I have focused on issues relating to infant outcomes and the extent of coverage available for potential claims made against midwives. Midwifery care, and MPP coverage, also applies to your provision of care to the birthing mother.

This article will focus on the most common form of maternal obstetric injury, namely, pelvic floor injury. It has been estimated in one 2006 study (Stepp et al.) that up to 65% of women incur a laceration or episiotomy during vaginal delivery that will require repair, although Canadian rates may be lower. The rates of laceration requiring repair for midwife assisted deliveries in BC are not clearly established, however, even with data missing with respect to homebirths for 2010/2011, BC Perinatal Database Registry statistics do show a 30% increase in third degree perineal tears in midwife or midwife trainee deliveries from the previous year. What is not clear from the data is what percentage of those tears led to an OB consult, what percentage were repaired by midwives, and what percentage of those midwife repairs had complications or poor outcomes. The data do seem to confirm our concern at MPP that we are reviewing an increasing number of reports of complications, and thus potential claims, following tears repaired by midwives.

Risk factors for pelvic floor injury include nulliparity, high foetal birth weight, malpresentation or malposition, lithotomy birth position, instrument (especially forceps) delivery, duration and rate of delivery. Perineal trauma is directly related to use of mechanical manoeuvres and oxytocin and may also be related to the liberal use of episiotomy. The literature seems uncertain whether the use of warm compresses and massage with lubricants provide any apparent advantage or disadvantage in reducing trauma however, these measures are certainly considered appropriate, and may very well assist.

Once a tear has occurred during the provision of midwifery care the assessment of the degree of that tear is of utmost importance. More serious lacerations involve deeper tissues including the anal sphincter (3rd degree) or even the rectum and its linings (4th degree). These tears have significant risk of complication including infection, bleeding, anal incontinence and increased pain. Repair of the

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Perineal Injury (continued)

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more serious cases will need to be referred to the obstetrician/gynaecologist.

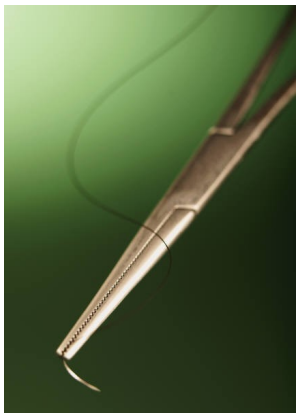
MPP has reviewed a number of reported incidents involving pelvic floor injury. Some of these have led to complaints to the College, but so far only one to litigation. The incidents have included the following themes and factors:

- the tear was assessed as being less serious than it was;
- the midwife was overly tired or inexperienced and did not perform the required assessment and suturing skills to a satisfactory standard;
- lighting conditions were inadequate;
- OB consult or referral did not occur in situations where an OB was available to assess and repair;
- suturing materials and methods of closure were not considered satisfactory for the case;
- the client was too active following repair and did not allow sufficient time for healing;
- the client did not receive or did not follow the midwife's instructions on limiting activity.

Prenatal and intrapartum assessment and documentation of risk factors and identification of any other complicating factors that could lead to a modification in birthing plan or referral or consult are essential considerations for the midwife. Failure, for example, to take adequate steps to inform clients of the appropriateness of a hospital birth where it is known that the foetus is of large size, especially in combination with other factors such as malposition can increase liability exposure. The combination of risk factors may lead not only to serious difficulties for the infant but can significantly increase the likelihood of serious pelvic floor injury and/or serious haemorrhaging which may also require availability of hospital blood transfusion.

Prenatal documentation must demonstrate clear communication between the midwife and the client regarding the choice of home versus hospital birth and any changing circumstances leading to increased risk such as pelvic floor injury.

As stated above, once a tear has occurred during the provision of the midwifery care the assessment of the degree of that tear is of utmost importance. When in doubt, overly tired, or unable to properly assess, a midwife should request assessment and suturing by the obstetrician if one is in attendance or can be called to attend. This can include transferring the responsibility for suturing a client who you believe may be non-compliant with your recommendations for activity limits. When you transfer responsibility you also transfer risk. Keep in mind it is the provider repairing the tear who will be the one exposed to the claim for any complications arising from that assessment and repair, including further complications such as bleeding, further intervention in the operating room, incontinence, loss of sensation, pain on future intercourse or other short and long term sequelae that can sometimes ensue.



In those cases reported to MPP where midwives have attempted to repair serious tears and any complications have arisen it has been difficult to establish for example, that an obstetrician would have chosen the same method of repair, including suturing techniques and materials. When faced with the opinion of an expert midwife stating that the suturing midwife met the standard of care and an expert obstetrician opining that she did not meet the standard of care, there is likely to be a bias in favour of the expert obstetrician opinion.

There is a body of evidence to suggest that there is a lower risk of birth trauma where the mother is birthing in an upright position and where delivery of the foetal head occurs between contractions.

There have been several cases reported to MPP where the midwife properly assessed the need for an upright birthing position but was challenged by other health care providers for this recommendation. To reduce this inter-caregiver tension and the risk of contrary action, or an undermining of the client's confidence in the midwife, the midwife needs to be able to communicate her expertise and choices to other health care providers in ways that reassure the nurses or other birth attendants that her decision has been made according to best practices.

Sometimes hospital based staff are unfamiliar

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Perineal Injury (continued)

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with the techniques and strategies used by midwives. This seems to be exacerbated for midwives who are new to a particular hospital, or have privileges in a less frequented facility and where the midwives are more accustomed to home deliveries and in better control of the birthing environment.

It is incumbent upon the midwife to anticipate possible lack of knowledge of the midwifery model of care (especially in hospitals without established midwifery departments or divisions), prejudices and biases. To reduce the likelihood of misunderstandings or challenges to her authority, the midwife should familiarize herself with the hospital culture and other health care providers' expectations, especially when her case is likely to progress to a hospital birth.

After any incidents, or even following simply challenging situations, seeking prompt review with the involvement of appropriate staff and taking any opportunities to appropriately educate others are important considerations. These steps may prevent or mitigate future case complications or the undermining of your relationship with your client and enhance your deserved acceptance by other care providers.

In summary MPP has seen a number of complaints and claims around suturing issues; some of them quite serious. It is incumbent upon the midwife to ensure that she has the appropriate skill sets and experience to undertake repair of pelvic floor injury. Given the fact that the actual repair represents a small (albeit very important) part of your overall role and overall care provided to your client, it may be that a conservative approach, with referral where available and appropriate is the prudent course of action.

Since the College of Midwives of BC does not provide a particular standard or guidelines for perineal injury assessment and suturing, guidance must be found elsewhere, such as in Society of Obstetricians and Gynaecologists of Canada and BC Perinatal Services Guidelines, and individual facility policies and procedures and current best practices literature.

Grant Warrington RPN BA LLB MA

References:

1. Elharmeel, SMA; Chaudhary, Y; Tan, S; Scheermeyer, E; Hanafy, A; van Driel, ML. *Surgical repair of spontaneous perineal tears that occur during childbirth versus no intervention (Review).* In *The Cochrane Library 2011, Issue 8. www.thecochranelibrary.com*

2. Kettle, Christine; Hills, Robert K.; Jones, Peter; Darby; Louisa; Gray Richard; and Johanson. *Continuous versus interrupted perineal repair with standard or rapidly absorbed sutures after spontaneous vaginal birth: a randomised controlled trial. The Lancet, Vol 359, June 29, 2002. www.thelancet.com*

3. Stepp, K.J.; Siddiqui, N.Y.; Emery, S.P. and Barber, M.D. (2006). Textbook recommendations for preventing and treating perineal injury at vaginal delivery. *Obstetrics and Gynecology*, 107 (2, Pt. 1), 361-366.

Links of interest:

Society of Obstetricians and Gynaecologists of Canada: www.sogc.org

BC Perinatal Services: www.perinatalservicesbc.ca

Risk Answers

What risks might be associated with the use of social media by midwives?

... a former client has invited me to be her "friend" on Facebook... I have been thinking of developing a Facebook page to promote my practice... I've been monitoring a blog for expectant mothers and would like to comment or offer advice from my perspective as a registered midwife...

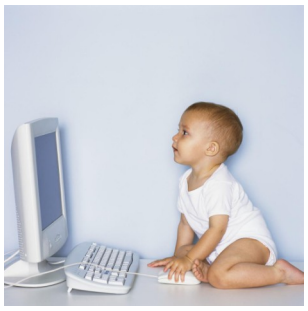
As technology and access to the internet grows, social media and networking websites create opportunities for midwives, such as staying connected with their communities or promoting their practices. However, these opportunities do not come without risk and midwives considering the use of social media should proceed with caution. Midwives need to be mindful of their professional and ethical obligations with respect to privacy and professional working relationships when making decisions about their online presence. The same guidelines and principles that apply to "in person" relationships also apply to the "virtual" relationships created online.

Midwives should treat any online social media or networking sites as public spaces where information can be viewed and further disseminated by others without permission of the original poster. Even if the midwife thinks information is being housed in a secure environment, there should be no expectation of privacy as it can be copied and reposted, sometimes even within a very different context than what was intended. Midwives should be wary of posting even de-identified stories of their experiences with clients online since this could be a breach of confidentiality if the client or family recognize themselves in the story.

Participation in professional forums or blogs may also appeal to many midwives. The opportunity to apply their expertise in discussions with peers or other interested parties may be very tempting. Again, midwives need to be mindful of their confidentiality obligations if drawing on real life experiences with clients. Midwives should also consider the extent to which others may rely on the information and advice they post in forums or blogs and whether it could be seen as having established a professional relationship with such individuals.

The sharing of personal information via sites like Facebook, even after the midwife-client relationship has ended, can blur the boundaries of a professional working relationship. Midwives need to be careful not only about what type of information they post about themselves and their clients, but also the extent of client-posted information they access. It is not usually beneficial to professional relationships for a midwife to make detailed personal information about herself available to her clients. Similarly, clients may post far more personal information on their websites than midwives need to know in order to provide care. Midwives must bear in mind that anything posted online is publicly accessible and should be comfortable that it could be read by past and current clients, potential clients, employers, legal counsel and review boards.

Sharon White, CIP, CRM
Senior Risk Management Consultant, MPP



MPP Incident Reporting Form Updated

MPP has revised its Incident Reporting Form. We are no longer gathering client address and phone number at the time of reporting. We are asking a few more questions around location of birth. While timely reporting of incidents according to the MPP Incident Reporting Guidelines is important, immediate reporting by telephone is not usually appropriate or practical.

A copy of the MPP Incident Reporting Guidelines and the revised MPP Incident Reporting Form are included on the back of this newsletter.

The MPP Team

Linda Irvine, Director, Client Services – Health Programs

Grant Warrington, Senior Claims Examiner/Legal Counsel

Kim Oldham, Director Claims and Litigation Management

Sharon White, Senior Risk Management Consultant – Health Programs

FEEDBACK IS IMPORTANT TO US AT MPP

Please let us know what you think about **Special Delivery**.
Did you find the **Privileging Issues** helpful and informative?
Will our article on **Perineal Injury** make any difference to your practice?
Will you think about how you use **Social Media** and your online presence?
Are there any topics you would like us to cover in **Special Delivery?**
Do you have any questions for the **Risk Answers** section?

Write to us at MPP@gov.bc.ca or
Midwives Protection Program PO Box 3586, Victoria BC V8W 3W6

Midwives Protection Program

MPP Incident Reporting Guidelines

PO Box 3586 Victoria BC V8W 3W6 · Telephone: (250) 952-0836 · Claims Fax: (250) 356-0661

FOETAL/NEONATAL

- Low APGARS, in particular < 4 at 1 minute and <6 at 5 minutes, with other indicators
- Foetal scalp blood pH <7
- Umbilical artery blood pH <7 at birth
- Intrauterine acidosis e.g. base excess > -12
- Deep variable decelerations or late decelerations, with other indicators
- >4 minutes of positive pressure ventilation before sustained respiration
- Seizure after birth or other neurological signs
- Severe Hyperbilirubinaemia; Kernicterus
- Abnormal head imaging related to possible birth injury; abnormal EEG
- Prolapsed/severed/snapped cord/cord strangulation, with other infant sequelae
- Significant birth injury including: shoulder dystocia; broken clavicle/ humerus; brachial plexus injury; head laceration; forceps/instrument/vacuum injury
- Meconium aspiration pneumonia
- Pneumothorax
- Unanticipated lengthy course in neonatal intensive care or equivalent unit
- Significant infection
- Unplanned extubation
- Death/Stillbirth

MATERNAL

- Significant tearing and/or episiotomy with other maternal sequelae
- Bladder laceration
- Uterine Rupture
- Significant haemorrhage (> 1000 ml and/ or transfusion)
- Complicated or serious infection/ septicaemia
- Untreated maternal genital herpes, syphilis, HIV
- Significant post c-section complication
- Maternal ICU admission
- Maternal trauma/death
- Eclampsia seizures
- HELLP Syndrome
- Thrombo embolic event (DVT, PE)
- Disseminated Intravascular Coagulation

GENERAL

- Unplanned unattended home birth
- Unplanned/unexpected early discharge of non-compliant patient
- Problem with planned follow-up for at risk infant/family
- Family raising credible concerns about care
- Complaint to College of Midwives
- Known breach of CMBC standard
- Any telephone or written complaint referencing law suit or compensation or complaint sent to Ombudsman, Minister etc.
- Any negative outcome complicated by interprofessional dispute over care
- Request for records by legal counsel specializing in obstetrical malpractice
- Request for records where reason indicated is “for litigation”
- Any other incident not listed here of concern and where advice may be sought

Note these are guidelines. They are not policy or regulation; common sense prevails. Whether or not the birth was planned/ unplanned, at home or in a hospital or other setting may be relevant to your reporting decision. Sources informing the Guidelines include: Health Care Protection Program and Midwives Protection Program claims history, BC Health Care Risk Management Society reporting guidelines, Society of Obstetricians and Gynaecologists of Canada guidelines, Canadian Patient Safety Institute, ECRI Institute, Health Care Insurance Reciprocal of Canada (HIROC), Harvard Foundation publications and Canadian jurisprudence along with midwife, client, claims examiner and legal counsel feedback. If uncertain about whether or not to report an incident, call us!

Midwives Protection Program

PO Box 3586, Victoria BC V8W 3W6
Ph (250) 952-0836 Fax (250) 356-0661
Email: RMBClaims@gov.bc.ca

INCIDENT REPORTING FORM

Date of Report:

Reported By: Registration #:

Address:

Telephone: Fax: Email:

Primary Midwife:

Secondary/Support:

Client/Claimant(s):

Home Birth: ☐ Yes ☐ No

Name of Hospital:

Date of Incident:

Please tell us what happened **(FACTS ONLY)**:

Letter of complaint/Notice of Claim enclosed: ☐ Yes ☐ No

Has the Client/Claimant indicated concern? If so, please explain.

PLEASE NOTE:
Should you have any questions regarding your claims-made policy, please contact:
The Midwives Association of British Columbia at (604) 736-5976 or e-mail at mabc@telus.net.