Midwife, Mrs C

A Report by the

Health and Disability Commissioner

(Case 03HDC07874)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Baby A	Consumer's son (deceased)
Mr B	Consumer's partner
Mrs C	Provider / Independent midwife / Registered nurse
Mrs D	Consumer's mother
Dr E	General practitioner
Dr F	General practitioner

Complaint

On 23 May 2003 the Commissioner received a complaint from Ms A about the standard of midwifery services provided to her by Mrs C, independent midwife. The following issues were identified for investigation:

On 9 December 2002 Mrs C did not provide services of an appropriate standard to Ms A. In particular Mrs C:

- *did not adequately respond to Ms A's concerns about her high blood pressure, weight gain and swelling*
- *did not determine whether there were signs of foetal distress present.*

On 6 January 2003 Mrs C did not provide services of an appropriate standard to Ms A. Mrs C:

- *did not adequately respond to Ms A's concerns about her high blood pressure, swelling and weight gain*
- *inappropriately allowed Ms A to return home instead of referring her urgently for a second opinion and further investigation.*

Furthermore, on 6 January 2003 Mrs C did not provide Ms A with adequate information about the status of her pregnancy. In particular Mrs C:

- *did not advise Ms A that she could not establish with certainty whether the baby's heartbeat was present and that Ms A should therefore seek a second opinion without delay*
- *subsequently admitted to Ms A's Lead Maternity Carer, Dr E, that she was concerned about the baby as she was sure that it was Ms A's heartbeat that she had heard and that she had told Ms A that it was the baby's heartbeat so she would feel better.*

An investigation was commenced on 1 September 2003.

Information reviewed

- Information from:
  - Ms A
  - Mrs D
  - Mrs C
  - Dr E, general practitioner, A Medical Centre
  - Dr F, general practitioner/senior partner, A Medical Centre
  - A Health and Disability Consumer Advocacy Service
- Ms A's clinical records from a public hospital
- Ms A's general practice clinical records
- Post Mortem Report for Baby A

Independent expert advice was obtained from Ms Sue Lennox, an independent midwife.

Information gathered during investigation

Background

Maternity services at the medical centre
Dr E, general practitioner, provides a maternity service at the medical centre in a "shared care" arrangement with Dr F, general practitioner and senior partner at the medical centre. At the time of the events complained about, Dr E and Dr F worked in a shared care arrangement with Mrs C, independent midwife. Mrs C had an access agreement with the birthing unit at the medical centre to use the facility and its equipment. In this arrangement the doctors are the LMCs or Lead Maternity Carers.

The term 'Lead Maternity Carer' refers to the general practitioner, midwife or obstetric specialist who has been selected by a woman to provide her with comprehensive maternity care, including the management of her labour and birth.

Dr E was Ms A's LMC for her pregnancy in 2002/03. Mrs C was her midwife. Ms A has not complained about the services provided to her by Dr E.

Antenatal visits July to November 2002
On 31 July 2002 Ms A, aged 21 years, saw Dr E at the medical centre to have her pregnancy confirmed. Dr E noted that the pregnancy was "unplanned but wanted" and that Ms A had a miscarriage two years earlier at 15 weeks' gestation. Ms A reported that a number of women in her family had suffered miscarriages and all her siblings were born by Caesarean section. Dr E prescribed Ms A daily iron tablets.

Dr E saw Ms A for her routine antenatal checks during the early part of her pregnancy, which appeared to be progressing normally. She was referred for an ultrasound scan on 14 November 2002. The scan report stated that no anatomical abnormalities were detected, and the foetal measurements were within normal range. The scan confirmed the gestational age of 20 weeks four days, estimated from the date of Ms A's last menstrual period. The estimated delivery date was 30 March 2003.

9 December visit
Mrs C first met Ms A on 9 December 2002 at a routine antenatal visit. (Dr E was on leave.) Ms A was 24 weeks pregnant.

Ms A informed me:

> "I did not want to see a midwife during the pregnancy concerned, due to a bad experience with a different midwife during an earlier pregnancy. I didn't have a choice. I was told that if I wanted to deliver in [the birthing unit] I had to have a few appointments with [Mrs C]."

Ms A told Mrs C that she had noticed some swelling of her legs, hands and face. Mrs C examined her and noted that there was some oedema (swelling) present and that Ms A had gained more weight than would be expected in a woman at that stage in her pregnancy. Mrs C tested Ms A's urine for protein (which was negative), and checked her blood pressure, which was 120/90. Mrs C stated:

> "This I felt was slightly elevated and I asked [Ms A] to come back to the health centre in the next few days to make a further check on her blood pressure. I palpated [Ms A's] abdomen and estimated the uterus size to be within normal growth range. I then listened for the foetal heart beat which I located at once. [Ms A's] mother was present and would also have heard this. The growth rate, foetal heart rate and the foetal movements are all very important indicators routinely used to assess the welfare of the baby. [Ms A] said that she was having good foetal movements and I believe there was nothing abnormal on the day to suggest foetal distress or demise."

Ms A is concerned whether at this consultation Mrs C was in fact able to identify the foetal heartbeat with confidence. She questioned whether the heart sounds Mrs C heard were maternal rather than foetal. Ms A informed me: "[I]t was the only appointment when I didn't determine for myself the difference in the heartbeat between mine and the baby's." In addition, Ms A stated that although she confirmed the presence of foetal movements, she never described them as "good", because she was unaware of what actually constituted "good" movements, having not carried a previous pregnancy beyond 15 weeks.

Mrs C suggested to Ms A that she have her blood pressure checked again in a day or two. Ms A returned to the health centre on 13 December. Her blood pressure was recorded as 140/60, which was within normal range.

6 January 2003
Mrs C saw Ms A again on 6 January 2003. Ms A had contacted the health centre to request an appointment for that day because she remained concerned about her swelling and weight gain. Mrs C told Ms A that although the antenatal clinic was fully booked she would see her.

Mrs C assessed Ms A, and recorded in the clinical notes that her legs had been swelling "but not today". She noted that Ms A's uterus seemed to be very small for the estimated gestation date, her blood pressure was 120/94, her weight 98.4kg, but there was no protein in her urine. (The presence of protein in the urine can be indicative of pre-eclampsia.) Mrs C again recorded that Ms A had felt good foetal movements but noted that she herself had difficulty finding the foetal heart.

Ms A informed me:

> "[I] told her how dizzy I was and she said to me, 'Oh, you don't seem to be so swollen at the moment'. … I don't think she was listening to me when I told her that I had been getting dizzy when I got up and down, out of chairs or anything.
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> …
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> [W]hen she was feeling the size of my uterus she said, 'Oh, there doesn't seem to be much there for 28 weeks', and she said, 'But there must be.' And then she was trying to listen to the heartbeat with a monitor and she just kept going like, 'That's you – that's you', and this kept going on for a few minutes I think. Then she was holding my pulse at the same time, and she went, 'No that's him, that's the baby. And then she said: 'No, that's fine.'"

Mrs C informed me that she was concerned about Ms A's general condition, her leg swelling and weight gain, and "her blood pressure gave rise for concern". Mrs C had difficulty hearing the baby's heartbeat because of the thickness of the abdominal wall. She said that when she did pick up what she thought was the baby's heartbeat, she checked it against Ms A's pulse. This was difficult because Ms A's wrists were bound with dressings to treat carpal tunnel syndrome. However, Mrs C was reassured by Ms A's report of foetal movements. She noted that Ms A was scheduled to see Dr E that week.

There is discrepancy in the information provided about what Ms A was told at this visit regarding her condition.

Mrs C informed me that she explained to Ms A her concerns about Ms A's weight gain, blood pressure, uterus size and leg swelling, and said that she wanted Dr E to check the baby as soon as possible.

Mrs C recalled:

> "I was aware that there was not an obstetric general practitioner immediately available as one was on leave and one was out of town that afternoon. I told [Ms A] that I was very concerned about her and insisted she make an appointment with her LMC [Dr E] as soon as possible. I ensured that [Ms A] made an appointment before she left the building. The appointment was booked with [Dr E] for the next day. I remained concerned about [Ms A] and I at no time told [Ms A] anything to make her feel better. I would only reassure a patient regarding my findings on examination, if my findings allowed me to be reassured myself."

However, Ms A informed me that Mrs C did not convey any sense of urgency. She said:

> "[Mrs C] didn't make it sound like it was overly important. I was going to make an appointment for Thursday when I was not going to be working because to me she didn't sound worried at all. I couldn't get in on Thursday, so I had to go in on Tuesday, which was the next day.
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> …
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> I was left out of the decisions regarding my baby's health. I was told everything was fine, and was sent home, when in fact nothing was fine. … I was not told what was going on, my worries were brushed aside, and there was no communication from [Mrs C].
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> …
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> What I think is not understood by [the birthing unit] staff, is that we would have done anything she asked. We would have driven to hospital in a heartbeat, this was not a broken leg, this was a very much loved and looked forward to little boy. I know that the care I received did in no way relate to our baby's death, that is not the complaint at all. But we were not given options about my care, or the right to make our own decisions, or even the truth about what was going on."

When Dr E returned to the health centre that evening, Mrs C told him of her concerns about Ms A, and that she had made an appointment for him to see her the next day.

Dr E informed me:

> "I had been away at one of our peripheral clinics and on returning [Mrs C] asked to have a word with me – this occurred at the Nurse's Station.
>
> [Mrs C] told me that she had seen [Ms A] that day and was a bit worried – she felt she had heard the Foetal Heart (FH) but was still uncertain. She told me she would like me to check the FH and that [Ms A] had an appointment to see me the next day.

> [Mrs C] was quite concerned about [Ms A's] baby and made a point of saying she wanted me to be sure I heard the FH properly and she didn't want me to rely on her having heard it the previous day."

Subsequent events
Ms A saw Dr E on 7 January. Dr E recorded in the clinical notes:

> "Hx [history] Seen midwife yest. and felt was SFD [small for dates] and diff ? did hear HR [heart rate]. Has had minimal foetal movements and no large ones at all. Hasn't had any illnesses etc.
> OE [on examination] 134/78, PR reg, No FHH [foetal heart heard]
> → RAD [radiology]: US [ultrasound] Preg: 28 weeks ([a radiology clinic])
> → Ref: [the public hospital] Delivery Suite."

Dr E referred Ms A for an urgent ultrasound scan. The report, which was telephoned through to Dr E on the afternoon of 7 January, stated:

> "Indication: No foetal heart heard.
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> Findings: The uterus contains a severely macerated foetus surrounded by very minimal amniotic fluid. Anatomical assessment is not possible.
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> …
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> COMMENT: Gestational age from the LMP [last menstrual period] and 20 week scan is 28 weeks and 2 days. Today's scan shows a deceased foetus which has grown to approximately 22 week size."

Dr E arranged for Ms A to be admitted to the public hospital maternity unit that day. In his referral letter Dr E outlined the recent antenatal checks and included Ms A's blood test results and the report of the ultrasound scan performed that day.

Ms A was admitted to the public hospital at 1.30pm by a midwife, and the obstetric registrar. Ms A and her partner, Mr B, were seen by a social worker, who discussed with them the plans of the obstetric consultant, to induce her labour and deliver the baby. The induction of labour was commenced at 5.30pm. Ms A delivered a stillborn baby boy.

The obstetric consultant contacted Ms A in March 2003 to discuss the post-mortem report on Baby A. He arranged for her to receive a copy of the report. The post-mortem report stated: "Duration of intrauterine death was between 2 (26/40) and 4 weeks (24/40) when the foetal and placental morphology and the external appearances of the baby are considered but the exact duration cannot be determined." The report confirmed that Baby A's gestational age was estimated as being 22 weeks, and noted that he "must have been growth restricted at 24/40 gestational age".

Advocacy
A meeting was arranged by a Health and Disability Consumer Advocacy Service on 9 July 2003 to discuss the issues complained about by Ms A. The meeting was attended by Dr F, Dr E, Mrs C and Ms A, supported by an advocate. The meeting failed to resolve the issues.

Additional information

Mrs C informed me:

> "I have always been very reflective in practice and consider myself to be a very thorough and caring practitioner. I have thought a lot about my care to [Ms A] and have questioned what I could have done differently. Although I felt I was clear in communicating my concerns to [Ms A], I am now double checking that women in my care understand clearly what I am communicating to them."

Dr F, general practitioner and senior partner at the medical centre, advised me:

> "[W]hile there was some uncertainty, [on 6 January] [Mrs C] considered this in the context of her next course of action. She was concerned about the issues but felt that the degree of urgency required involved assessment by her LMC, [Dr E], the next day.
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> …
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> Any reassurance offered to [Ms A] [by Mrs C] at that appointment was on the basis of what she felt was the foetal heart beat. Subsequent events have demonstrated that her findings were clearly incorrect. [Mrs C] has not, nor currently denied the error of her findings.
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> …
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> No changes have been made to our service except that [Mrs C] has retired from midwifery practice."

Ms A informed me:

> "I know that the care I received did in no way relate to our baby's death, that is not the complaint at all. But we were not given options about my care, or the right to make our own decisions, or even the truth about what was going on.
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> …
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> What I worry about is that there doesn't appear to be a system in place for when something like this happens. … My complaint is attempting to make it the best, before another pregnant woman's baby dies in utero, and she is told everything is fine and sent home.
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> …

One of the most offensive things that was said at the meeting [on 9 July 2003] was that they would have no qualms about treating another expectant mother the same way."

Independent advice to Commissioner

The following expert advice was obtained from Ms Sue Lennox, an independent midwife:

"**Report to the Health and Disability Commissioner on complaint file 03/07874**

…

Documents viewed

- Complaint letter to HDC from [Ms A] including information pertaining to communications with [the medical centre], marked 'A' (1-8)
- Transcript of interviews with [Mrs D] and [Ms A] (and covering letters) marked 'B' (9-31)
- Report from [a Health and Disability Consumer Advocacy Service] and enclosures from [Ms A] marked 'C' (32-38)
- Response and medical records provided by the Practice Manager of [the medical centre], [Dr F], marked 'D' (39-65)
- Response from [Mrs C] marked 'E' (66-69)
- Response from [Dr E] marked 'F' (70)
- Medical records from [the public hospital] marked 'G' (71-105)
- Post mortem report marked 'H' (106-113)

Questions

Was [Mrs C's] response to [Ms A's] concerns on the 9th December 2002 adequate and appropriate in the circumstances?

I don't believe [Mrs C's] response was adequate on the 9th December. [Ms A] was at 24 weeks' gestation and her diastolic blood pressure was 90. [Ms A's] concern on this visit was about her leg swelling and, in this case, [Mrs C's] response was appropriate. Enkin et al, say 'As oedema in pregnancy is common and does not define a group at risk, it should not be used as a defining sign of hypertensive disorders in pregnancy (p.71).' (Enkin et al., 2000)

Although [Mrs C] appropriately reassured [Ms A] in regard to her oedema, her response to high blood pressure – she was simply asked to have it rechecked at the end of that week – was not adequate.

According to *A Guide to Effective Care in Pregnancy* (2000)

'Pregnant women with a diastolic blood pressure between 90 and 100 mmHg in the second half of pregnancy experience an increased incidence of proteinuria and perinatal death. For that reason, a diastolic blood-pressure level somewhere between 90-100 may be considered to be a threshold between women at low risk and women with an increased risk of pregnancy complications. Mid-trimester blood pressure and mean arterial pressure are not useful for predicting pre-eclampsia, although they do predict pregnancy-induced hypertension.

A diagnosis of hypertension thus defined, is not a diagnosis of a disease but a marker of an increase in risk, and an indication for careful monitoring of mother and fetus. It is clinically important to realise that, in view of the physiological blood-pressure changes in pregnancy, a diastolic blood pressure of 90 mmhg in mid-pregnancy is more abnormal than such a pressure would be if it occurred for the first time at term' (Enkin et al., 2000 p.69)

The heart beat and fundal size seemed normal to [Mrs C], an experienced midwife, and she claims to have heard the heartbeat 'at once' and there seems no reason to doubt this claim. However, I think she should have taken the finding of raised blood pressure at this stage in pregnancy more seriously. She should have ordered blood tests, alerted the lead maternity carer to her concerns, and explained the situation to the mother.

Was [Ms A] at risk of developing problems given her previous history of miscarriage?

On its own a previous history of miscarriage would not signal or indicate a risk of developing a problem in this pregnancy. However, in the light of the raised blood pressure, the previous history of a prior fetal loss at fifteen weeks' gestation was a further reason to give the blood pressure rise significance.

Was it reasonable for [Mrs C] to rely on [Ms A's] self reporting on 'normal' foetal movements on 9 December, given [Ms A] had never experienced advanced pregnancy and did not know what 'normal' foetal movements felt like?

This was reasonable. At this stage of pregnancy there is considerable variability in how movements are felt. Movements are so minor for some women that they are not quite sure that what they are feeling are the movements and yet for other women they are so strong there is no doubt at all. Thus any sensation of movements can be considered normal.

What questions should be asked of an expectant mother in respect of foetal movements?

Movements are not a key focus at this stage of pregnancy unless there is a query about hearing the fetal heart. Feeling movements later in the pregnancy is an indication of

health but at 24 weeks' gestation there is such variability in the sensation of movement that this sign is an unreliable indicator of health. Even when there is a concern about the fetal heart it is the presence not the degree of movements that is important.

Was [Mrs C's] response to [Ms A's] concerns on 6 January 2002 adequate and appropriate in the circumstances?

No, it was inappropriate for [Mrs C] not to share her concerns about the fetal heart with [Ms A]. There was no good reason not to do so. When the concerns were so serious it was inadequate not to tell the mother because of a fear of worrying her.

[Dr F] (p.038) obviously felt that by discussing her concerns about hearing or not hearing the fetal heart with [Dr E], [Mrs C] had acted appropriately and 'Any reassurance offered to [Ms A] at that appointment was on the basis of what she felt was the foetal heart beat.' This style of practice where the carers take responsibility for any problem without 'worrying the patient' has traditionally been practised on the assumption of doing good and preventing harm. However, this is exactly what [Ms A] finds inappropriate. [Mrs C] was operating in an environment of paternalism and her practice on the 6th January reflects this style. It is inappropriate to independent midwifery standards but perhaps reflective of the context in which she worked.

The fact that [Mrs C] did not explain her concerns reflects her lack of confidence in her own findings. Her lack of action in response to her findings is another indication of this lack of confidence. If [Dr E] could order a scan in [a town] the following day, [Mrs C] could have organised one the previous day. [Mrs C] as a registered midwife was able to order scans and blood tests and both of these would have seemed a minimum expectation with high blood pressure and concern about the presence of a fetal heart.

I accept that [Mrs C] was in a difficult situation fitting [Ms A] into a busy clinic but, unless she acts on concerns as they appear, then 'being checked' is of little benefit to anyone.

[Mrs C] was not sure if she heard the foetal heart rate on 6 January. What action should a midwife take in these circumstances and what information should be given to the expectant mother?

[Ms A] should have been informed that the midwife had some concerns and then a scan arranged as soon as possible. It is possible not to hear the fetal heart initially but on closer examination or a scan find the heart is present. However the mother should be told what is found with an explanation that it may be a mistake but it does need investigating.

Was not referring [Ms A] for another opinion about the baby's heart rate a departure from expected standards? If so, how significant a departure was it?

[Ms A] was referred for another opinion and this was reasonable. However, the fact that the referral was on the next day and [Ms A] was not informed that there was an issue, is a problem. If an earlier referral was not possible then I think that [Mrs C] should herself have ordered a scan.

[Ms A] did not obtain a second opinion from [Dr E] until the following day. Was that appropriate and timely? Did she need to be seen earlier?

Yes she did need to establish whether the fetal heart was there on the previous day when she was concerned about whether it was there or not.

Were [Mrs C's] comments to [Dr E] appropriate? If not, in what way?

The comments she made to [Dr E] were appropriate. She informed him of her concerns: '[Mrs C] told me she had seen [Ms A] that day and was a bit worried – she felt she had heard the foetal heart but was still uncertain. She told me she would like me to check the FH and that [Ms A] had an appointment to see me the next day.'

The timing of her comments were inappropriate in that she did not take responsibility herself for her findings by ordering a scan and acting on her concerns.

Are there any other matters relating to the standard of care provided to [Ms A] that you wish to comment on?

[Ms A] returned on the 13th December 2002 following her December 9 appointment to have her blood pressure checked and this should have alerted the other professionals involved that despite the blood pressure having dropped, on that occasion, the fact that it had been found high warranted closer attention. [Mrs C] was not [Ms A's] Lead Maternity Carer. Instead [Ms A's] follow-up appointment was made for four weeks hence on the 6th January, (see page 076).

…

Reference

Enkin, M., Keirse, M., Neilson, J., Crowther, C., Duley, L., Hodnet, E., & Hofmeyr, J. (2000). A guide to effective care in pregnancy and childbirth: Oxford University Press."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*
2) *Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.*

RIGHT 6
Right to be Fully Informed

1) *Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –*
   a) An explanation of his or her condition; …

Other standards

New Zealand College of Midwives (Inc) **Midwives Handbook for Practice (2002)**

"**Code of Ethics**

Responsibilities to the woman

a) Midwives work in partnership with the woman.
b) Midwives accept the right of each woman to control her pregnancy and birthing experience.
c) Midwives accept that the woman is responsible for decisions that affect herself, her baby and her family/whanau.
d) Midwives uphold each woman's right to free, informed choice and consent throughout her childbirth experience."

Opinion: Breach – Mrs C

Response to Ms A's concerns – 9 December 2002
Rights 4(1) and 4(2) of the Code of Health and Disability Services Consumers' Rights (the Code) state that every consumer has the right to have services provided with reasonable care and skill and in compliance with professional standards.

Ms A complained that on 9 December 2002 Mrs C did not respond appropriately to her concerns about her high blood pressure, weight gain and leg swelling and did not determine whether there was any indication of foetal distress. (Ms A accepts that her baby's death is not related to the care she received.)

When Ms A saw Mrs C, independent midwife, for the first time at a routine antenatal visit on 9 December 2002, Ms A was in the 24th week of her pregnancy. She reported that her legs were swollen. Mrs C noted that Ms A had some oedema in her legs and that she had gained excessive weight. Mrs C palpated Ms A's abdomen to estimate the size of the foetus and checked the foetal heart rate (which she located without difficulty), and found that both were within the normal range.

Ms A's urine showed no protein, but her blood pressure was 120/90. As this was slightly elevated, Mrs C asked her to return to the medical centre in the next few days to have her blood pressure rechecked. Mrs C made an appointment to see Ms A again on 6 January 2003.

I am satisfied that Mrs C carried out the appropriate tests for a routine check-up on a patient at 24 weeks' gestation. Mrs C's response to Ms A's concern about her leg swelling was appropriate. My expert advised that oedema in pregnancy is common and by itself should not be used as a "defining sign" of hypertension in pregnancy. However, my expert commented that although Mrs C appropriately reassured Ms A about her oedema, her response to Ms A's elevated diastolic blood pressure on 9 December – asking her to return to the medical centre in a few days for a recheck – was not adequate.

My expert referred me to '*A Guide to Effective Care in Pregnancy*' (2000) which states: "Pregnant women with a diastolic blood pressure between 90 and 100mmHg in the second half of pregnancy, experience an increased incidence of proteinuria and perinatal death."

Ms A did not have proteinuria at this time but her blood pressure indicated an increased risk of pregnancy complications. I am advised that mid-trimester hypertension is not a diagnosis of disease but is a marker for increased risk and an indication that careful monitoring of the mother and foetus is required. Ms A's raised blood pressure together with her previous history of foetal loss at 15 weeks was sufficient reason to consider further assessment.

Ms A told Mrs C that she had felt the baby moving but because her previous pregnancy ended at 15 weeks, she did not know whether what she was feeling was normal foetal movement. My expert stated that it was reasonable for Ms A to assume that the foetal movements she experienced were "normal". At 24 weeks of pregnancy there is considerable

variability in how movements are felt. Some women experience very minor movements; for others the movements are so strong they are in no doubt about what they are feeling. Therefore any sensation of movement can be considered normal, but is an unreliable indicator of foetal health.

I am satisfied that Mrs C was able to locate the foetal heartbeat during this consultation and therefore it was appropriate for her to be reassured by Ms A's report of foetal movements. However, the critical aspect of the consultation was Ms A's elevated blood pressure. Mrs C should have taken the finding of raised blood pressure at this stage in Ms A's pregnancy more seriously. Mrs C should have explained the situation to Ms A, ordered blood tests and alerted the LMC, Dr E, to her findings.

Accordingly, in relation to her response to Ms A's presenting symptoms on 9 December 2002, in my opinion Mrs C did not provide midwifery services with reasonable care and skill or in compliance with professional standards, and breached Rights 4(1) and 4(2) of the Code.

Response to concerns – 6 January 2003
Ms A complained that when she attended for a further antenatal check on 6 January, Mrs C should have responded to her ongoing concerns about the progress of her pregnancy by urgently referring her to secondary services, instead of recommending that she return the following day for an assessment by the doctor.

When Mrs C assessed Ms A on 6 January she recorded that her legs had been swelling but were not swollen at that time. Mrs C noted that the uterus seemed to be too small for the estimated gestation (28 weeks) and that she had difficulty finding the foetal heartbeat. Although there was no protein in Ms A's urine, her blood pressure was 120/94 and she had gained further weight.

Ms A reported her belief that the baby had been moving. Mrs C, who was concerned about the difficulty she had in locating the foetal heartbeat, was reassured by this information. However, it is evident that Mrs C was not confident in her own findings, and more importantly lacked confidence in her own clinical judgement. Although she was reassured by Ms A's report of foetal movement, she wanted Dr E to check her findings.

In my view, Mrs C's uncertainty about her findings and concern about aspects of Ms A's general condition should have prompted her to contact Dr E where he was working, or to order further investigations. Mrs C was able to order scans and blood tests and should have done so. She did not need to wait until Dr E returned to the medical centre. My expert stated:

> "[B]oth of these would have seemed a minimum expectation with high blood pressure and concern about the presence of a foetal heart. … If [Dr E] could order a scan at [a town] the following day [7 January], [Mrs C] could have organised one [on 6 January].

…

I accept that [Mrs C] was in a difficult situation fitting [Ms A] into a busy clinic but, unless she acts on concerns as they appear, then 'being checked' is of little benefit to anyone."

Instead, Mrs C delayed acting on her concerns until Dr E returned to the medical centre that evening, when she told him of her findings and that she had arranged for Ms A to return for a further assessment the following day.

My midwifery expert stated that Mrs C's lack of action in response to her findings demonstrated a lack of confidence in her own judgement I accept my expert advice that the comments Mrs C made to Dr E about Ms A were appropriate, but the timing was not. I am concerned that Mrs C did not take responsibility herself for her findings by ordering a scan and acting on her concerns in a timely manner.

In my opinion, on 6 January 2003 Mrs C failed to provide midwifery services to Ms A with reasonable care and skill and in compliance with professional standards, and therefore breached Rights 4(1) and 4(2) of the Code.

Provision of information – 6 January 2003
Right 6(1) of the Code states that every consumer is entitled to the information that a reasonable consumer, in the circumstances, would expect to receive, including an explanation of her condition. The New Zealand College of Midwives states in the 'Midwives Handbook for Practice' (2002) that midwives must work in partnership with the woman, and accept that the woman is responsible for decisions that affect herself and her baby.

Ms A complained that Mrs C did not provide her with adequate information about the concerns she had about her baby's well-being on 6 January 2003. The essence of this aspect of the complaint is that Mrs C failed to inform Ms A that, having examined her, she could not establish with certainty or confidence whether the baby's heartbeat was present.

As previously discussed, Mrs C had difficulty in locating the heartbeat of Ms A's baby on 6 January. Ms A alleges that either Mrs C was unable to confidently identify the baby's heartbeat (as distinct from the maternal heartbeat), in which case her clinical competence is a matter for concern, or that she knew she had been unable to accurately identify the foetal heartbeat and failed to convey this and what it meant.

There is a clear difference between Mrs C's and Ms A's recollection of what information was conveyed about her condition and her baby's well-being at this visit.

Mrs C informed me that she explained to Ms A her concerns about her weight gain, blood pressure, uterus size and leg swelling, and said that she wanted Dr E to check the baby as soon as possible.

However, Ms A stated that she was sent home after seeing Mrs C on 6 January with instructions to return to see Dr E, but was given no indication that there was any urgency or that Mrs C was concerned about not being able to readily locate the foetal heartbeat. Ms A was seen by Dr E the following day only because there was no available appointment on 9 January, the day she had planned to return to the medical centre.

My expert advised that it is possible not to hear the foetal heart initially, but on closer examination, or by a scan, find that the heartbeat is present. Mrs C should have informed Ms A that she had some concerns and that an urgent scan was required. It was inappropriate for Mrs C not to share her concerns about the foetal heart with Ms A. My expert stated:

> "When the concerns were so serious it was inadequate not to tell the mother because of a fear of worrying her.
>
> [Dr F] obviously felt that by discussing her concerns about hearing or not hearing the foetal heart with [Dr E], [Mrs C] had acted appropriately and 'Any reassurance offered to [Ms A] at that appointment was on the basis of what she felt was the foetal heart-beat.' This style of practice where the carers take responsibility for the problem without 'worrying the patient' has traditionally been practised on the assumption of doing good and preventing harm. However, this is exactly what [Ms A] finds inappropriate. [Mrs C] was operating in an environment of paternalism and her practice on 6th January reflects this style. It is inappropriate to independent midwifery standards, but perhaps reflective of the context in which she worked."

[Ms A] clearly expected, and had the right to receive, a full explanation of her condition and that of her baby. I note my expert's comments about the traditional style of practice where carers take responsibility for any problem so as not to "worry the patient" on the assumption of doing good and preventing harm. In my view, whatever the nature of relevant information, a consumer is entitled to know. Although discretion in communicating is necessary, it is not for the provider to censor what information is given. Ms A was entitled to be told in a gentle but factual manner that the midwife had a suspicion there was no foetal heartbeat, which required further investigation by way of an urgent ultrasound scan. Accordingly, in my opinion Mrs C breached Right 6(1)(a) of the Code.

Actions taken

Mrs C, who has retired from nursing, provided a written apology to Ms A.

Follow-up actions

- A copy of my final report will be sent to the Nursing Council of New Zealand and the Midwifery Council.

- A copy of this report, with details identifying the parties removed, will be sent to the New Zealand College of Midwives and the Maternity Services Consumer Council, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.