Direct Entry Midwives and Professional Liability

- **What problem is this renewed interest in professional liability trying to solve?**
  - In a 2016 survey of Coloradans who had given birth in the past 5 years, +92% reported that they did not feel harmed by their provider during pregnancy, birth or the postpartum period. Of those who did only two people felt harmed by a direct-entry midwife (98% of those who felt harmed had a hospital-based provider). [1]
  - In Colorado, all DEM clients sign 2 forms that clearly disclose that midwives are not currently covered by liability insurance - the public is well informed when make a decision to work with a midwife for their home birth
- **The existing system of professional liability coverage in maternity care doesn't work for consumers– and it won't work any better for DEM consumers than hospital consumers.[2]**
  - Only 1.5%-2.5% of hospital-based maternity-care consumers who sustained negligent injury filed a claim.
  - Only 1% of the hospital-based maternity-care consumers who were negligently injured received compensation.
  - 54%-78% of compensation payments were made to lawyers, experts and courts.
  - "Available evidence, not separately available for maternity care, suggests that the present liability system fails in about 99% of cases to compensate people who are injured as a result of medical error."
  - There is limited evidence that joint underwriting associations, insurance premium subsidies, and patient compensation funds would help.
- **Alternatives to this system are already recognized and supported in Colorado.**
  - COPIC's 3Rs program for communication and resolution is nationally recognized.[3]
  - The 3Rs program incorporates evidence-based strategies for prevention and redress of maternity care related injury like quality improvement alongside disclosure/empathy/apology and offer of compensation.
  - The 3Rs program was built on existing infrastructure like a strong relationship between the Division of Insurance, the insurers, the medical associations and boards, a culture of quick disclosure of unexpected outcomes, and the Apology for Unanticipated Outcomes Act (13-25-135).
  - These strategies coincide with what consumer want. Of those consumers who reported being harmed by a health care provider during pregnancy, birth or the postpartum period – the remedies they wanted were apology, acknowledgement, and a change of providers. See the Colorado Maternity Care Survey.
- **Credentialing and accrediting processes, shared decision making between consumers and providers, and aligning legal standards with best evidence are promising *prevention strategies* that could work for Colorado direct-entry midwives.**
  - Ensuring that direct-entry peer review is confidential and protected would support existing quality improvement efforts.
- **Health courts, administrative compensation systems, and high-low award limit agreements are promising *redress strategies* that could work for Colorado direct-entry midwives – as well as other maternity care providers.**

[1] 2016 Colorado Maternity Care Survey. This scientifically validated and reliable survey was distributed to Coloradans who have given birth in the State in the last five years. The survey is highly representative of Coloradans who choose home birth.

[2] Sakala C, Yang YT, Corry MP. Maternity Care and Liability: Pressing Problems, Substantive Solutions. New York: Childbirth Connections, January 2013.

[3] Physician Insurer, 2007: http://tinyurl.com/gtjjytq.

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"We, along with the Colorado Medical Society, think that the current tort environment is ineffective and inefficient" --COPIC Chairman and CEO Ted Clarke, MD[4]

Strategy:

- **Require midwives to carry liability insurance at levels comparable to doctors or CNMs.**

Pitfalls:

- With a small risk pool (there are less than 2000 of these midwives nationwide) less products are available, the existing products are more likely to leave the market, and they cost more.
- There is not enough competition in the market for midwifery insurance to keep rates reasonably low.
- The cost of existing premiums will drive some providers (especially rural, new, and part-time) out of business.
- The same problems facing obstetricians, that led to the creation of COPIC, are faced by direct-entry midwives, but there are fewer midwives, and they make less money.[5]
- Comparing the business model of these midwives to other maternity care providers in the state is like comparing apples to oranges.

Strategy:

- **Create a Joint Underwriting Association for direct-entry midwives like they did in Washington State.**

Pitfalls:

- Requires all insurers to participate.
- Program is currently in debt to insurers.

Strategy:

- **Create a Risk Retention Group for direct-entry midwives, or with other alternative health care providers.**

Pitfalls:

- The risk pool of direct-entry midwives, even nationwide, is probably too small.
- An alternative health care provider risk retention group would take time and money to start.

Strategy:

- **Require midwives to get a surety bond or self-insure.**

Pitfalls:

- It's not clear that such a bond is available to midwives in Colorado.
- These midwives do not generally make enough money for self-insurance type options.

Potential remedies:

- *Better integrate direct-entry midwives into the health care system.*
    - *Ensure that private and public health insurance companies are required to include direct-entry midwives in their networks and reimburse them at fair rates.*
    - *Ensure that the Health Care Availability Act includes direct-entry midwives – in particular, 13-64-202 (definitions), 13-64-301 (financial responsibility), and 13-64-502 (limitation on actions).*[6]
        - *Ensure that direct-entry midwives are properly referred to as "licensed" and not just "registered" in their practice act and regulations.*
    - *Ensure that direct-entry midwives are included in the Apology for Unanticipated Outcomes Act 13-25-135.*
    - *Ensure that direct-entry midwives are included in other health care systems infrastructure.*

[4] Colorado Medical Society, Precious Pearls, January 2015: http://www.cms.org/communications/cover-precious-pearls

[5] COPIC Description of the History of the Health Car Availability Act, https://cqrcengage.com/copic/Colorado2.

[6] "The Health Care Availability Act (HCAA) took effect on July 1, 1988, establishing a $250,000 cap on non-economic damages and a $1 million soft cap on economic damages." http://www.cms.org/communications/cover-precious-pearls Could follow recent example of Dental Hygienists with lower limits and discretion of Director to adjust.