Is childbirth safe in the UK and are there enough obstetricians? Letter to a Chief Executive

John W Eddy

If you are at term after a normal pregnancy and are not lucky enough to live in Portsmouth, then your chance of losing the baby during labour is higher in Great Britain than in nine other European countries, including Slovenia. The NHS Litigation Authority have put aside £1.3 billion for the next 5 years to cover litigation relating to cases of cerebral palsy, the majority of which will occur in GP- and midwife-led units. The European work directive will severely restrict staff grade and consultant hours of work over the next few years and this can only be made up by appointing more consultants.

CESDI REPORT

The recent Cesdi Report on perinatal mortality, which was extensively reported in the press (Irwin, 1999) in July of last year, drew attention to the fact that there are nearly 600 still births or neonatal deaths of full term babies occurring each year in the UK, which can be attributed to sub-standard care in labour. *The Daily Telegraph* in its reporting at that time, pointed out that perinatal mortality in the UK came 10th in Europe, after Slovenia. Not a position which we should be proud of.

A recent letter to the *British Medical Journal* from Professor Drife stated that the chance of losing a full term baby in labour was 1 in 400 for a home delivery, 1 in 800 for a GP or midwifery unit and 1 in 1500 for a standard obstetric consultant unit in the UK (Drife, 1999). However, in Portsmouth the loss was 1 in 15 000 because they have full consultant cover to the labour ward (Professor R Shaw, personal communication, 1999).

If we look at the maternal mortality figures over the years, we note that the anaesthetic deaths have gone down quite considerably over the last few years. If we ask ourselves why, the answer is that the anaesthetists have agreed to, and have instituted, consultant labour ward cover, 9am–5pm from Monday to Friday in most units. In some big units like Portsmouth, they have instituted 24-hour cover 7 days a week. This has resulted in a considerable reduction in maternal morbidity and mortality. That being so, it is reasonable to assume that similar consultant cover from the obstetric side would result in a fall in fetal morbidity and mortality.

I have already quoted the number of 600 deaths, which were sub-optimally managed, according to the Cesdi Report. But one must also consider the near misses which result in damaged babies, because unfortunately, they will cost a lot more than a dead baby and will have to be paid for out of the hospital budget.

OBSTETRIC LITIGATION

At a presentation by Lord Wolf on litigation in obstetrics and gynaecology, at the Royal College of Obstetricians and Gynaecologists (RCOG) in April 1999, the Litigation Authority for the NHS showed that until 1 April 1999, some £290 million was paid out on medical litigation for obstetric cases. Added to that are the hidden costs to hospitals, the loss of medical staff time while staff are dealing with these complaints, and also the cost of the lawyers.

BMA Review includes a quote by a reviewer that the additional costs for litigation in the NHS has now reached £1.7 billion a year, or that £1 in every £12 of the NHS budget is spent directly or indirectly on litigation (Toynbee, 1999). The Litigation Authority has put aside £1.3 billion to cover the cost of cases of cerebral palsy which will occur over the next 5 years, most of them in GP- or midwife-led units. If the amount of litigation could be reduced, the money saved would fund an awful lot of consultant posts. In the early 1990s, it was not uncommon to be asked to state in medical litigation reports whether the junior doctors had been on duty for an excessive amount of time and therefore, it could be argued, were tired and had made mistakes.

Recently, a barrister asked in a case where the specialist registrar (SpR) had certainly done his best and came up to the standard you would have expected of an SpR, whether if a consultant had been present on the labour ward at that time (2 pm) they would have managed the case differently. The answer of course was that if the consultant had been there since 9 am, his greater experience would have picked up the early signs of the labour going wrong and an early decision would have been made.

Therefore, by inference, the lawyers are already aware that they can argue not, did this doctor come up to the standard expected of a first year registrar, but shouldn't this patient have had a consultant looking after her, who would have managed her to the standard of a consultant. In this case, the lawyers are obviously going to argue that the hospital failed to come up to an adequate standard by failing to have fully trained staff on the labour ward at the time, as opposed to on call. They

Dr John W Eddy is Regional Adviser for Obstetrics and Gynaecology, North Thames East Department of Gynaecology, Colchester General Hospital, Colchester, Essex CO4 5JL

have clearly cottoned on to the Royal College report that there ought to be a consultant obstetrician on the labour ward from Monday to Friday, 9am–5pm.

To take this one step further, you only have to look at two recent cases in court: the Railtrack disaster and the P&O ferry disaster. In both of these, the lawyers successfully argued that safety equipment that could have been fitted to the train or boat, which would have prevented the disaster, had not been fitted because of a decision by the directors of the two appropriate companies and this constituted negligence.

Thus is it possible that we could see a case where the lawyers will argue that the lack of a consultant on the labour ward Monday to Friday, 9am–5pm, as a result of a decision by the management of a hospital, makes the management liable for any resulting problems. Could we therefore see a Chief Executive subjected to the charge of manslaughter?

I accept that in the case of the rail disaster, there was difficulty in working out which manager was responsible, because of the lack of a strict line of responsibility. However, this is not the case in a hospital when the Government has clearly stated that the Chief Executive is responsible.

Those who look after the litigation in your hospital will know that the premiums paid to the Litigation Authority have a grading of 1–3. With grade 2 you have a 15% premium reduction because of the presence of certain standards within your hospital. In the case of obstetrics, this consists of a full set of labour ward protocols. I believe that grade 3 gives you a 25% discount and it is possible that this, in the future, will be based on consultant presence on the labour ward.

While I am aware that a hospital only pays the first £100 000 of any settlement, the rest coming from the Litigation Authority, one settlement each year would probably pay for two extra consultants. Therefore, can hospitals afford not to have a consultant on cover Monday to Friday, 9am–5pm?

EUROPEAN WORK DIRECTIVE

The European Work Directive came into force in this country in October 1998. The British Medical Association (BMA) had already, before this, attempted to negotiate with the NHS Executive about the effects of this on hospital service. It was clear that the NHS Executive believed the spin doctors, that consultants do not do any work and having got the junior doctors excluded from the directive, they do not have much motivation to sort out the trained medical staff.

However, the BMA managed to persuade them that there was a problem and that it would be sensible to consider instituting derogation 21. This allows rest periods to be rolled up: a rest period is 11 hours' uninterrupted rest for 24 hours, or 24 hours' uninterrupted rest per week, or 48 hours' uninterrupted rest in a fortnight. This demonstrated that the BMA had recognized the need of the service.

The ministry has now realized the significance of this law because of the reports by KPMG about working hours for consultants that was undertaken in 1997 and again early in 1999, which confirms that the average working week of a consultant is 52 hours. This is 4 hours in excess of the European directive, which is a 48-hour week and thus the dragging of ministry feet now appears more related to their appreciation of the costs of such a problem, rather than their lack of appreciation of the problem. The BMA, however, have made it clear that, by the end of this year, those hospitals which have not affected the introduction of this directive will be prosecuted under health and safety rules. That is a criminal prosecution where managers can be subjected to up to 2 years' imprisonment and fines of up to £10 000.

Therefore, has your hospital a staffing level capable of supplying the obstetrics and gynaecology needs of your hospital and complying with the working hour directive. I am aware of one hospital in Scotland, with probably the highest consultant staffing level per delivery of any unit in the UK, where the consultants have 4 days off every 3 months, to allow for this directive.

In the unit in which I work, which has four consultants and nearly 4 000 deliveries, our work diary shows that the four of us are entitled to approximately 48 working hours (6x8-hour working days) off under derogation 21 for every month we work. To comply with derogation 21, this means we must each be given 2 months off every 8 months. Thus to cover our labour ward from Monday to Friday, 9am–5pm, the number of consultants would have to increase to eight.

TRAINING

The Royal College has decided that from April 2001, for a hospital to be recognized for training, the trainees should have direct supervision on the labour ward by a consultant Monday to Friday, 9am–5pm. If you are therefore asked why only 9am–5pm, why not a 24-hour labour ward cover, it is clear that in a number of countries, both in Europe and Japan, where consultant cover is 24 hours, 7 days a week, the minimum number of consultants required in a unit would be between 18 and 22.

At the present time, the number of training posts in obstetrics and gynaecology is being reduced. This, it is argued, is a result of the fact that we need less consultants, in spite of the above arguments. The reduction in these training posts over the next few years plus the reduction in working hours will mean that in many regions, the number of hospitals required to supply the necessary training posts could be as few as four or five. Therefore, it is quite possible for the Royal College to remove recognition of training posts from a large number of hospitals without upsetting the training programme. We have seen in the past that the General Medical Council selectively 'picked off' individual consultants when they brought in an annual yearly retaining fee in spite of the profession being against it. I can seen no reason why the College should not pick off individual units who do not comply with training standards.

To replace junior staff, who are outside the working directive, you will

have to appoint doctors who are covered by the working directive. This means they cannot work more than 48 hours a week and they cannot be on the rota to work more than 13 hours in one day, as they have to have 11 hours off. The presence of a doctor in hospital is considered to be working, not on call, which would permit him/her to work 24 hours and roll his/her time up under derogation 21.

Therefore managers have some serious problems ahead. Bad press for a hospital for not having adequate consultant labour ward cover is something best avoided. The cost of litigation will add an extra burden to the ability to balance the budget and I am sure managers could also do without being prosecuted by health and safety for failing to comply with the hours of work.

SOLUTION

A solution to this problem is at hand. The Short Report in 1979, by the last Labour government, suggested that the minimum level of staffing in obstetrics and gynaecology was one consultant for 500 deliveries. With the coming of Calman teaching and the possible loss of junior doctors and the European directive on hours, it may be that this figure should be reduced to 300 or 350 deliveries per consultant.

At the time of the Short Report, one of the problems with bringing it in, was the lack of trained senior registrars to take up an increase in obstetric posts. Other specialties in the NHS have, over the years, had problems dealing with workload because of the lack of staff. However, in the case of obstetrics now, this need not be a problem. The numbers of doctors holding or obtaining a Certificate of Completion of Specialist Training (CCST) over the next few years is quite high and there will be adequate numbers to supply the qualified consultants needed to prevent the problems listed above.

There are 240 obstetric units throughout the UK. On 1 October 1999 there will be 150 qualified CCST holders in obstetrics and gynaecology and this will rise to about 240 by the end of 2000. This only constitutes the equivalent of one consultant per unit and will in fact be inadequate to increase staffing levels to meet the above requirements. However, it is a start.

KEY POINTS

- Consultants working on the labour ward reduce perinatal mortality.
- Britain's perinatal mortality figures are the 10th highest in Europe.
- Litigation consumes £1 of every £12 in the NHS.
- Consultants work on average a 54-hour week.
- Breaking the European Working Time Directive can result in up to a £10 000 fine, or 2 years' imprisonment for the Chief Executive of a Trust.

CONCLUSIONS

It is said that the most dangerous journey of your life is down the parturition canal and that the most dangerous time of your life is the 3 minutes after birth, although, as I get older, I cannot help thinking that the last 3 minutes must be a bit 'dodgy'. That aside, can managers justify running hospitals where the staffing levels of the labour ward do not comply with the European hours of work. A haulage firm and an airline have already been prosecuted by health and safety for overworking their staff. It is now possible for managers to be prosecuted.

I therefore suggest that more consultant obstetricians should be appointed to labour wards as an immediate priority. By chance, it is possible to do this because we have a number of trained obstetricians available to fulfil this requirement for the first time since the NHS was instituted. The argument that you cannot reach a necessary standard because of lack of trained personnel is no longer valid. **HM**

Conflict of interest: none

Drife J (1999) Data on babies' safety during hospital births are being ignored. Letter. *Br Med J* **319**: 1008

Irwin A (1999) Poor medical care at birth 'kills 600 babies a year'. *The Daily Telegraph* 7 July

Toynbee P (1999) Shellshocked by cost of complaints. *BMA News Review* **17 July:** 29