Medical Leader	
Medical Expert	
Communicator	•
Advocate	•
Scholar	
Professional	
Collaborator	•
Manager	☐

Independent midwifery issue

2014 Day 1&2 – (Reserve)

You are advised of an incident that has just occurred at a small house owned by the Health Service This house is leased to two independent midwives to provide home births for the last 10 years. There have been no reviews of the lease during that time.

There is no governance connection between the independent midwifery service and the Health Service and no formally-agreed clinical protocols.

The original arrangement had been made by the then Chairperson of the Board of Management that has oversight and responsibility for all public health services within your Region / Area. She was well-known for championing maternity choices in the community especially in the promotion of choice of services.

When a client unexpectedly developed complications during delivery a hospital obstetrician was contacted and went to the house, managed the delivery and transferred the client and baby to hospital.

Your CEO asks for advice on the risk management processes that need to be considered with this service and whether the health service may carry any liability for any this independent service.

Censor's Notes

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A pass answer should include the following:

- A brief discussion / acknowledgement of the issue of vicarious liability – is the health service still vicariously liable for the performance of a health service in one of their own buildings? Even if the candidate does not know whether or not vicarious liability exists, they should mention the issue and indicate that they would seek legal advice before talking to the CEO.
- Licensing of health facilities – has the jurisdictional licensing processes for health facilities been followed in this case?
- Seek a formal review of this clinical incident between your hospital and the independent midwives.
- Acknowledgment that this arrangement, if it is to continue (regardless of the outcome of the index case), must be underpinned by strong clinical governance structures as soon as possible (Memorandum of Understanding: this might include such items as credentialing and scope of clinical practice information on health professionals providing services; review of the model of care / clinical pathway documentation; agreed common emergency protocols; risk management analysis including insurances; agreement on shared data regarding clinical outputs)

Other issues that might be touched upon:

1. Registration of the midwives – for Australian candidates: if the review shows that the care being provided is suboptimal – mandatory reporting to AHPRA? Reporting to licensing authority in the state or territory?
2. Client / patient complaint – who is responsible in this scenario for providing open disclosure?
3. Legal position of the hospital obstetrician if clinical outcome poor? Discuss good Samaritan laws or concepts. Who indemnifies the obstetrician if the obstetrician is sued as a result of this incident?

1. Licensing arrangements

2. Clinical output data?

3. What was the legal situation for the obstetrician providing care in a facility with which he/she was not familiar, not credentialed, not employed?? He/she had a duty to provide care in an emergency but how would he/she be placed if there proved to be inadequate or unsafe facilities, equipment, infection control etc

4. What is the role of the registration body for the midwives? If the client made a complaint in NZ this would go to the HDC but the Midwifery Council would certainly be involved and would be likely to carry out its own enquiry, and potentially a review of the competence of the midwives, which is called into question by their lack of planning for management of unexpected emergencies. Who approves the use of this facility for this purpose? Is it really a home birth if the home is not the woman's own or chosen home?