Ethics and Clinical Governance in Obstetrics and Gynaecology

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ST6 Obstetrics and Gynaecology

Topics

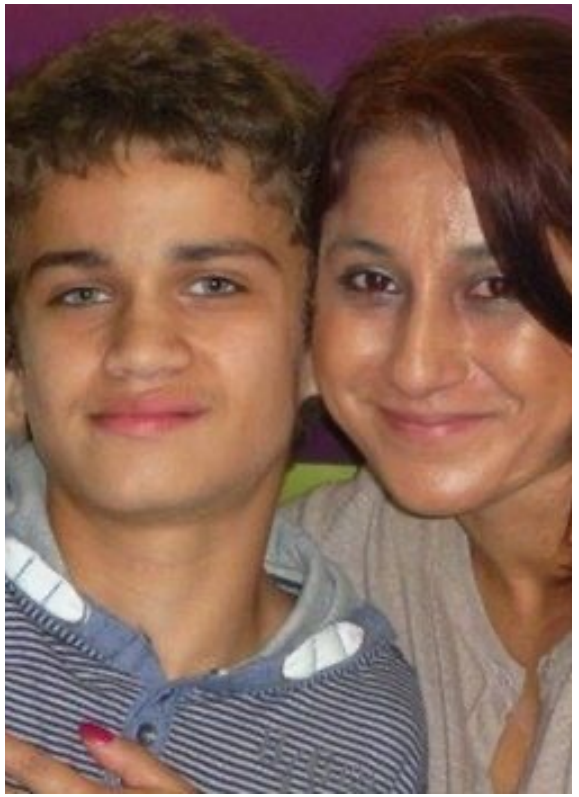
- Ethical Principles
- Montgomery vs Lanarkshire
- Abortion in the UK
- Clinical Governance
- Incident reporting and investigations
- MNSI
- MMBRACE and Perinatal Mortality Review Tool
- Ockenden

Ethical Principles in UK Obstetric Practice

- Mother’s health/life takes priority (including mental health)
- Patient autonomy
- Mental capacity
  - Understand
  - Retain
  - Weigh up
  - Communicate
- Consent and informed decision making - Montgomery

Montgomery vs Lanarkshire

- Nadine Montgomery – T1DM, fetal macrosomia
  - Not informed of the risk of shoulder dystocia or offered caesarean section
  - Shoulder dystocia resulting in cerebral palsy for her son
- Changed the Bolam test to “the general duty to attempt the disclosure of risks”
- Patients should be informed of any “material risks” of the treatment and be informed of reasonable alternatives
- These are risks that a “reasonable patient” would attach significance to (or any risk that would be significant to that particular patient)
- A patient should be told whatever they want to know, not what the doctor thinks they should be told



Abortion in the UK

Abortion is legal in the following circumstances:

a) The pregnancy has not exceeded its twenty-fourth week and that the continuance of the pregnancy would involve risk, greater than if the pregnancy were terminated, of injury to the physical or mental health of the pregnant woman or any existing children of her family; or

b) The termination is necessary to prevent grave permanent injury to the physical or mental health of the pregnant woman; or

c) The continuance of the pregnancy would involve risk to the life of the pregnant woman, greater than if the pregnancy were terminated; or

d) There is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

Abortion – conscientious objection

- “You must explain to patients if you have a conscientious objection to a particular procedure.
- You must tell them about their right to see another doctor and make sure they have enough information to exercise that right.
- In providing this information you must not imply or express disapproval of the patient’s lifestyle, choices or beliefs.
- If it is not practical for a patient to arrange to see another doctor, you must make sure that arrangements are made for another suitably qualified colleague to take over your role.”

Clinical Governance

Service User/Patient Involvement	• Involvement of patients to create/improve the service
Clinical Audit & Quality Improvement	• A way to measure and benchmark quality of care
Staffing & Staff Management	• Recruitment, retention and working conditions
Clinical Effectiveness	• Good quality, evidence based care
Risk Management & Safety	• Identifying what can/does go wrong, learning lessons, systems change
Data & Information	• Appropriate use of data, maintaining confidentiality
Education & Training	• Giving staff opportunities to update and learn new skills

Incident investigation

- Incident reporting tools - datix, Ulysses
  - A method to highlight incidents that occur and for these to be investigated
- Investigations
  - Level 1 – Concise internal investigation
  - Level 2 - Comprehensive internal investigation
  - Level 3 – Independent Investigation

Principles of Serious Incident Management

Morbidity and mortality meetings (M&Ms)

- For surgical specialties including gynaecology
- Forums where clinical staff can review the quality of care provided to patients and engage in patient safety and quality improvement processes.
- They are also an opportunity for education

Maternity and Newborn Safety Investigations (MNSI)

- Previously Healthcare Services Investigation Branch
- Undertakes maternity investigations for babies born following labour after 37 weeks and where the outcome is:
  - Baby dies during labour and before birth (intrapartum stillbirth).
  - Baby born alive and dies in the first week (0-6 days) of life (early neonatal death).
  - Baby born with a potential severe brain injury diagnosed in the first 7 days of life.
- Also investigates maternal deaths (deaths whilst pregnant or within 42 days of the end of their pregnancy).

MNSI
Maternity & Newborn Safety Investigations

MBRRACE-UK

Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

- National programme for surveillance and investigation of
  - maternal deaths
  - Perinatal mortality
  - Severe maternal morbidity
- Aim is to provide robust national information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services.
- Aims to identify themes in national mortality and morbidity that can be shared to improve practice
- Influences national guidance as well as local

Ockenden Report

- Independent review of maternity services at Shrewsbury and Telford NHS trust in response to a letter from bereaved families
- Concerns were raised after babies and mothers died or potentially suffered significant harm whilst receiving maternity care at the hospital.
- The trust “failed to investigate, failed to learn and failed to improve”
- 15 Immediate and Essential Actions (IEAs) for all trusts to undertake

Questions?