Law and Ethics for Midwifery

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Law and Ethics for Midwifery

Legal and ethical competence is a cornerstone of professional midwifery practice and an essential part of midwifery training. *Law and Ethics for Midwifery* is a unique and practical resource for student midwives.

Written by an experienced midwifery lecturer, this text draws on a wide variety of real-life case studies and focuses particularly on the core areas of accountability, autonomy and advocacy. Opening with two chapters providing overviews respectively of ethical theories and legislation, the book is then arranged thematically. These chapters have a common structure which includes case studies, relevant legislation, reflective activities and a summary, and they run across areas of concern from negligence through safeguarding to record-keeping.

Grounded in midwifery practice, the text enables student midwives to consider and prepare for ethical and legal dilemmas they may face as midwives in clinical practice.

Elinor J. Clarke is a Senior Lecturer in Midwifery at Coventry University, UK. Elinor trained at Birmingham Women's Hospital and registered as a midwife in 1982. She worked in hospital and community midwifery before undertaking a PG Certificate in Adult Education. Elinor gained a Masters in Child Care Law and Practice at Keele University. The author has many years of teaching on undergraduate and postgraduate courses in midwifery, nursing and allied healthcare professions. Elinor has considerable experience in teaching law and ethics to student midwives. She has served as an elected member of council for the Royal College of Midwives (RCM). Elinor has particular interest in ethical and legal issues around safeguarding babies and female genital mutilation (FGM). Elinor is a member of an FGM national clinical group.

This book is dedicated to two amazing women:
Dr Jenny Burton and Baroness Ruth Rendell

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My thanks also go to work colleagues who learned quickly not to ask 'Did you have a relaxing weekend?' and 'How's the book coming on?'. Especial thanks to my parents, who did ask 'How many words?' and 'How's it doing?' and then left it as 'work in progress'.

Thank you to students for asking questions, discussing dilemmas and eventually recognising that midwifery cannot be studied in isolation, and that ethics and law are fundamental to all aspects of midwifery care.

Finally, thank you to all mothers, babies and families that I have been privileged to share childbirth experiences with.

Statutes and statutory instruments

Statutes

Title	*Year*	*Source/comments*
Abortion Act	1967	Chapter 12
Abortion Amendment Act	1990	Chapter 12
Abortion Regulations Act	1991	Chapter 12
Abortion (Amendment) Regulations Act	2008	Chapter 12
Access to Health Records Act	1990	Chapter 6
Adoption Act	1976	Chapter 16
Adoption Act	2002	Chapter 16
Adoption and Children Act	1976	Chapter 13
Births and Deaths Registration Act	1953	Section 1 (4) 42 days Section 10 (1) Fathers Section 11 (1) Qualified Informant
Children Act	1989	Section 44–45 Chapter 9
Children Act	2004	Chapter 9
Congenital Disabilities (Civil Liability) Act	1976	Chapter 5, 17
Coroners and Justice Act	2009	Chapter 5, 17
Data Protection Act (DPA)	1998	Chapter 6
Disability Discrimination Act	1995	Chapter 12, 17
Domestic Violence, Crime and Victims Act	2004	Chapter 9
Domestic Violence, Crime and Victims (Amendment) Act	2012	Chapter 9
Family Law Reform Act	1969	Chapter 7
Female Genital Mutilation Act	2003	Chapter 9
Freedom of Information Act (FIA)	2000	Chapter 6, 18

Title	*Year*	*Source/comments*
Health Act	2006	Chapter 17
Health Act	2009	Chapter 17
Health Care Professions Act	2002	Chapter 5, 17
Health and Social Care Act	2001	Chapter 6
Health and Social Care Act	2008	Chapter 2, 7
Health and Social Care Act	2012	Chapter 7; Section 1, 3, 4, 5, 10, 11, 12, Chapter 1; Section 61, 62, 68 Chapter 3; 81 Part 8 (NICE) Chapter 2; HSIC Part 10 Abolition NPSA
Health Rights Act	1998	Chapter 6
Hospital Complaints Procedure Act	1985	Chapter 17, 18
Human Fertilisation & Embryology Act	1990	Chapter 12, 15
Human Fertilisation & Embryology (Deceased Fathers) Act	2003	Chapter 6
Human Fertilisation & Embryology Act	2008	Did not change the legislation (remains at 24 weeks)
Human Medicines Regulations Act	2012	Chapter 8
Human Organ Transplant Act	1989	Chapter 7
Human Tissue Act	1961	Chapter 7
Human Tissue Act	2004	Chapter 6
Infant Life Preservation Act	1929	Chapter 13
Infanticide Act	1938	Chapter 13
Medicines Act	1968	Chapter 7; Section 58 (2)
Mental Capacity Act	2005	Chapter 8
Mental Health Act	1983	Chapter 8
Mental Health Act	2007	Chapter 8
Midwives Act	1902	Chapter 4
Midwives Act	1918	Chapter 4
Midwives Act	1926	Chapter 4
Misuse of Drugs Act	1971	Chapter 8
Misuse of Drugs Regulations Act	2001	Chapter 8
National Health Service & Community Care Act	1990	Chapter 2, 11, 17 Health of the Nation (review of the NHS) White paper Working for patients Radical reform of the NHS
National Health Service Act	2006	Chapter 5

Title	*Year*	*Source/comments*
Nurses, Midwives and Health Visitors Act	1992	Chapter 3, 4
Nurses, Midwives and Health Visitors Act	1997	Chapter 3, 4
Offences Against the Persons Act	1861	Chapter 17
Prohibition of Female Circumcision Act	1985	Chapter 9
Public Interest Disclosure Act	1998	Chapter 6
Public Records Act	1958	Chapter 6
Safeguarding Vulnerable Groups Act	2006	Chapter 47
Surrogacy Arrangements Act	1985	Chapter 14

Statutory instruments

Title	*Year / No.*	*Focus*
SI 1977/1850	1997 No. 1850	Abolished the need for medical supervisors
Prescription Only Medicines (Human Use) Order No. 1997 (SI 1997/1830)	1997	Medicines
The Nurses and Midwives Approval Order SI 1983 No. 873 33/1175	1983	Principle rules Teaching qualifications
The Nursing and Midwifery (Qualifications) Order SI 1983 No. 884	1983	Identification of midwifery qualifications
SI 1986 No. 786	1986	Education
SI 1989 No. 1456	1989	Education
SI 1990 No. 1624	1990	Midwifery training
SI 1991 No. 135 The Nurses, Midwives and Health Visitors (Registration) Modification Rules Approval Order	1991	Changes to principle rules
SI 1993 No. 210 The Nurses, Midwives and Health Visitors (Midwives Amendment) Rules Approval Order	1993	Changes to Midwives Rules
SI 1996 No. 3101	1996	New rules and code
Nursing and Midwifery Order 2001 SI 2002 No. 253	2002 No. 253	Article 5.2.b NMC to prescribe requirements regarding good character
NMC (Education, Registration & Registration Appeals) Rules Order of Council 2004 (SI 2004 No. 1767)	2004 No. 1767 Rule 6	
SI 2013 No. 261 (National Health Service, England, Mental Health, England, Public Health England) Regulations	2012	Updated Midwives Rules

Title	*Year / No.*	*Focus*
NHS, England, Mental Health, England, Public Health, England. The National Health service and Public Health (Functions and Miscellaneous Provisions) Regulations 2013	2013 No. 261	Part 3 (9, 10, 11) notification of births and deaths (home birth)
SI 2014 No. 1887 The Healthcare and Associated Professions (Indemnity Arrangements)	2014 No. 1887	Professional indemnity arrangements

Cases

Legal cases

Legal Case	*Location*	*Chapter*
Baby P	Public inquiry	9
Bolam v *Friern HMC* [1957] aka *Bolam* Case	1 WLR 582	6, 17, 18
Bolitho v *City & Hackney HA* [1997]	3 WLR 1151	5, 17
Mayra Cabrera aka *Cabrera* Case 2008 (unlawful killing – Bupivacaine toxicity)	2005 2008	6
C v *S* [1987] Abortion	2 All ER 987 1 All ER 1230	12
Donaghue v *Stevenson* (1932)	AC 562	17
D v *An NHS Trust* (2004) (medical treatment consent: termination)	FLR 1110	12
Doogan and Wood v *Greater Glasgow & Clyde NHS* (2012) *Doogan & Anor, Re Judicial Review* [2012]	Scotland CS CSOH 32 (29 February)	12
Gillick v *West Norfolk & Wisbech AHA* 1986 aka *Gillick* case	AC 112	4, 6, 12
Hills v *Potter* [1938]	3 All ER 716	6
Janaway v *Salford Health Authority* (1989)	AC 537	12
Jepson v *The Chief Constable of West Mercia Police Constabulary* [2003]	EWHC 3318	12
Keeler v *Superior Court of Amador County* (1970) California Supreme Court	470 P 2d 617	12
Maynard v *West Midlands RHA* [1984]	1 WLR 634 (HL)	17
Owen v *Coventry Health Authority* 1986	See Montgomery (2003: 19)	6
Paton v *Trustees of BPAS* (1978)	2 All ER 987	12
Paton v *UK* (1980) Challenged in Brussels – failed	3 ECHR 408	12

Legal Case	*Location*	*Chapter*
P, C & S v *The UK* [2002]	2 FLR 631	9
Pearce v *United Bristol Healthcare Trust*	48 BMLR 118	6, 17
Pretty v *UK* [2002]	2 FCR 97	6
Pretty v *DPP* [2001]	UK HL	
St Georges Heathcare Trust v *S* [1998]	3 All ER 673	6
Sidaway v *Board of Governors of Bethlem Hospital* [1985]	1 All ER 643 HL	6, 17
RCN v *DHSS* (1981)	1 All ER 801, 1 All ER 545	12
Reynolds v *North Tyneside Health Authority* [2002]	Lloyds Rep Med	17
R v *Anderson* (1975)		12
Daniel Pelka	31 July 2013	9
Diane Blood (1999) Court of appeal Diane Blood (2003) *R* v *HFEA ex parte Blood*	2 All ER 687 CA 269–271	4
R v *Bourne* (1939)	1 KB 687	12
Re *MB* [1997] (adult: medical treatment)	2 FLR 426	6
Re *A* [1987] (adoption, surrogacy)	2 All ER 826	16
Re *B* 1991 (minor, abortion)	*The Independent* 22 May 1991 (Family Division)	12
Re *C* [1985] payments [2002]	1 FLR 909	16
Re *P* [1987] (family)	2 FLR 421	16
Re *S* [1992] (adult, refusal of treatment)	4 All ER 671	6
Re *T* (adult, refusal of treatment)		6
Re *W* [1992]	3 WLR 758	6
R (*Axon*) v *Secretary of State for Health* [2006]	EWHC 37	4, 12
Potts v *NWRHA* 1983	QB348	6
Jamie Whitaker 2003	HFEA	6
Mr A and Mr B 2002 (IVF mix up) Justice Butler-Sloss *Leeds Teaching Hospitals NHE Trust* v *Mr A*	High Court 2003 Lloyds Rep Med	6, 17
Whitehouse v *Jordan* (House of Lords) [1981]	1 All ER 267	17
Wilsher v *Essex Area Health Authority* [1986]	3 All ER 801	17
Natalie Evans 2005	Court of appeal ECHR 2005	6
Beth Williams 2014 (dead husband's frozen sperm)	HFEA	6

Professional misconduct cases

General Dental Council (GDC 2013) Mr Omar Addow (56 years), Birmingham UK. Misconduct hearing: struck off the GDC register for allegedly offering to perform FGM.

General Medical Council (GMC 1993) Doctor Farooque Hayder Siddique, London, UK. Struck off the GMC register for misconduct.

General Medical Council GMC (2004) Doctor struck off the GMC register for misconduct.

Nursing and Midwifery Council (2007) Midwife struck off NMC register for professional misconduct (Paul Beland).

Nursing and Midwifery Council (NMC 2013) Midwife struck off for performing male circumcision without due care (baby died following a haemorrhage) (Grace Adeleye).

Preface

Why should midwives be interested in ethics and ethical theory?

Midwifery is an old and honourable profession, which meets the needs of childbearing women and their families. While the physical act of childbirth itself is fundamentally the same as it ever was, childbirth practices, women's wishes, medical techniques, culture and our understanding of interventions are constantly evolving and changing. Midwifery has also changed and while midwives remain predominantly female, it is unethical to exclude males from joining the profession and the term midwife is not gender-specific. Midwifery practice is changed and shaped by values, beliefs and cultures, which impact upon the relationship between women and midwives. Midwives encounter ethical dilemmas on a daily basis and to ignore or fail to consider the relationship between ethics and midwifery is impossible. Midwifery education is grounded in ethics; from clinical skills through codes of conduct to professional development, NHS Constitution to evidence-based practice, mentorship to preceptorship, birth plans to care pathways, the midwife is immersed in ethical issues. In 1994, a 62-year-old Italian lady became the oldest mother, raising the ethical dilemma: just because something is possible to achieve should it be undertaken? Professor Servino Antinori has subsequently pursued other assisted reproductive techniques which may be morally questionable. Midwives are and will continue to be ethically challenged and a personal midwifery ethic needs to be identified and understood.

Ethical theory is the term given to the explanations of and application of reasoning based upon personal values, morals and behaviours. Midwifery care and maternity services are founded upon an ethical basis regarding childbirth. Attitudes and behaviours may be personal, such as honesty, compassionate and professional. Maternity services can also be ethically based, such as evidence-based, equitable and safe.

Women-focused care is a priority for midwives, and constraints of services, managers' requirements for data (evidence of efficiency and effectiveness) and the need for evidence to support practice challenges midwives to remain focused upon the basics of care. Saving mothers' lives during childbirth necessitates midwives paying attention to five aspects of care (five Cs): continuity, communication, compliance, constraints and complacency (Mander, 2011).

Why should midwives be interested in law?

Midwives should be interested in legislation because it affects all aspects of the role and responsibilities of a midwife. Regardless of where a midwife works or the type of practice the midwife is engaged in, it is necessary to understand the legal framework for practice. Midwives are accountable for their personal and professional conduct and practice. Midwives are required to have an understanding of appropriate ethical, legal and professional frameworks. In the interests of the public, purchasers and providers of services, other healthcare professionals as well as the users of maternity services, it is necessary for midwives to fully understand the implications. The NMC (2008b) identify that 'In order to provide appropriate care for women and their families midwives need to act within the law and help women to make choices, find solutions to care and consent to care.'

If it was not for the tenacity of our forebears, midwifery legislation in the form of the Midwives Act 1902 would not exist, and the right to practise midwifery as we know it today would not be possible. The Midwives Act 1902 gives protection to the name, role and responsibilities of midwives. The system of supervision in midwifery is 'enshrined in legislation'; other professions do not share this requirement. Midwifery supervision serves many purposes, but fundamentally it is intended to protect the public, enable all midwives to continue to develop following registration, and receive support when struggling to fulfil their professional role. The annual notification of intention to practise (NoP) enables the regulating body (Nursing and Midwifery Council – NMC) to fulfil its legal duties, namely protection of the public, by maintaining a live register of all midwifery practitioners (clinical, educational, research and midwifery consultants). Changes to legislation can alter and amend existing statute and midwives need to be proactive in the legislative process.

Control and regulation of midwives

Midwives and midwifery practice are currently regulated and controlled by the NMC. Most midwives, when asked, will say that the NMC is a statutory body, whose function is to protect the public. It is uncertain how many midwives would be able to identify the relevant legislation or the ethical theory and principles which underpin the role and responsibility of either the NMC or midwifery. It is a personal concern of mine as to how many midwives incorrectly think that the Royal College of Midwives (RCM) fulfils the above role. Confusion regarding regulation, professional practice, education and responsibilities need resolving. The RCM and the NMC are very different and distinct organisations: statute defines the NMC, while the RCM attempts to influence statute. A better understanding of English Law may clarify the issue. Midwives and midwifery are controlled by regulations enshrined in legislation. Primary legislation in the form of statute, such as the Midwives Act 1902, identifies how midwives and midwifery practice is controlled. While some controls of midwifery (registration) are in common with other professions, others, such as supervision, are unique. In addition the Health Care Professions Act (2002, §25) identifies the establishment of an overarching regulatory body: the Council for Healthcare Regulatory Excellence (CHRE), whose function is to regulate the regulators.

Change and ethics and law

Keeping up to date with legislation and case law is challenging. However it is important that the law evolves and changes. New legislation may be necessary to meet a developing issue such as the

commercialisation of surrogacy, physical abuse or where there is an ethical dilemma (rights of the mother versus the rights of the fetus). Sometimes, court cases do not come to or reach a good outcome, or reach a verdict which if followed would not be considered ethical. An example is the brief venture into forced Caesarean sections, whereby women were subjected to a court order to undergo a Caesarean section delivery due to fetal compromise and likely intrauterine death. A court order requiring a woman to undergo major surgery against her wishes, for the purpose of 'saving' an unborn baby, is removing her basic human right to determine what happens to her (autonomy). Pivotal cases such as *Re S (Adult-refusal of treatment)* [1992] ordered a Caesarean section against the woman's wishes, breached her fundamental human rights, increased her risk of subsequent ill health and provided opportunity for other cases to follow suit. If this case set a precedent, then other similar cases would need to come to the same result. This example illustrates how potentially ethically unsound case law can be. A poor decision should not be applied to another situation. Subsequent case law has not gone down the route of enforced Caesarean section. Even if the facts of the case share some similarity, it is not ethical to set a precedent in such complex cases, each must be considered individually, especially when complicated by other variables such as age, mental health and use of medication.

Another reason for students to be interested in ethics, legislation and case law is the context of maternity services. It is one of the most highly litigious areas (in terms of cost) of healthcare. Of cases held at the National Health Service Litigation Authority (NHSLA), currently 20 per cent concern obstetrics and childbirth cases. The NHSLA identified an expenditure of £729.1 million in 2010–2011. Care should be taken when considering this figure as the amount includes damages paid to claimants (patients, staff and members of the public) as well as legal costs incurred on both sides (claimant and defence lawyers). The NHSLA (2011) also identified a continued rise in the number of claims recorded under the Clinical Negligence Scheme for Trusts (CNST) and Liabilities to Third Parties Scheme (LTPS). While it can be argued that the number of cases for some trusts have not increased, the costs incurred in investigation, preparation for court, fees and payments ensure that NHS trusts cannot afford not to invest in providing high standards of clinical care and effective and efficient services with a good approach to user satisfaction.

Historical aspects of law and midwifery education

Law was introduced into the midwifery curriculum in the late 1980s (Jones and Jenkins, 2004). Students were usually given an overview of the English legal system, including the courts and specific legislation such as the Abortion Act 1967, and focused on professional issues (regulations, rules, codes and supervisors of midwives) as well as legal obligations of a midwife attending a home delivery (Flint, 1986). During the 1980s midwives who were fortunate enough to undertake professional development in the form of an Advanced Diploma in Midwifery (ADM) were provided with the opportunity to critically analyse midwifery regulation and were further educated in other legal aspects, such as independent midwifery and indemnity insurance. Mary Cronk and Caroline Flint captured the specific legal issues relevant to the midwives working in the community in 1989. After a brief overview of the legislation, the authors focus on the Midwives Rules (available from the then United Kingdom Central Council at a cost of £1) and professional conduct. A section of the *British Journal of Midwifery* was dedicated to the national bodies to enable midwives to improve their understanding of the regulation and control of midwifery (Henderson, 1995). The first book dedicated specifically to the legal aspects of midwifery was published in 1994 (Dimond, 1994). The foreword, by Dame Margaret Brain (at the time president

of the RCM), identified that 'it is essential that all midwives, regardless of their place of work or type of practice, fully understand the legal framework within which they practice' (Brain, 1994: vi). Since 1994 a succession of legal textbooks for midwives have been produced (Dimond 2002, 2006a, 2013; Jenkins 1995; Jones and Jenkins, 2004), all of which reinforce the message that midwives need to be familiar with the legislative process, have an understanding of litigation and accountability, comply with the statutory provisions associated with childbirth and uphold professional practice. Having an understanding of law and ethics is important, then, but being able to apply this to all aspects of midwifery practice is associated with professional development. Midwives need to develop skills for ethical and legal decision making. Hence the need for *Law and Ethics for Midwifery*!

Why this book, *Law and Ethics for Midwifery*?

The report of the Public Accounts Committee (2014) identifies that

> Having a baby is the most common reason for admission to hospital in England and, in 2012, there were almost 700,000 live births. The number of births has increased by almost a quarter in the last decade, placing increasing demands on the NHS maternity services. Maternity care is thought to have cost the NHS around £2.6 billion in 2012–2013.

Maternity cases account for one-third of total clinical negligence payments and maternity clinical negligence claims have risen by 80 per cent over the last five years. Nearly one-fifth of trusts' spending on maternity services (some £480 million in total, equivalent to £700 per birth) is for clinical negligence cover. The NHS Litigation Authority has recently produced helpful research on the causes of maternity claims, looking at data from the last ten years. The most common reasons for maternity claims have been mistakes in the management of labour, or relating to Caesarean sections and errors resulting in cerebral palsy.

Pre-registration midwifery education currently consists of a combination of theory and clinical practice. Student midwives are unable to graduate if they cannot meet requirements for both theory and practice. While the midwifery curriculum is heavy, ethical thinking and decision making are fundamental to the role and responsibilities of a midwife. *Law and Ethics for Midwifery* defines the subject, considers medical and other ethical theory, and with the use of case studies illustrates the ethical decision-making process. The use of case studies is a practical approach to enabling students to understand theory and practice. For many healthcare practitioners consideration of the law and legal cases is a daunting prospect: 'It does not interest me', 'Its too difficult' or 'If I wanted to be a lawyer I would have done a law degree' are common comments made by students who have yet to recognise that clinical practice does require a good understanding of law and the legal system. Wheeler (2012) considers the English legal system to be the drier notion of law, but recognises that students do require an understanding of the English legal system and how it can affect them and their practice as both students and registered practitioners. Initial student protestations are often followed by a gradual interest when students realise that ethics and law permeates every aspect of their lives (personal and private, as well as professional and within the wider society). Law is a complex subject and requires an appetite and motivation for thought, memory and critique – all higher-level academic skills. Law and legal proceedings are not for the faint-hearted, those lacking stamina or experiencing headaches. The main reasons that midwives may find the law difficult is the use of legal jargon and terminology, hierarchical structure, sections, and finding