

Why do women sue?

Statistics published by the National Health Service Litigation Authority relating to ten years of maternity claims provoke a sharp intake of breath. The total value of these claims over the first decade of the 21st century was £3,117,649,888 (NHS Litigation Authority 2012). The United Kingdom is not the only country to witness an astronomical increase in the level of litigation relating to maternity services. As far afield as Saudi Arabia (Henary *et al* 2012) and the United States (Berkowitz 2011), reports are being published of the demands on maternity budgets as a result of dissatisfaction with care received during pregnancy, labour and birth.

The papers referenced above attribute adverse outcomes to negligence, misdiagnosis, surgical blunders and inefficient administration. Berkowitz (2011:7) suggests that what is needed is wholesale and whole-hearted adoption of '*...electronic fetal monitoring [EFM] certification for all staff working on their Labor and Delivery floor, protocols for managing common clinical scenarios, simulation drills for dealing with uncommon dangerous events, and pre-procedure checklists*'. The NHS Litigation Authority (2012:5) recommends that Trusts '*...engage with the risk management process at all levels; provide suitable learning and training; ensure appropriate supervision and support; have in place up-to-date protocols and guidance with which staff are familiar; learn lessons from claims*'.

It is relatively easy to ensure that staff are sent on fetal heart rate (FHR) training days (although whether use of EFM produces better outcomes has, of course, never been clearly demonstrated (Alfirevic *et al* 2013) and that protocols for managing events during labour and birth are drawn up and even put into practice. It's uncertain, however, whether doing so will make the problem of maternity litigation go away. There is something 'rotten in the state of Denmark' that is fuelling women's dissatisfaction and which 'the system' has not been able to get its head round.

The rhetoric of 'woman-centred care'

I think we have to question whether it is the *relationship* between the woman and her caregivers that is the most likely source of women's (and society's) outrage when things go wrong. The rhetoric of 'woman-centred care' and of 'informed choice' has been with us for a long time now, and should be deeply embedded in interactions with childbearing women and their families. These are concepts meant to empower women and to ensure that health professionals put women at the centre of their own care. However, I would suggest that women feel themselves to be as subject to medical authority and as awe-inspired by it as they ever were.

In her ground-breaking book, co-edited with Carolyn Sargent, *Childbirth and authoritative knowledge* (1997), Robbie Davis-Floyd wrote that authoritative knowledge is not dependent on the technology of care, the 'machines that go ping' so famously featured in the Monty Python sketch; it is a means of organising power relationships in such a way that everybody concerned, both those with power (doctors, midwives, nurses) and those without (women, partners) cannot imagine a situation in which birth is defined or care delivered in any other way. This kind of authoritative knowledge is created and supported by the language of obstetrics which has so singularly failed to democratise itself over the last 40 years. Penny Simkin and Mary Stewart (2012) provide examples in their roundtable discussion in *Birth* journal:

My lady is doing really well

(Whose lady? And why 'lady'? Ladies are 'expected to behave' in a certain way not usually typical of labour)

She's 3 cms

(The woman defined as her cervix)

The section in room 9

(Woman reduced to her mode of delivery)

I'm just going to break your waters

('Just' – perhaps one of the most commonly used words to excuse a procedure which staff do not want to take time to explain)

I'm just going to break your waters, OK?

('OK' taking the place of informed consent)

In the same roundtable discussion, Marc Keirse (2012) gives examples of the (deliberate?) confusion caused by acronyms, and also explains how their use adds to the aura of authoritative knowledge:

You can add BP (blood pressure) to the BP (birth plan), MH (maternal height) to the MH (medical history), FH (fundal height) to the FH (family history), PR (pulse rate) to the PR (pregnancy record) and the PI (pulsatility index) to the PI (patient information).

Keirse describes this as ROAR – Rely On Acronym Rhetoric or Respect Our Almighty Rituals!

The language of obstetrics

Every movement which has tried to change the prevailing culture, be it to achieve equal rights for people from black and ethnic minority groups, or for people who are gay, lesbian or transgendered, or for women in science, technology and engineering, has started by challenging the language that demeans or distorts those groups of people. In maternity care, the language which belittles women and reduces them to mere incubators for their babies, has not really changed in decades.

The language reinforces a power differential which gives health professionals agency, and creates dependence in women. Feeding into this is the all-pervasive emphasis on risk. Smith (2014) has written wonderfully well about the change in women's relationship with their babies and with health professionals since the advent of ultrasound and prenatal testing. She observes that prior to such technologies, the mother remained free from 'the medical gaze' and accepted uncertainty about the outcome of her pregnancy '*...as a natural part of what it was to be a mother*'. Since it became possible to see inside the womb and monitor the pregnancy, there has been what Smith describes as a '*...profound loss of confidence in the maternal body*' and a hand-over of power from mother to health professional.

Women have always known that pregnancy and birth are risky. That is part of the vast reservoir of female knowledge transmitted down the millennia of human evolution and doubtless encoded in female DNA. It is a 'known known'. However, women are also programmed to *keep their babies alive*; this is at the heart of 'the motherhood constellation' that Daniel Stern discusses (1995). Upon this programming depends the future of the species. Once women started to lose confidence in their own capacity to nurture their unborn babies, and medical science gained in confidence to manage the unpredictability of pregnancy and birth, women naturally made the decision to accept medical control in order to secure a better chance of survival for their baby.

However, to magnify risk is not to practise evidence-based medicine. In 2008, 94% of births in the USA were reported as having some degree of 'complication' (Elixhauser & Wier 2011). Such statistics do not imply better care for women and their babies but rather

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greater power and status for obstetric professionals. Women find themselves labelled as ‘at risk’ if this is their first pregnancy; if they are over 30 (this accounts for a lot of mothers now as the standardised average age of women for all births was 29.8 years in 2012 (ONS 2013)); if their baby is below/above the 50th centile on ultrasound; if they live 10 miles from the hospital. . . Being focused on the survival of their child, at the cost of any sacrifice to their own well-being, women will make the entirely sensible and laudable choice to trust the professionals who are offering to protect their baby from the risks which they have been told are omnipresent. It is, therefore, not surprising that when things go wrong, as they inevitably will from time to time, the mothers blame those whom they perceive as having promised to manage the risk of harm (Figure 1).

Figure 1. Risk, dependence and litigation

<p>The risk</p> <ul style="list-style-type: none"> • There are various risk factors in your pregnancy -> • Your baby may be at risk
<p>The promise</p> <ul style="list-style-type: none"> • We can monitor your pregnancy, your labour and your birth -> • And therefore protect your baby from all the risks
<p>The outcome</p> <ul style="list-style-type: none"> • Something goes wrong -> • Litigation

The woman sues because her expectation of the extent to which her baby can be protected from mishaps, both those relating to nature and those relating to medical error, has been warped as a result of the implicit promises made to her through medical jargon, technology and (confused) advice about her lifestyle. She sues as a result of iatrogenic unrealistic expectations.

Disappointment and anger may be enhanced if the interpersonal care that women have received has also not met their expectations. While it is difficult to change our society’s highly risk-averse attitude, it is certainly possible to address issues around care. It’s strange that while ‘the evidence’ is constantly cited to justify an increasing range of intrusive and demoralising (for the woman) interventions, the evidence, and there is plenty of it, for what kind of care women appreciate doesn’t seem to be implemented in practice nearly as readily.

This article started by discussing the way in which health professionals’ style of communication may belittle women. Penny Simkin (2012) explains that labouring women are ‘in survival mode’ and she advises that midwives and doctors choose their language carefully. The aim is to achieve non-threatening communication without compromising honesty. Never exaggerate; if the ‘risk’ is small (eg thin meconium; long latent phase; pushing for more than two hours) don’t terrify the woman. The surge of adrenalin in her system generated by a worried look, apparent blame (‘you’re not getting on very well’) or subtle threat (‘we need a doctor to look at this trace’) is very unlikely to make the labour safer. After all, that adrenalin rush will be transmitted to her baby.

The woman and her birth partner are constantly thirsty for information. Poor communication leaves women in limbo, imagining the worst. If there is an adverse outcome, and there has been no communication, women may seek legal advice simply to find out what happened. How often have we heard people caught up in tragedies such as Hillsborough or Bloody Sunday saying that they ‘just want to know what happened’?

Reducing litigation

Reducing the risk of litigation starts in pregnancy with ongoing discussion at every clinic appointment, about the woman’s feelings, wishes and expectations, preferably with a midwife she knows. The Mid Staffordshire NHS Foundation Trust Public Enquiry (2013) advised that in order to avoid another mid-Staffs-type disaster, health professionals must show a willingness to listen to patients and service-users *to discover what they want for themselves*. A formal birth plan may be unnecessary and possibly counter-productive (Lothian 2006), but women appreciate the opportunity to talk through what they would like to happen in terms of interventions, and what they would very much like not to happen. Several studies have argued that attending antenatal education enhances women’s satisfaction with their birth experience (Quine *et al* 1993, Hart & Foster 1997, Goodman *et al* 2004). It is, therefore, almost certainly unhelpful in terms of reducing the level of litigation, that NHS antenatal classes are no longer being offered by so many Trusts.

During labour, women need to feel they are in control of their internal environment — emotions, behaviour — and of the external. Support to use their own pain-management strategies, or ones they have acquired in classes enhances that sense of being in control

and the satisfaction of doing something to help oneself. Women who feel more in control of their behaviour are likely to feel more satisfied with their birth (Green *et al* 1998; Gibbins & Thomson 2001). The study by Spiby *et al* (2003) concluded that women are unlikely to use their own resources unless encouraged to do so by their midwives. Are midwives confident to demonstrate a variety of active birth positions to women, to show a birth partner how to do massage, and to help a woman breathe through her contractions?

Women also want to control the external environment. Rooms with a centrally placed hospital bed, no space to move around, and cluttered with monitoring equipment shout loudly and clearly that control does not lie with the woman, but with those who work in this environment.

Conclusion

When problems arise, women and their loved ones must be helped to understand why their expectations have not been met (Goodman *et al* 2004). Every major enquiry into sub-standard care in the UK in the last 30 years (or more) has, in my view, focused on information being *deliberately* kept from patients, or simply not given to them. The aim has at least sometimes, been to prevent awkward questions from being asked and medical mistakes from being exposed. However, if you listen to *You and yours* (BBC Radio 4) for a few weeks, you quickly learn that people who can't get information and/or an apology become aggressive and more and more determined to seek redress. They don't just go away.

It will be argued that these recommendations for practice are unrealistic because they require more staff with more time to be with women and to listen to them. However, if an intelligent, woman-centred and holistic strategy for reducing the cost of claims against the maternity services is to be devised, it must, I would suggest, include weighing up the cost of employing more midwives against a figure of £3bn in litigation.

References

- Alfirevic Z, Devane D, Gyte GML (2013). Continuous cardiotocography (CTG) as a form of electronic fetal monitoring (EFM) for fetal assessment during labour. *Cochrane Database of Systematic Reviews*, Issue 3.
- Berkowitz RL (2011). Of parachutes and patient care: a call to action. *American Journal of Obstetrics and Gynecology* 205(1):7-9.
- Davis-floyd R, Sargent CF eds (1997). *Childbirth and authoritative knowledge: cross-cultural perspectives*. Berkeley, CA: University of California Press.
- Elixhauser A, Wier LM (2011). *Complicating conditions of pregnancy and childbirth. Healthcare Cost and Utilization Project (HCUP) Statistical Brief #113*. Rockville, MD: Agency for Health Care Policy and Research. <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb113.pdf> [Accessed 27 January 2015].
- Gibbins J, Thomson AM (2001). Women's expectations and experiences of childbirth. *Midwifery* 17(4):302-13.
- Goodman P, Mackey MC, Tavakoli AS (2004). Factors related to childbirth satisfaction. *Journal of Advanced Nursing* 46(2):212-9.
- Green JM, Coupland VA, Kitzinger JV (1998). *Great expectations: a prospective study of women's expectations and experiences of childbirth*. 2nd ed. Cambridge: University of Cambridge, Childcare and Development Group.
- Hart MA, Foster SN (1997). Couples' attitudes towards childbirth participation: relationship to evaluation of labor and delivery. *Journal of Perinatal and Neonatal Nursing* 11(1):10-20.
- Henary BY, Al-Yahia OA, Al-Gabbany SA *et al* (2012). Epidemiology of medico-legal litigations and related medical errors in Central and Northern Saudi Arabia. A retrospective prevalence study. *Saudi Medical Journal* 33(7):768-75.
- Keirse MJNC (2012). Roundtable discussion: the language of birth. Just ROAR – rely on acronym rhetoric. *Birth* 39(2):163-4.
- Lothian J (2006). Birth plans: the good, the bad, and the future. *JOGNN: Journal of Obstetric, Gynecologic and Neonatal Nursing* 35(2):295-303.
- Mid Staffordshire NHS Foundation Trust Public Enquiry (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Volume 3, present and future. Annexes. HC-898-III*. London: The Stationery Office.
- NHS Litigation Authority (NHLA) (2012). *Ten years of maternity claims: an analysis of NHS Litigation Authority data*. London: NHS Litigation Authority. <http://tinyurl.com/p6roerh> [Accessed 30 August 2014].
- Office for National Statistics (2013). *Characteristics of mothers: 1*. <http://www.ons.gov.uk> [Accessed 30 August 2014].
- Quine L, Rutter DR, Gowen S (1993). Women's satisfaction with the quality of the birth experience: a prospective study of social and psychological predictors. *Journal of Reproductive and Infant Psychology* 11(2):107-13.
- Simkin P (2012). Roundtable discussion: the language of birth. How do women interpret caregivers' language? *Birth* 39(2):156-7.
- Smith A (2014). Honouring the intimacy and privacy of the parents' relationship with their unborn baby. *International Journal of Birth and Parent Education* 2(1):7-10.
- Spiby H, Slade P, Escott D *et al* (2003). Selected coping strategies in labor: an investigation of women's experiences. *Birth* 30(3):189-94.
- Stern D (1995). *The motherhood constellation*. London: Karnac Books.
- Stewart M (2012). Roundtable discussion: the language of birth. Failure to progress or failure to wait? *Birth* 39(2):157-8.



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