PERINEAL INJURY
Assessment, suturing techniques and reducing the risk of claims or complaints

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In previous articles 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 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.

It should be clearly understood that this document and the information contained within is not legal advice and is provided for guidance from a risk management perspective only. It is not intended as a comprehensive or exhaustive review of the law and readers are advised to seek independent legal advice where appropriate. If you have any questions about the content of this article please contact the Midwives Protection Program to discuss.

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 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.

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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.

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References:

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Links of interest:

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

BC Perinatal Services: www.perinatalservicesbc.ca

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