PERINATAL JOURNAL

Original Article

Perinatal Journal 2025; 33(1):376-380

https://doi.org/10.57239/prn.25.03310044

Tribal and legal litigation in obstetrics in Basrah city; southern of Iraq

Maysara M. Albadran[1], Ayman M. Albadran[2]

[1]Department of Obstetrics & Gynecology, College of Medicine, University of Basrah, Iraq
[2]FABHS(FM)- Basrah Health Directorate- Family Health Department

Abstract

Litigation in obstetric practice has been increased worldwide. So many obstetricians adapt a defensive practice which may lead negative effect on care provided or even quitting fields of obstetrics to specialty less susceptible to litigation. To identify the commonest causes of legal and tribal litigation in the field of obstetric in our locality in order to create strategies to decrease their incidence and thus improve the quality of health delivered to pregnant women. This is a retrospective observational study held in Basrah/Iraq covers the period from 2017-2022. Information about medical litigation was collected from obstetricians and Basrah Health Directorate, including whether or not there was faults in medical care according to the decision of professional investigative committee. Non-standard medical care was found in 29.4% of litigations. 11.8% of litigations were tribal and 25% were both legal and tribal. The main cause of litigation was maternal death (42.6%), Followed by Stillbirth (13.2%). caesarean section complications (10.3%). early neonatal death (8.8%.),and hysterectomy (7.4%) . Maternal death (mainly due to postpartum hemorrhage) and stillbirth are the commonest causes of litigation in obstetrics. One third of litigation was associated with negligence or misjudgment in medical care.

Keywords: Litigation, Obstetrics, Obstetrics Nonstandard care

Introduction

Litigation in obstetric practice has been increased worldwide (1). As the family suspect new healthy member with healthy mother, the reaction to adverse outcome in obstetric may be more aggressive than that in ther medical field (2).

Studies show that 75% of senior obstetricians and gynecologists in in United Kingdom had been involved in litigation (3). Similarly, an article in Washington Post reported that 76% of Obstetrics/Gynecology professionals have been sued at least once (4). The high rates of litigation in obstetrics have had the negative impact of increasing the rate of medical indemnity given by obstetricians, thereby increasing their apprehension to obstetrics practice or even abandon the practice (5,19).

The cause of medical litigation is either due to medical negligence: when a doctor drops to do what a rational doctor would do (6), but sometimes complications and subsequent litigation occur despite reasonable medical care and attention (7,20).

If the cause of the dispute is malpractice of the doctor , usually the doctor would not like to talk about it and would prefer to give indemnity for the patients, however ,the problem is when the unsatisfactory outcome occur despite appropriate practice of the obstetrician, all these cases had discussed in details in Jordan case(8).

In Iraq in addition to legal litigation, tribal intercession has an important role in obstetric dispute mainly due to vulnerable new Iraqi state after 2003 especially in its legal system (9).

So many cases now are solved tribally without reaching legal level.

Because of fear from such disputes, many obstetricians adapt a defensive practice which could expose the patient to unnecessary exams or intervention as performing caesarean section rather than giving trial for normal vaginal delivery which result in increase in surgical complications or even quitting fields of obstetrics to speciality less susceptible to litigation (10,11).

The International FIGO plays an important role in the development of sexual, ethical, and reproductive rights guidelines that regulate professional obstetrics practice, through its committee on the ethical aspect of human reproduction and women's health. There are three major parts of this ethical and professional responsibility guideline domiciled under professional competence, women's autonomy and

Correspondence: Maysara M. Albadran, Department of Obstetrics & Gynecology, College of Medicine, University of Basrah, Iraq, **e-mail:** Maysaram1979@gmail.com, Maysara.khaluf@uobasrah.edu.iq, **Received:** June 30, 2025 **Accepted:** August 28, 2025

confidentiality, and responsibility to the community (12,13,14).

There is little information on litigations in obstetrics practice in developing countries (1). In Iraq there is no study show the volume of such issue after 2003.

The aim of this study is to identify the commonest causes of legal and tribal litigation in the field of obstetric in our locality in order to create strategies to decrease their incidence and thus improve the quality of health delivered to pregnant women.

Materials and Method

This is a retrospective observational study held in Basrah/Iraq, involves information collected from hospitals in the center and outskirts of Basrah in addition to data obtained from Basrah Health Directorate, covers the period from 2017 till 2022.

This work has been registered and approved by the College Research Ethics Committee/College of Medicine, University of Basrah, and approval also has been obtained from health directorate.

A questionnaire was used to collect information from obstetricians who work in central and rural hospitals, the questionnaire includes information about the medical degree of the obstetrician whether diploma or board degree and duration of practicing obstetric, cause and type of litigation whether tribal or legal and how it was settled. More information about legal litigations was obtained from complaints section/department of legal affairs in Basrah Health Directorate, including whether or not there was faults in medical care according to the decision of professional committee to which the cases of complaints referred.

Statistical analysis

Data were processed using Microsoft Excel 2016. Data analyzed by MedCalc statistical software version 12, using chi square analysis to find P-value. Data is expressed as N and percentage while age, gravidity and parity were expressed as mean +/- SD.

P value of < 0.05 is considered significant

Table 1. Characteristics of both patients and obstetricians and causes of litigations

Parameters	Values
Characteristics of the patients.	
Age	31.3 ± 7
Gravidity	3.9 ± 2.1
Parity	2.8 ± 1.8
Characteristics of the obstetricians	
Medical Degree	
Diploma	48 (70.6%)
Board	20 (29.4%)
Duration of practice (years)	
<10 years	28 (41.2%)
≥10 years	40 (58.8%)
Type of medical facility	
Central Hospital	51 (75%)
Rural Hospital	17 (25%)
Faults in medical care	
Standard	48 (70.6%)
Non-standard	20 (29.4%)
Type of litigation	
Legal	43 (63.2%)
Tribal	8 (11.8%)
Both (legal & tribal)	17 (25%)
Causes of litigations	
Maternal death	29 (42.6%)
Early neonatal death	6 (8.8%)
Stillbirth	9 (13.2%)
Shoulder dystocia/Erb's palsy	3 (4.4%)
Caesarian section complications	7 (10.3%)
Episiotomy complications	1 (1.5%)
Hysterectomy	5 (7.4%)
Missed pack	5 (7.4%)
Birth trauma	2 (2.9%)
Rupture uterus (repaired)	1 (1.5%)

Data are expressed as N(%)

Result

Table 1: most women with litigation were young (31.3 years ± 7SD) and of low parity (2.8 ± 1.8SD),70% of obstetricians hold diploma degree in obstetrics and gynecology.

Non-standard medical care was found in 29.4% of litigations. 11.8% of litigations were tribal and 25% were both legal and tribal.

The main cause of litigation was maternal death (42.6%): ten maternal death (34.5%) were due to primary postpartum hemorrhage, five case (17.2%) were due to uterine rupture, two cases(6.9%) were due to blood reaction after blood transfusion, other causes of maternal death were: preeclampsia complications, antepartum hemorrhage, suspected amniotic fluid embolism and suspected pulmonary embolism. The last two causes haven't been confirmed because the family refused autopsy due to cultural causes. In only seven (24.1%) of cases of maternal death autopsy was done. Stillbirth (intrauterine death and intrapartum death) was the second commonest cause of litigation (13.2%).10.3% of litigation was due to caesarean section complications including wound infection, suture sinus and burst abdomen (in one case). 8.8% was due to early neonatal death mainly due to intrapartum hypoxia. Five case (7.4%) were due to hysterectomy: one case with secondary postpartum hemorrhage, one with placenta accreta and unfortunately 3 cases with uterine rupture.

Table 2. Association between type of medical faults with medical degree, years of practice, type of medical facility and type of litigation

Parameters	Standard care n=48	Non-standard n=20	P value
Medical Degree			
Diploma	35 (72.9%)	13 (65%)	0.517
Board	13 (27.1%)	7 (35%)	
Duration of practice (years)			
<10 years	19 (39.6%)	9 (45%)	0.682
≥10 years	29 (60.4%)	11 (55%)	
Type of medical facility			
Central Hospital	38 (79.2%)	13 (65%)	0.222
Rural Hospital	10 (20.8%)	7 (35%)	
Type of litigation			
Legal	35 (72.9%)	8 (40%)	0.021
Tribal	3 (6.3%)	5 (25%)	
Both	10 (20.8%)	7 (35%)	

p-value<0.05 considered significant
Data expressed as N (%)
Data are analyzed using X^2 test (chi square analysis)

Table 2: Most (65%) of non-standard medical care cases were in diploma group, while only 35% were in board group; however, there was no statistic significant association between academic degree and faults in medical care.

There was statistically insignificant difference in adequacy of medical care among obstetricians with variable duration of experience with P value of > 0.05.

There was no significant difference in the competence of medical care whether standard or non-standard between central and rural hospitals, despite that, the incidence of medical faults were higher in central hospitals (65%).

The bulk of litigations were settled legally, while those settled both legally and tribally come in the second place.

Discussion

Before the American invasion to Iraq, tribal disputes and indemnity against doctors were prohibited by law (15,21). However, after the downfall of regime in 2003, tribal ruling councils play a remarkable role in conflicts between the women's family and doctors because of the new state vulnerability.

In total 36.8% of litigation were tribal and the incidence may even more but some obstetricians are reluctant to talk about.

Some suggest that tribal government councils settle conflicts amicably between individual away from the exorbitant expenses endured by the courts and litigants in a more flexible and faster manner (16)

Whether legal or tribal, litigation is stressful to the obstetrician financially and emotionally and may lead them to change their practice to protect themselves.

According to our study, approximately one third of litigation is associated with faults in management mainly due to misjudgment according to the opinion of investigative committee, this result agrees with the result of Hamasaki T. study, who found 35.5% of litigations in obstetrics and gynecology were associated with non-standard care (17).

Our study shows that the commonest cause of litigation in obstetrics is maternal mortality (42.6%), with primary postpartum hemorrhage is the leading cause, hence the significance of active management of the third stage of labor. The second commonest cause of litigation is stillbirth mainly due to intrauterine death. The third commonest cause was caesarean

section complications, followed by early neonatal death mainly due to intrapartum hypoxia, these findings are in harmony with those of Gowda SL. study (18).

During our study 8 cases of uterine rupture were found; 5 ended with maternal death and 3 with hysterectomy; this could be due to increased incidence of caesarean section and improper use of oxytocin for augmentation of labour in multipara.

7.4% of litigation was due to missed pack during caesarean section which we categorized separately from caesarean section complication because gossypiboma usually associated with negligence and is avoidable, this is may be due to skipping manual counting of sponge or pack by nurse and doctors especially in emergency operation.

Another 7.4% of litigations were due to hysterectomy, one of them was due to placenta accrete. This may point to the possibility of poor communication and counselling with the pregnant women and her family before the surgery.

According to our study most cases with non-standard care were within diploma group(in our locality diploma courses study takes 1 to 2 years while board degree takes 5 years) and in central hospitals despite better facilities in central hospitals which could be due to the higher number of labors and admissions in the central hospitals compared to outskirts hospitals.

Conclusion

Maternal death (mainly due to postpartum hemorrhage) and stillbirth are the commonest causes of litigation in obstetrics. One third of litigation was associated with negligence or misjudgment in medical care.

Acknowledgement: None

Financial support: This work is funded by authors themselves

Conflict of interest: There is no conflict of interest to declare

No. of figures: zero

No. of tables: 2

Ethical committee approval: EC22

References

1. Adinma J. Litigations and the Obstetrician in Clinical Practice. Ann Med Health Sci Res. 2016 Mar-Apr;6(2):74-9. doi: 10.4103/2141-9248.181847. PMID: 27213088; PMCID: PMC4866370.
2. Chou MM. Litigation in obstetrics: a lesson learnt and a lesson to share. Taiwan J Obstet Gynecol. 2006 Mar;45(1):1-9. doi: 10.1016/S1028-4559(09)60183-2. PMID: 17272201.
3. Vincent C, Bark P, Jones A, Olivieri L. The impact of litigation on obstetricians and gynaecologists. J Obstet Gynaecol. 1994;14:381–7.
4. Alice Langholt. Has Your OBGYN Been Sued for Malpractice? [Last accessed on 2015 Jan 21]. Available from: http://www.life123.com/parenting/pregnancy/prenatal.care/malpractice.shtml .
5. MacLennan AH, Spencer MK. Projections of Australian obstetricians ceasing practice and the reasons. Med J Aust. 2002;176:425–8.
6. Gillon R, editor. Principles of Health Care Ethics. Chichester: John Wiley and Sons; 1994.
7. Pandit MS, Pandit S. Medical negligence: Criminal prosecution of medical professionals, importance of medical evidence: Some guidelines for medical practitioners. Indian J Urol. 2009 Jul;25(3):379-83. doi: 10.4103/0970-1591.56207. PMID: 19881135; PMCID: PMC2779964.
8. Symonds EM. Litigation in obstetrics and gynaecology. Br J Obstet Gynaecol. 1985 May;92(5):433-4. doi: 10.1111/j.1471-0528.1985.tb01344.x. PMID: 3994926.
9. Carroll, Katherine Blue. “Tribal Law and Reconciliation in the New Iraq.” Middle East Journal, vol. 65, no. 1, 2011, pp. 11–29. JSTOR, http://www.jstor.org/stable/23012091.
10. Domingues AP, Belo A, Moura P, Vieira DN. Medico-legal litigation in Obstetrics: a characterization analysis of a decade in Portugal. Rev Bras Ginecol Obstet. 2015

May;37(5):241-6. doi: 10.1590/SO100-720320150005304. PMID: 26107576.
11. Wayne R. Cohen, Barry S. Schifrin. Medical Negligence lawsuits Relating to Labor and Delivery. Clinics in Perinatology. 2007; 34(2): 345-360.ISSN 0095-5108.https://doi.org/10.1016/j.clp.2007.03.011.
12. Adinma JI. International Federation of Gynaecology and Obstetrics/Society of Gynaecology and Obstetrics of Nigeria (FIGO/SOGON) Human Rights Code of Ethics on Women's Sexual and Reproductive Healthcare for Health Professionals in Nigeria. FIGO/SOGON Women's Sexual and Reproductive Rights Project (WOSRRIP) 2003.
13. Ogwuche AS. Compendium of Medical Law. 1st ed. Ikoyi, Nigeria: Maiyati Chambers; 2002. [Last accessed on 2016 Apr 29]. Available from: http://library.nsa.gov.ng/handle/123456789/352 .
14. FIGO Professional and Ethical Responsibilities Concerning Sexual and Reproductive Rights. Dec. 2004. [Last accessed on 2015 Jan 21]. Available from: http://www.figo.org/Codeofethics .
15. Iraqi Penal Code (Law No. 111 of 1969) section 229-231https://www.ilo.org/dyn/natlex/natlex4.detail?p_isn=57206&p_lang=en
16. Social and cultural factors affecting disputes resolution methods according to the rules of customary law. Journal of Wassit for human sciences 2022, Volume 18, Issue 52
17. Hamasaki, T., Hagihara, A. A comparison of medical litigation filed against obstetrics and gynecology, internal medicine, and surgery departments. BMC Med Ethics 16, 72 (2015). https://doi.org/10.1186/s12910-015-0065-1
18. Gowda SL, Bhandiwad A, Anupama NK. Litigations in Obstetric and Gynecological Practice: Can it be prevented? A Probability to Possibility. J Obstet Gynaecol India. 2016 Oct;66(Suppl 1):541-7. doi: 10.1007/s13224-016-0881-3. Epub 2016 Apr 16. PMID: 27651659; PMCID: PMC5016466.
19. Tarameshloo, S., & Danaee, E. (2025). Effect of adjusting the salinity of irrigation water on Catharanthus roseous plant pigments and enzyme activity changes using jasmonic acid and salicylic acid. Environment and Water Engineering, 11(2), 134-143.
20. Abbas, M., Jam, F. A., & Khan, T. I. (2024). Is it harmful or helpful? Examining the causes and consequences of generative AI usage among university students. International journal of educational technology in higher education, 21(1), 10.
21. Jam, F. A., Rauf, A. S., Husnain, I., Bilal, H. Z., Yasir, A., & Mashood, M. (2014). Identify factors affecting the management of political behavior among bank staff. African Journal of Business Management, 5(23), 9896-9904.