MIDWIVES ASSOCIATION OF IRELAND
MIDWIVES SUPPORTING MIDWIVES, WOMEN, BABIES, FAMILIES.

Midwifery Association of Ireland (MAI)

A response to call for submissions by the NMBI in respect of Section 40 of the Nurses and Midwife Act which covers indemnity insurance 22/05/2019

Introduction:

The Nursing & Midwifery Board of Ireland (NMBI), which is the Irish regulatory body, has recently been requested by the Health Service Executive (HSE) to make rules on statutory Clinical Indemnity Insurance (CII) for its registrants. Section 40 (1) of the Nurses and Midwives Act 2011 (the Act) states that "No person shall, for reward, attend a woman in childbirth unless the person is: (a) a registered midwife who maintains adequate clinical indemnity insurance in accordance with the rules" (Government of Ireland 2011). It is now a criminal offence not to have 'adequate and appropriate' indemnity arrangements in place. Section 40 (3) (a) states that if a person is found guilty of an offence "a fine or imprisonment for a term not exceeding 6 months or both" could apply (Government of Ireland 2011). It is our professional responsibility as midwives to be adequately indemnified for liability in the event of an adverse incident.

But a closer look suggests that in practice, enacting mandatory indemnity insurance for midwives may impact negatively on our scope of practice and may prevent us from practicing altogether in certain contexts unless the NMBI, our Regulatory Body, the Department of Health and other agencies engage with insurers to ensure fair, reasonable and equitable access to indemnity insurance and / or other such actions as may alleviate obstacles that are hindering access to work by midwives and access to midwifery services for women . This paper aims to set out the difficulties and possibly unintended consequences of various actions/ decisions and laws which taken together are resulting in adverse situations for midwives as well as for women babies and their families requiring maternity services in Ireland

As with all professional regulatory bodies, the NMBI's role is to safeguard the public from poor and dangerous practice. International best evidence has shown that the best way of safeguarding women using the maternity services is to give them access to midwife-led, relational continuity of care models (McLachlan et al 2012, Tracy et al 2013, Renfrew et al 2014, Sandall et al 2013, 2018). Having appropriate indemnity insurance does not make you a safer practitioner, it makes you a practitioner who can pay out in the event of liabilities incurred in practice. The key point is which requirement comes first, registration followed by access to affordable indemnity insurance, or indemnity insurance as a requirement for registration. The former gives priority to the registrant, and by doing so safeguards the

midwifery profession and the public, while the latter gives priority to acquiring indemnity insurance, and by doing so hands over control of midwifery practice to the multinational Medical Insurance Companies. In order to gain an in-depth understanding of the implications of mandatory indemnity insurance trumping registration, the issues of restrictive access to insurance for midwives in different practice setting in the Irish context needs to be explored.

State employed hospital midwives: Under the Clinical Indemnity Scheme (CIS) established in 2002, the State in the form of State Claims Agency (SCA) assumes full responsibility for the indemnification and management of all clinical negligence claims for state employed midwives. No problems here.

This is covered through the principle of vicarious liability; the principle that an employer [in this case, the State] is legally responsible and therefore liable for the acts and omissions of employees during the course of their employment.

General Practitioner employed nurse/midwives:

Timeline:

- The General Medical Services (GMS) Scheme was established in 1972.
- The 'Practice Nurse' was introduced in 1989 (Circular 89-5, DoH 1989).
- The first Direct Entry Midwifery registrant 2010.

The General Medical Services (GMS) Scheme was established in 1972. "Those GPs who opted to provide public maternity care under the combined-care scheme, enter into a contractual agreement with the health service to provide antenatal and postnatal services, and are reimbursed through the public purse via a fee-for-service contract with the HSE" (HSE 2019).

The 'Practice Nurse' was introduced in 1989 (Circular 89-5, DoH 1989). The scheme, developed by the Department of Health gave a subsidy {commonly referred to as 'the grant'] to GPs towards recruitment of the Practice Nurse. At this time, according to The Nurses Act 1950, the title nurse included the title midwife, and the majority of nurses recruited to these positions, also had a midwifery postgraduate qualification. The first four-year Direct Entry Midwifery Programme commenced in 2006, and the first NMBI Direct Entry Midwifery Students registered in 2010, some 21 years after the introduction of legislation for Practice Nurses. Direct Entry Midwives do not have a pre-existing Nurses qualification. Practice Nurse Legislation has not been amended to reflect these changes.

For GPs who have signed up to the GMS, to qualify for the HSE grant in 2019, the Practice Nurse is required to have a nursing qualification, as per the 1989 Circular. If GPs employ direct-entry midwives as opposed to nurse/midwives, they do not *officially* qualify for the HSE

grant under the current arrangements. Yet in practice, many Direct Entry Midwives are currently working in these positions. This failure to update Practice Nurse Legislation to reflect the introduction of Direct Entry Midwives has resulted in their discrimination by the HSE, inadvertently or otherwise. This situation needs to be addressed urgently.

GP employees are indemnified under the GPs/Group practices vicarious liability. What practices are indemnified depends on which insurance company is used by the Practice, i.e. Medical Protection Society (MPS) or MEDISEC

According to the Medical Protection Society (MPS), employees of GP membership are indemnified when conducting basic antenatal care including weight measuring, blood pressure and urinalysis but are not automatically indemnified when undertaking assessment of foetal growth, presentation or viability (which midwives are educated and trained and registered to carry out, within their Scope of practice). (https://www.medicalprotection.org/ireland/join/practice-nurse-membership).

MEDISEC is an Irish company owned by GPs in Ireland, for GPs in Ireland. Its website states that "*Subject to notification, Indemnity is provided in respect of the malpractice of any of your employees without additional charge. This extension cannot include a medical practitioner, dentist or midwife, but will include a practice nurse*".

https://medisec.ie/Medical-Indemnity-Insurance-Cover

Indemnity for all types of antenatal care, where the midwife is deemed to be working autonomously, requires specific approval of the Medical Defence Union (MDU), and may not always be agreed.

So, depending on what they have negotiated with their insurance company, some GPs indemnify midwives to carry out the full antenatal clinic including abdominal palpation and listening to the fetal heart, while others do not.

If not covered by their employee's indemnity insurance, practice midwives are required to have individual, "appropriate and adequate indemnity" for their own practice (INMO 2009, RCM 2012).

We urge the NMBI/INMO/HSE/Government bodies to negotiate with and inform the insurance companies that once a midwife is accepted on the register of Midwives, that she/he is legally entitled to work as a midwife and to the full scope of her practice. This is regardless of the educational path taken. As both post-registration and undergraduate midwives successfully complete their course of training, they are eligible to register as midwives and so they should both have access to affordable indemnity insurance cover.

Independent midwives (IM) and Self- Employed Community Midwives (SECM)

Timeline:

- The Irish Nurses and Midwives Organisation (INMO) ceased insurance cover for independent midwives in 2009.
- Since 2009, SECM can avail of the state clinical indemnity scheme, by signing a Memorandum of Understanding (MOU) with the HSE.

Many argue that signing the MOU seriously restricts SECM scope of practice and subjects them to scrutiny and monitoring by the HSE based on criteria/guidelines that are not always evidence based, risks SECM having their indemnity suspended without evidence of misconduct, and exposes them to the risk of prosecution and criminalization. This in turn impacts women's access to quality and safe community-based maternity services.

The first example of the negative impact of the HSE's restrictive criteria on midwives work and scope of practice is 'the rule' that three years labour ward experience out of the last five years' are required in order to be eligible to sign the MOU and register as a SECM. This rule applies to both newly qualified midwives and midwives with extensive midwifery experience. A recent enquiry to the HSE, National Home Birth Services, regarding the criteria for obtaining indemnity insurance for a practising midwife (with 30 years' experience, who in recent years has worked mostly in midwifery third level education, and on a part-time basis in a midwife-led antenatal clinic), yielded the following response: "in order to comply with the regulations set down by the HSE, three years' labour ward experience out of the last five years' are required to be eligible to sign the MOU and register as a SECM" (personal correspondence). Surely it would be more appropriate for the midwife in question to work second on call in a community midwifery setting for a short and defined period until she/he felt competent to be a named midwife with her own caseload.

It appears that instead of professional registration ensuring access to affordable indemnity, proof of indemnity is becoming a prerequisite for obtaining a licence to practice in the first instance. This is extremely concerning, given the barriers to accessing indemnity cover to work as a SECM imposed by the HSE.

The second example of the HSEs draconian powers over the midwife's right to work in the community was the tragic incident whereby a SECM with over 30 years' experience and unblemished safety record had her indemnity insurance summarily suspended with no prior notice and for reasons that were later proven to be unfounded. This had devastating personal, financial and professional consequences for the midwife concerned and the women in her care.

An example of the negative impact of the HSE's restrictive criteria on the woman's pregnancy and birth experience is the issue surrounding post-term. Currently once the woman's pregnancy is designated post-term, the SECM is legally obliged, under risk of prosecution, to hand over care of a woman, by this time trusted and well known to her/him and vice versa, to hospital-based anonymous service-providers. This threat of 'being abandoned' at your most vulnerable time in pregnancy and labour, creates fear and distrust amongst women availing of home birth services, and is acutely felt by midwives. Some women who find themselves in these circumstances may choose not to engage with the hospital services.

Finally, another example of the negative impact of the HSE's restrictive guidelines concerns women's eligibility to access home birth. Many women in the Irish jurisdiction who expressed a preference for home birth are currently excluded from availing of same, despite being well-informed of the issues involved. While these restrictions are being enforced under the guise of safety, they have not necessarily resulted in safer practice. One unintended consequence of these policies is an increased incidence of 'free birthing', the phenomenon whereby women, who do not meet the strict criteria for home birth set down by the HSE, often in desperation, decide to birth alone, without a registered midwife in attendance, with the obvious dangers that this entails.

In the first two scenarios the HSE is acting as a secondary and pseudo-licensing authority; by restricting/denying access to state insurance, it is also restricting/denying access to practice as a SECM, with potentially catastrophic consequences for community midwifery practice. The HSE's pseudo-licensing role is questionable in terms of its legality and fairness, particularly where such draconian policies are in conflict with best international evidence, do not support woman-centred care, nor do they facilitate a safe and quality maternity service. Safeguards must be put in place to prevent the HSE or any other agency from cancelling/suspending indemnity cover without notice or due regard for the harm it can do, to both the midwife and the women she serves, without concrete evidence of misconduct.

This policy by the HSE of restricting community midwifery is in direct conflict with government policy, which has prioritised the development and expansion of primary care since 2001. In 2001, the government published, the first ever policy for the development of primary care services: Primary care: A new direction (DoHC, 2001a). This proposed wider availability of GP services and the establishment of multi-disciplinary primary care teams (DoHC 2001a). It also is in conflict with the spirit of the National Maternity Strategy (DoHC 2016) which has as a main focus the "development of a community midwifery service" (DoHC 2016, Pont number 16, pg. 6).

Moreover, it is potentially damaging to the view of midwifery as a profession. In the main our hospital based maternity services are in crisis; they are underfunded, understaffed, under developed and mainly obstetric led apart from a small number of special schemes around the country. They are staff centric rather than patient/woman centred. Due to these limitations,

hospital based services lack /restrict the opportunity for any midwife to gain experience in the provision of evidence based care, continuity of care and carer and holistic care, all of which are vital requirements for the promotion and maintenance of safety of women during pregnancy labour and childbirth and in the postnatal period and care of her baby by midwives. This consolidation of experience can and should be undertaken in the community and before midwives are exposed to outdated and institutional models of care which undermine confidence in the normal and enable (through creation of fear and defensive practices) widespread interventions of questionable practices amongst low risk women such as Induction of labour, Continuous CTG monitoring and operative deliveries as evidenced in the ever increasing complicated outcomes of birth for women without any accompanying benefits.

Private Midwives' Organisations

The organisation, Private Midwives Ireland, are the only national provider of midwifery services outside of the HSE, as far as we know. They have insurance cover in the region of £15m sterling. This cover is comparable to the traditional HSE indemnity cover. The criteria does not appear to be as restrictive as those set out by the HSE. Instead, decisions regarding eligibility to birth at home are made on an individual case by case basis. Informed consent is of primary importance where the woman is given all the relevant evidenced based information and the midwife supports her in her decision making. More complex decisions will involve the multidisciplinary team. If this can work for a private organisation with good results, why can it not work for the HSE?

What level of cover is considered 'adequate and appropriate' in different clinical contexts?

To date, a clear mandate of what the minimum level of cover required has still not been clarified. The sky is the limit. No reference to what equates to 'adequate indemnity' was found in the Irish Nurses and Midwives Act 2011. According to PART 1 Section (3) Amendments to the Medical Act 1983 UK " "*appropriate cover", in relation to practice as a medical practitioner, means cover against liabilities that may be incurred in practising as such which is appropriate, having regard to the nature and extent of the risks of practising as such*" (Government of England 1983).

This same definition was applied to adequate indemnity cover when it came to UK Midwives.

Conflating midwifery and obstetric practice in terms of risk assessment

The insurance industry tends to combine midwifery with obstetrics in terms of risk assessment when it comes to deciding on premiums. However, there appears to be no

differentiation in terms of the variance in rates of pay for both of these professions and / or their very differing scopes of practice. Again, this is a crude calculation which effectively has the effect of ensuring that extremely few midwives are prepared to countenance undertaking what they are trained and educated to do, practice midwifery in the community as well as in the hospital. This conflation of midwifery with obstetrics is not surprising given that in a recent submission to the Irish Government's Health Committee on progress regarding implementation of the first National Maternity Strategy in 2016, a senior obstetrician, representing the Irish Institute of Obstetrics and Gynaecology (IOG) suggested that '……*they are both the same.* ***All obstetricians are midwives and are proud to be midwives*** *but they are also looking after more complicated cases*' (Oireachtas Health Commission February 2018). For the full transcript go to

https://www.oireachtas.ie/en/debates/debate/joint_committee_on_health/2018-02-21/3/

This conflation of the midwives' work with obstetric work results in exorbitant and unaffordable insurance premiums for midwives who work outside of the HSE and require personal clinical indemnity insurance. We note that the acceptable definition of the word "midwife" is that as defined by the ICM and endorsed by FIGO and accepted by NMBI as it in in all countries in the developed world. To propose or argue for a "watering down" or "blurring of the edges" to allow other professions/disciplines/ and other bodies to use the word midwife or midwifery is to invite further erosion of the profession of midwifery, its practice and safety records and is likely to result in increased risk and gravely adverse outcomes for women in Ireland and across the developed and third world countries. The MAI urges the NMBI to strengthen its resolve in this regard.

The MAI respectfully requests that the NMBI correspond directly with the Irish Institute of Obstetricians and Gynaecology and to Nurse registrants (those who do not hold midwifery qualifications to inform them that the use of the title 'midwife' is protected in law under section 49 of the Nurses Act, 1985 and later superseded by updated acts (Irish Nurses and Midwives Act 2011, 2018).

Section 49 (1) states that: Any person who –

"not being a person registered in the register of nurses, takes or uses the name or title of nurse or midwife, either alone or in combination with any other words or letters or any name, title or description, implying that the person is registered in the register…. shall be guilty of an offence under this section and shall be liable on summary conviction to a fine not exceeding £1,000 or to imprisonment for a term not exceeding twelve months or, at the discretion of the court, to both such fine and such imprisonment".

Much of what is decided regarding what practices are covered and costs of CII in maternity care has been informed by leaders in Obstetrics with midwifery opinion being ignored or devalued in general deliberations.

There is a need to educate insurance companies about the distinction between obstetric care and midwife care, as has been successfully done in the UK.

Self–employed midwife's individual indemnity insurance premiums should be based on analysis of the midwife's work alone, which is low risk by comparison to obstetric care, which would make their premiums more affordable. It also should be estimated based upon a % of average income for a midwife. Highly priced insurance premiums effectively kill off the right to work as a midwife in the community and perversely fly in the face of the EU directives. This must be addressed if the profession of midwifery is not only expected and required to survive but to thrive in the provision of safe and affordable maternity and neonatal care for the population of Ireland. For self- employed community midwives, we suggest that insurance companies when deciding premiums, should/could distinguish between midwives providing antenatal and postnatal care only, and midwives providing a continuum of care including childbirth however it is still necessary to do so in the context of the type of case load and average salary for midwives in Ireland as affordability is a crucial factor in the enablement of practice in the community by SECMs.

Restrictions imposed on practice midwives by Insurance companies severely limits their scope of practice and their legal rights to work as a registered midwife. This impacts women's choice and the quality of care received by the woman. It results in an antenatal encounter that is task orientated, fragmented, and involves multiple care providers. This does not promote the development of a therapeutic relationship, known to be the lynchpin for a safe, quality maternity service.

Midwives in Consultancy /Advisory/ Academic/ Administrative Roles

There is a number of midwives on the Midwives Register who are either directly or self-employed. They fulfil the criteria as set out in the definition of a midwife (ICM 2011) and contribute to the practice and body of knowledge of midwifery in a wider sense. They are practising midwives as their work is based upon and impacts the care of women during pregnancy, labour and the postnatal period and so require consideration. Whilst professional indemnity is currently provided by trade unions, one is aware of the fact that up until a few years ago, trade unions also provided indemnity for self-employed midwives conducting home births and that was subsequently withdrawn.

Bring back state-employed District Midwives

The obvious solution to this indemnity issue is to bring back the state-employed community midwife, who would have indemnity covered under the State Clinical Indemnity Scheme. Alongside the practice nurse/midwife who is an employee of the GP, the HSE could re-introduce the state-employed district/community midwife, who should be acknowledged as

an independent practitioner in her/his own right, that works in equal partnership with a named general practitioner, a named obstetrician, and other members of the primary care team, in the true spirit of interprofessional collaboration.

These midwives could work in community midwifery practices as caseload midwives who offer relational antenatal and postnatal continuity of carer, like the Swedish model. Intranatal care is provided by designated midwives in the local birthing centres or hospital setting, depending on need.

State-employed community midwives could also provide a continuum of relational continuity of care through antenatal, intranatal and postnatal period. Women could either birth at home or in the local birthing centre, or in the consultant-led hospital centre, with a known midwife in attendance, and depending on need and the wishes of the woman.

Re-introducing state-employed district midwives would support staff recruitment, staff retention, and be in keeping with the implementation of the recommendations of the Irish National Maternity Strategy (DoH 2016).

NB: The MAI recommends a concerted effort on the part of all government agencies, professional bodies, regulatory bodies, trade unions and birth activist groups to reinstate state-employed district midwifery.

Conclusion:

Great care is required when the NMBI make the rules on statutory Clinical Indemnity Insurance (CII) for its registrants. Whether registration is followed by guaranteed fair and reasonable access to affordable indemnity insurance, or indemnity insurance becomes a pre-requisite for registration is key. The former gives priority to the registrant, and by doing so safeguards the midwifery profession and the public, while the latter gives priority to acquiring indemnity insurance, and by doing so, gives control of midwifery practice over to the multinational Medical Insurance Companies. Many midwives are now finding that they cannot exercise their right to self-employment. The work of the midwife will be regulated by the insurers and employers than by their regulatory body.

As outlined above, accessing affordable clinical indemnity insurance depends largely on the midwives' chosen place of work. Thus, if a midwife works in the hospital setting as a state-employed midwife, or is eligible and agrees to signs a Memorandum of Understanding (MOU) with the HSE as a Self-Employed Community Midwife (SECM), she will automatically be covered by the state Clinical Indemnity Scheme (CIS). On the other hand, if she works outside the HSE's remit, as a self-employed independent midwife, or as a practice midwife in the private sector, or is not deemed eligible to sign the MOU with the HSE, she will need to access private clinical indemnity insurance, which is prohibitively costly at best and often simply just not available. The conflation of midwifery with obstetric practice in terms of risk assessment when it comes to deciding on premiums is partly to blame for this.

The HSE, who control access to Clinical Indemnity Insurance, appears to be stepping into the role of pseudo- regulator of midwifery practice. Is this the unthinking kind of state regulatory apparatus that continues to impose layer after layer of bureaucracy and regulation without due regard for the consequences? Or is this another strategy in the historic struggle for medical hegemony and the control of independent midwifery practice? Midwives need to be at the table and have a unified voice on this issue.

Whilst the MAI acknowledges that the NMBI is not responsible for providing indemnity cover, they are responsible for safeguarding the public. International best evidence has shown that the best way of safeguarding women using the maternity services is to provide access to midwife-led relational continuity of care models (Renfrew et al 2014). If it is now mandatory for midwives to have 'adequate and appropriate' indemnity arrangements in place in order to practice as a midwife, it is incumbent upon the NMBI to safeguard the midwifery profession by ensuring that all midwives, regardless of chosen place of work, can at least access affordable clinical indemnity cover, which does not impact or restrict the scope of their practice.

Recommendations:

Perhaps the simplest solution to this indemnity crisis is to bring back state-employed community midwives, who are respected as practitioners in their own right, and who can offer relational continuity of care models in equal partnership with the women and other professionals. The state employed community midwives offer a quality and safe maternity service, improve choices for women, are cost effective and are valued by women (Begley et al 2009, McLachlan et al 2012, Tracy et al 2013, Donnellan-Fernandez 2013Sandall et al 2018). All state employed midwives, whether working in the hospital or community setting, should have non-restricted access to clinical indemnity insurance provided for under the state Clinical Indemnity Scheme.

The development and provision of a pathway for direct entry midwives to undertake general nurse training- should they wish to. This would enable many existing practice midwives to carry out related aspects of work within the practice setting- a necessary addition given that we have 9 year's-worth of direct entry midwives registered, many of whom are currently employed as "practice nurses" as described above (with all the confusion those arrangements and titles present) and where there is a national shortage of nurses and midwives with an ageing workforce where many of the last generation of newly qualified nurses and midwives emigrated – most of whom may not return to work in Ireland as is the usual trend. Urgent revision of arrangements re the employment of GP practice Nurse /Midwives, their Scope of Practice, and their indemnity.

MIDWIVES ASSOCIATION OF IRELAND
MIDWIVES SUPPORTING MIDWIVES, WOMEN, BABIES, FAMILIES.

Written on behalf of the Midwifery Association of Ireland (MAI) by

Margaret Dunlea, Assistant Professor in Midwifery, Trinity College Dublin, MAI Committee Member.

Nanni Schluenz, Midwife, HSE Homebirth Scheme

Margaret Whiteley, Midwife, Primary Care -GP Practice

Patricia Hughes, MW & Chairperson, MAI

Footnote: we respectfully request that the authors of this paper are acknowledged and credited whereby information from this is used by others.

For reference list apply to 1st named author.