Ms A

A Report by the

Health and Disability Commissioner

(Case 01HDC05774)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms B	Complainant/Consumer
Ms A	Midwife/Provider

Complaint

The Commissioner received a complaint from Ms B in relation to the services she received from Ms A, an independent midwife practising in her district. The issues arising out of the complaint that I investigated were as follows:

- *Ms A failed to assess, diagnose, and act on the symptoms Ms B presented to her with, after week 39 of her pregnancy. In particular:*
    - *Ms A did not act on presentation of a mucous plug passed from Ms B on 2 April 2001.*
    - *Ms A did not act when Ms B was leaking green coloured liquor.*

- *Ms A failed to explain options available, including an assessment of the expected risks and side effects, when Ms B showed signs of meconium stained liquor prior to Ms B's labour and birth of her baby.*

- *Ms A failed to attend to Ms B's baby in a timely manner after the baby was delivered. In particular, Ms B's baby was not suctioned on delivery.*

- *Ms A failed to attend to Ms B after Ms B's baby was delivered. In particular, Ms B was left to deliver the placenta on her own.*

Information gathered during investigation

At the time of the complaint Ms B was 18 years old. In her 39th week of pregnancy, on 30 March 2001, it was noted that her blood pressure was elevated and there was protein in her urine, symptoms indicative of toxaemia. Ms A took blood to test urates and platelets and consulted a locum consultant who advised that induction of labour was indicated.

The recommendation for induction was discussed with Ms B and her family and Ms B was admitted to hospital that night for assessment of possible induction. At 9:00pm Prostin gel was applied to induce labour. Ms B was also monitored with a CTG machine, to record uterine activity and foetal heart rate. The midwifery notes record "CTG prior – good trace. CTG continuous in situ".

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Throughout the rest of the evening, the foetal heart rate remained satisfactory. However, at 2:30am Ms B was re-assessed and it was apparent that she had not progressed into labour. A further dose of Prostin gel was therefore applied at 3:00am. This resulted in contractions. Ms B's cervix was 1-2 centimetres dilated at this time.

On the morning of 31 March, Ms A noticed irregularities in the CTG tracing. She notified the Locum Consultant, who felt there was no need for a Caesarean section at that time. At 8:00am the situation was discussed with the family, who did not wish to proceed with a Caesarean section. The Locum Consultant suggested that the situation be reassessed in two hours, so long as the CTG readings remained satisfactory. The CTG recordings subsequently improved and Ms B was discharged from hospital at 10:30am the following day, 1 April.

In her response to the complaint, Ms A stressed that the decision to induce labour and then not to perform a Caesarean section was not hers, and that she is not able to dictate the appropriate course of action to an obstetric consultant.

Ms B was closely monitored over the next 10 days, with daily checks indicating that she and the baby were doing well.

On 2 April, Ms B passed a mucous plug. Ms B states that she was leaking green-coloured liquor, although Ms A says that this would not have been possible until Ms B's waters were broken when she was in active labour on 12 April. Ms A commented that the mucous plug was not an event of any particular significance.

Ms B started having contractions at 5:30pm on 10 April. She was in contact with Ms A throughout this time. Shortly after 12 midnight on 11 April, Ms B was admitted to hospital. Although Ms B was suffering severe abdominal cramps, Ms A advised that there was no sign of uterine contractions on the CTG and Ms B's cervix was not dilating. Ms A gave Ms B pain relief and sent her home.

In the early hours of 12 April Ms B returned to the hospital, this time with regular contractions. At 7am Ms A manually ruptured the membranes. There is a slight discrepancy in the information provided to me by Ms A in relation to this issue. In her response to the complaint, Ms A stated that she ruptured the membranes at 10:00am, and at that stage noticed meconium-stained liquor. However, the clinical notes record that the membranes were in fact ruptured at 7:00am and that no liquor was observed. It was not until later – about 10:00am – that meconium-stained liquor was observed. In the circumstances, it seems apparent that this was a mistake in Ms A's response to the complaint. Her clinical notes are detailed and full, and I consider it likely that they present an accurate description of the relevant clinical events.

After rupturing the membranes, Ms A tried to contact the Locum Consultant but was unable to do so. Ms A did, however, arrange for an anaesthetist, to attend. CTG monitoring was still taking place, and the foetal heart was recorded as "satisfactory" but with a "flattish" trace.

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At 10:00am a vaginal examination was conducted, and it was at that stage that meconium-stained liquor was noted. A foetal scalp electrode was also placed on the baby. Following this, at 10:35am, the CTG tracing was recorded as being "unsatisfactory", and Ms B was repositioned and given oxygen. Ms A again paged the Locum Consultant, but received no answer. He was eventually contacted at 11:00am and attended Ms B at 11:15am. His advice at that stage was that no intervention was required and that Ms B should be reviewed at 2:00pm. At 11:45am a further change in the CTG tracing was noted and this was again brought to the Locum Consultant attention. His advice was that the tracing was probably positional, and was in the circumstances satisfactory.

Ms B's labour continued to progress satisfactorily and by 2:30pm she was fully dilated. Her CTG was noted to be "reactive". Ms A decided to wait for the onset of second stage of labour, when there is an urge to push with contractions. At 3:00pm the second stage had still not commenced and Ms A recorded that "pea soup meconium" was present.

At 5:30pm Ms A recorded that the CTG tracings showed some "variable deceleration" and that there was "copious" meconium-stained liquor present.

Ms B's perspective
Ms B informed me that she felt that she was kept completely in the dark about what was happening over the course of her labour. She was not given the opportunity to discuss matters with the specialist, and felt that she was not being communicated with because she was "too young".

In her response to the complaint, Ms A stated that she thought the specialist was providing some "reassurance" for Ms B, but clearly Ms B does not agree this was the case.

Delivery and the immediate post-partum period
At 6:23pm Ms B delivered a baby girl who breathed at birth. Shortly before delivery, Ms A asked Ms B's partner to ring the bell to summon another midwife. In the event, further assistance arrived only after several attempts to summon it, after delivery had been completed.

When the baby was delivered, the cord was tightly round her neck. Ms A informed me that at this stage she had to prioritise her actions, as she needed to deal with the cord around the neck, suction the baby and also cut and clamp the cord. She considered that the cord around the neck was the most immediate obstetric emergency, and thus she dealt with it first. Ms A stated that ideally she would have suctioned the baby prior to delivery but, in the circumstances, dealing with the positioning of the cord, and getting it cut and clamped, were the priorities.

Ms A also informed me that in her view it was unlikely that suctioning would have made any difference to the ultimate outcome, as suctioning only removes fluid and substances from the upper airways. In this case, the baby's lungs had ingested old meconium and it is doubtful whether suctioning would have been of any benefit. Ms A's view was that the meconium in the lungs was most likely present from the time of the failed induction of labour.

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Ms A cut and clamped the cord, and then checked the baby's respiratory function. Ms A noted that the baby appeared to be breathing freely, but later asked a house surgeon to check the baby's airways. Ms A then wrapped the baby in a warm towel, and gave her to the parents. Ms A then rang three bells for assistance. Hospital staff attended within three minutes of the baby's birth.

Ms A noticed that the baby's Apgar score was not improving, and she was not "pinking up". Ms A commenced resuscitation by suctioning her and giving her oxygen, to which the baby appeared to respond well. Ms B then complained of feeling shaky, and Ms A noticed she was losing blood. Accordingly, Ms A gave Ms B an ecbolic drug, and returned to caring for the baby, administering oxygen and suction. Ms A talked to the house surgeon and informed him that there had been meconium present during labour but no other signs of foetal distress. Ms B then delivered the placenta while Ms A was still attending to the baby.

After 15 minutes the paediatric team was called as the baby appeared "pale and dusky". She was later transferred to a Public Hospital's Special Care Baby Unit. She was then transferred to another Public Hospital's Neo-Natal Unit. On 26 April she was transferred to another Public Hospital and then discharged back to her family on 28 April.

I was informed by the paediatrician who subsequently cared for her that she suffered moderately severe respiratory distress soon after birth. Clinically, she had severe meconium aspiration syndrome and was ventilated for four days. Thankfully, she appears to have made a good recovery from the difficulties of her birth and does not suffer any ongoing problems.

Independent advice to Commissioner

Expert advice was obtained from Ms Anne Yates, an independent midwife. Because Ms Yates' advice contains a detailed factual chronology, to a significant degree it is replicated in the "Information gathered" section of this report. Accordingly, I have not incorporated the full text of Ms Yates' advice, to avoid unnecessary repetition of the facts. Only the concluding section of Ms Yates' advice is included in the body of this report.

The concluding section of Ms Yates' report, entitled "Expert advice required", reads as follows:

> "1. It is my opinion that [Ms A] provided reasonable and competent care during the antenatal period. Her documentation of [Ms B's] progress and rationale around specialist referral demonstrate a good knowledge of referral guidelines and pregnancy complications.

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2. [Ms A] recorded the presence of meconium stained liquor and notified the obstetrician. She continued to monitor the foetal heart rate, and record details in the clinical notes – this was appropriate management.

3. [Ms A] did provide reasonable care during delivery under the circumstances. Although it would have been preferable to have had an assistant, she prioritised her actions to enable [the baby's delivery]. It appears that [the baby] was vigorous initially and then deteriorated a few minutes later.

4. The cord was around [the baby's] neck and would have needed cutting if it was tight as this would have caused asphyxia and further compromised [her]. Without this problem occurring it is stated by [Ms A] that she would have suctioned the baby's airways, however [the baby] appeared vigorous and breathing already and so her airways were not cleared until she collapsed. It is unlikely given the research, that suctioning would have made any difference.

   It was completely appropriate under the circumstances, to ask assistance from family members in obtaining help by pressing the call bell present in the room.

5. It is not possible for the liquor to appear prior to rupturing of membranes.

   The membranes are essentially a sac, which if broken, would lead to leakage of the contents of the sac.

   Rupture of membranes can be confused by a heavy vaginal discharge common in late pregnancy or urinary incontinence also common in pregnancy. For meconium to be visible there would have to have been a rupture of membranes, regardless of whether labour occurred or not.

6. The appearance of a mucous plug does not necessitate any action and presents no risk or danger to mother or baby. It is a normal occurrence prior to or during labour, as the cervix alters its shape and consistency when the 'plug' is released. This plug is often dark brown and thick in consistency and could easily be confused with old meconium.

7. The third stage (or delivery of placenta) was noted to have taken 7 minutes following delivery.

   [Ms B] was administered an intramuscular injection of syntometrine to slow down blood loss and aid with delivery of the placenta. This injection was given 2 minutes after [the baby] was delivered, her cord clamped and cut and baby being wrapped and handed to her mother.

   It would have been around this time that [Ms A] noted the baby to be needing assistance and quite likely that for a few moments until assistance arrived, that her priority was the baby. The clinical record states that the House Surgeon was present at the time of delivery of placenta.

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There was appropriate management of third stage labour and [Ms B] did not appear to be compromised under the circumstances.

8. The placenta was noted to be old, grey and gritty and covered in meconium. The significance of this is uncertain, except that a poorly functioning placenta is often the result of antenatal pre-eclampsia, which would have made it even more likely that a baby undergoing induction is likely to show signs of distress, as its ability to cope with the stresses of labour becomes reduced by pre-existing disease and poor placental function. An unhealthy appearance of the placenta is often noted where pre-existing disease has been identified.

CONCLUSION

With hindsight it appears that [the baby] suffered some distress in the attempts to induce labour. This was demonstrated in the CTG tracing where after inserting the second dose of prostin gel there were a series of late, prolonged, decelerations for 30 minutes followed by an increase in baseline and non reactive tracing. Throughout labour, [Ms A] expressed concern regarding the 'flat' or 'reduced variability' of the foetal heart.

Often the only evidence of compensated chronic hypoxia is an increase in baseline heart rate. The late decelerations are minor images of contraction but with a time lag, if variability is reduced this is associated with foetal hypoxia.

'Severely hypoxic fetuses often return to a default heart rate of around 140bpm with absent variability, no accelerations and may also show very shallow late deceleration. This CTG appearance is often overlooked because no large decelerations are present and the baseline rate is normal.

An abnormal variability occurs when the heart rate is <5 bpm with no acceleration for >40 minutes.'

(Jenny Westgate – Guidelines for interpretation of cardiotocograms National Women's Hospital).

It is my opinion that [Ms A] provided competent and safe midwifery care to [Ms B]. She identified deviations from the normal, discussed and documented these, and referred to specialist care as required. The medical decisions made subsequently were not the responsibility of the midwife. These were:

1. Decision to induce labour.
2. Decision to stop induction of labour.
3. Decision to continue without intervening when there were foetal heart irregularities prior to labour.
4. Decision to continue labour in the presence of thick meconium liquor.
5. Decision to not proceed to caesarean or forceps birth.

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There is well documented evidence of communication throughout labour with the Obstetrician and clear handovers between [Ms A] and hospital midwives when this was required.

The inability to summons immediate medical assistance is a problem for managers of smaller maternity units, where medical and midwifery staff are also carrying out other duties. However, a response of seven minutes may also have been experienced in a larger well staffed Delivery Unit and demonstrates the complexity of providing flexible cover on a 24 hour 7 days a week basis in any maternity unit."

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 5
Right to Effective Communication

1) *Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided…*

Opinion: No breach – Clinical management

In my opinion, based on the comments of my expert advisor, Ms A did not breach the Code of Health and Disability Services Consumers' Rights. My advisor was of the opinion that Ms A provided competent care during the antenatal period, and during Ms B's labour followed decisions made by the consultant obstetrician while ensuring that appropriate monitoring was taking place, and communicating relevant matters to the obstetrician.

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The antenatal period
At 39 weeks' gestation Ms B was noted to have elevated blood pressure with protein in her urine. In the opinion of my advisor, Ms A acted appropriately in referring Ms B to an obstetric specialist because of hypertension and proteinuria. My advisor noted that the decision to induce labour is a medical decision, in this case made by the obstetric consultant after consultation with the family. My advisor noted that the midwife's responsibility in these circumstances is to carry out the induction under the supervision of the obstetrician. There is no suggestion that Ms A did so inappropriately.

In the morning, after another dose of Prostin gel had been inserted during the night, it was apparent that the labour was not progressing as anticipated and Ms A recorded a poor foetal heart trace. At that point, Ms A immediately notified the obstetrician and the possibility of a Caesarean section was considered and discussed with Ms B's family. It appears from the midwifery notes that the family was not happy with the idea of proceeding with a Caesarean. The obstetric consultant decided at that point that monitoring should continue for two hours, so long as the CTG remained satisfactory. At 9.30am decided that there was "no indication for C/S [Caesarean section] at this stage".

It is again clear that the decision not to proceed to Caesarean section was made by the obstetrician. There is no evidence that Ms A ineffectively monitored Ms B's labour, or failed to communicate any relevant information to the specialist. It appears from the medical notes that the obstetrician was properly appraised of the situation.

When the decision was made to discharge Ms B on 1 April it was also made in consultation with the obstetrician.

Accordingly, there is no evidence to suggest that Ms A provided inappropriate care to Ms B during this part of the antenatal period. It appears that Ms A was involved in closely monitoring Ms B's labour, and communicated appropriately with, and took direction from, the consultant obstetrician, who made the decisions as to Ms B's management.

Presentation of mucous plug
My expert advisor advised me that, of itself, the appearance of a mucous plug does not necessitate any action by the midwife and does not present a risk to mother or baby. In the absence of any other evidence that Ms A provided inappropriate services, the fact that she did not take specific action when Ms B passed a mucous plug on 2 April is not significant.

Failure to act when leaking green-coloured liquor
This allegation appears to be a factual mistake. Ms B's membranes were not ruptured until 12 April. Prior to that point in time, it would not have been possible for Ms B to have been leaking liquor, as the amniotic sac remained intact. My advisor noted that the rupture of membranes can be confused with other occurrences late in pregnancy, but that Ms B would not have been leaking liquor prior to the rupture of her membranes.

Progression of Ms B's labour
Over the 10 days prior to her admission on 11 April, Ms A closely monitored Ms B. There is nothing to suggest that this monitoring was ineffective or inappropriate.

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When Ms B was readmitted to hospital on 11 April after she had gone into labour, Ms A monitored her. When there was a suggestion of a poor foetal heart rate after the artificial rupture of the membranes at 7:00am that morning, Ms A unsuccessfully attempted to contact the obstetrician. It was following a vaginal examination at 10:00am that a slight trace of meconium staining was noted. Ms A again attempted to contact the obstetrician after the CTG continued to be unsatisfactory, and the specialist attended at 11:15am. At that point in time he determined that intervention was not required, and again 30 minutes later when the CTG showed non-reassuring signs. The obstetrician reviewed Ms B at 4:00pm and again it was decided that a normal vaginal delivery would be attempted.

In relation to this course of events, my midwife advisor was clear in her conclusions:

> "[Ms A] recorded the presence of meconium stained liquor and notified the obstetrician. She continued to monitor the foetal heart rate, and record details in the clinical notes – this was appropriate management. …
>
> It is my opinion that [Ms A] provided safe and competent midwifery care to [Ms B]. She identified deviations from the normal, discussed and documented these, and referred to specialist care as required. The medical decisions made subsequently were not the responsibility of the midwife. … There is well documented evidence of communication throughout labour with the Obstetrician and clear handovers between [Ms A] and the hospital midwives when this was required."

I accept this advice. It is apparent from the clinical notes that throughout Ms B's labour Ms A closely monitored Ms B, identified concerning signs such as the meconium-stained liquor and the unsatisfactory CTG trace, and sought specialist advice about the appropriate way to proceed. There is no suggestion that Ms A failed to recognise, record or communicate relevant clinical signs.

For these reasons, I consider that Ms A provided an appropriate standard of care during Ms B's labour, and did not breach the Code.

Information about options

Ms B alleged that she was not appropriately informed of the risks consequent on proceeding with a vaginal delivery in the presence of the warning signs, and that other options – such as Caesarean section – were not discussed at that time.

While I acknowledge Ms B's concerns, based on the advice from my expert advisor, I do not consider that Ms A breached the Code in relation to this issue. As I have discussed above, the decision to proceed with a vaginal delivery rather than a Caesarean section was a medical decision, and was not made by the midwife. During the course of Ms B's labour, Ms A noticed signs that gave rise to some concern. She brought these concerns to the attention of the specialist obstetrician. At that point, Ms A had recognised that decisions as to the appropriate and safe management of Ms B's labour were outside of her scope of expertise, and it was for a medical specialist to weigh the risks and benefits of the various options.

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In circumstances where a midwife has consulted a specialist because of his or her expert ability to assess the risks and benefits associated with available options, I do not consider that the midwife has a legal obligation to explain the respective risks and benefits of the options to the consumer or her family. Clearly in this case the specialist determined that vaginal delivery was the most appropriate option, despite the presence of warning signs. Ms B believes that she was not fully informed about the risks of proceeding with a vaginal delivery in the circumstances she faced, as opposed to delivery by Caesarean section. However, because the midwife is not the expert in making that assessment (which is why she seeks specialist advice) and because ultimately it is a medical, not a midwifery decision, I consider that the midwife should not be held accountable in law for a failure to explain the relative risks and benefits.

My opinion has been confirmed in discussion with my expert advisor, who considered that the obligation to explain the options in this situation did not rest with the midwife.

Accordingly, I do not consider that Ms A breached the Code in relation to the alleged failure to provide information relevant to the decision to proceed by way of vaginal delivery.

Delivery

Based on my expert advice, I have formed the opinion that Ms A did not breach the Code in relation to the care she provided to the baby following delivery.

My advisor noted that while it would have been preferable to have an assistant present, Ms A nevertheless appropriately prioritised her actions to enable the baby to be safely delivered. The cord was around her neck and needed to be cut, as it could have caused asphyxia.

In relation to the issue of suctioning, my advisor noted that suctioning would have been highly unlikely to have cleared meconium from the baby's lungs. This accords with Ms A's response to the complaint in which she stated that as the meconium was in the lungs, suctioning would not have had good effect. In any event, my advisor noted that immediately after delivery the baby appeared vigorous and was breathing, and it was for this reason that her airways were not cleared until she collapsed.

Based on comments from my advisor, I am satisfied that Ms A was faced with a difficult situation in which a multiplicity of tasks was required for the safety of the baby. My advisor agreed with Ms A's response that her immediate priority was to prevent asphyxia from the cord around the baby's neck and that this was appropriately her first action. In relation to the suctioning, my advisor also noted that as the baby was vigorous and breathing, the decision not to suction was appropriate and would be unlikely to have made any difference.

I also note my advisor's comments that it would have been preferable to have somebody present. Ms A did attempt to summon further assistance prior to the delivery, but at that stage no one was available. Overall I am satisfied that Ms A appropriately prioritised her

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actions. The fact that the baby suffered meconium aspiration was not due to Ms A's inability to suction her immediately following delivery.

Accordingly, I consider that in relation to the delivery of the baby Ms A did not breach the Code.

Delivery of placenta
About two minutes after the baby was delivered, Ms B was administered an intramuscular injection of Syntometrine to slow down blood loss and to aid with the delivery of the placenta. Shortly beforehand Ms A noted that the baby required assistance and, until assistance arrived, her priority was the baby. Ms A nevertheless did take the time to administer the ecbolic drug to Ms B.

My advisor considered that this was appropriate management in the circumstances. Ms A noted, in her response to the complaint, that she was sorry that Ms B felt she was left alone. However, there was a hospital midwife and a house surgeon present as well as herself when the placenta was delivered. It was possible that they had their backs to Ms B as they were concentrating on her baby at that time.

It is unfortunate that Ms B felt she was left to manage on her own, after the draining and emotional experience of giving birth. However, in the immediate aftermath of the birth, it was appropriate that attention was focussed on the baby.

In these circumstances, Ms A did not breach the Code.

Opinion: Breach – Communication

Relevant standards
The former Health Funding Authority's Maternity Services document, effective from March 1998, specifies relevant standards for lead maternity carers/midwives. Under the section entitled "General Service Requirements", in paragraph 3.1.3.5, the document states:

> "All Lead Maternity Carers will continue to be available to provide support and/or care if there is a transfer to Secondary Care during labour including for women planning a home birth. Lead Maternity Carers are required to be familiar with the delivery suite in secondary care units that they may from time to time need to transfer a woman to.
>
> *The decision regarding ongoing clinical roles/responsibilities is a three way process between the secondary care provider, the Lead Maternity Carer and the woman concerned. The outcome for the health of the woman and baby will be the paramount consideration.*" (emphasis added)

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As discussed above, I have found that Ms A acted appropriately in her management of Ms B's labour. Ms A did not have the primary responsibility for explaining the risks and benefits of a vaginal delivery as opposed to a Caesarean section. However, the guidelines clearly state that it is important that the lead maternity carer take an active role in discussing with the woman the respective ongoing roles of the specialist and the midwife.

I have seen no evidence that Ms A in fact engaged Ms B or the specialist in a discussion as to whether it was more appropriate for Ms B to be transferred to secondary care in light of the ongoing concern about the CTG and the meconium.

In her response to the provisional opinion, Ms A noted that due to the limited secondary facilities available in her area, even in the event of a transfer to secondary care she would have had to stay on and continue to provide midwifery care. This does not alter the need recognised by the guidelines, for a joint decision-making process among all the parties about the respective involvement of the midwife and the obstetrician. Such a discussion could still have been beneficial, even in the event that a full transfer of care to the obstetrician was not possible.

I acknowledge that Ms A has informed me that she took her clinical lead from the specialist. Nevertheless the Health Funding Authority document makes it clear that Ms A, as lead maternity carer, had an obligation to raise the issue of ongoing responsibility for care in a three-way discussion with Ms B and the specialist. Such a discussion would have provided Ms B the opportunity to have input into the management planned for her labour and birth, and allowed her to be more informed about the relative risks and benefits of the various options, and the reasons for the course of action being recommended.

In not facilitating such a discussion, Ms A did not adhere to the Health Funding Authority Guidelines – which were relevant standards in the circumstances – and thus breached Right 4(2) of the Code.

Effective communication

There was a lack of effective communication between Ms A as lead maternity carer and Ms B. Ms B felt "left in the dark" during the course of her labour, and that decisions were being made for her. In my view, Ms A's role as lead maternity carer, even when she had sought specialist consultation, necessitated her communicating effectively with Ms B to ensure that Ms B understood how her labour was progressing and why Ms A was consulting a specialist, and also to facilitate communication between Ms B and the specialist.

From Ms A's response to the complaint, it appears that she assumed the specialist was providing a degree of reassurance to Ms B. Clearly from Ms B's perspective that was not the case. As lead maternity carer, Ms A should have been more attuned to the need to ensure that Ms B was well informed. Ms A had the opportunity to build a rapport during the pregnancy and Ms B naturally looked to Ms A for information and reassurance throughout her labour.

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In her response to my provisional opinion, Ms A emphasised to me that she tried very hard to facilitate communication with Ms B. Ms A said that she informed Ms B and her family about the reasons for consulting the obstetrician. Ms A also noted, however, that the obstetrician appeared "reluctant" to communicate effectively with Ms B and her family and that he appeared to be "unused to working in a collaborative fashion". Ms A noted that this apparent reluctance to communicate was a concern to her at the time, as well as to the attending anaesthetist. Ms A also informed me that she did not feel that she was in a position to contradict the obstetrician, as this would have been unprofessional and may caused the family additional stress.

Clearly, to a certain extent, Ms A was placed in an unenviable position. As a result of clinical concerns, she consulted an obstetrician, who subsequently directed management of the situation. Ms A was also concerned at the lack of collaborative approach of the obstetrician, and that he appeared unwilling to communicate. As noted above, I consider that Ms A, in clinical terms, acted appropriately in seeking specialist assistance.

However, Ms A had an ongoing obligation to act in partnership with Ms B and to take reasonable steps to ensure that she felt informed and empowered. I acknowledge that Ms A may have felt hindered in her ability to do so as a result of her perceived attitude of the obstetrician. This made it all the more important for Ms A to maintain effective communication with Ms B, and to ensure that she was 'kept in the loop' by being a conduit of information from the various health professionals. I do not consider that this would have necessitated her contradicting clinical decisions made by the specialist.

Ms A informed me that she considers her communication to have been effective, but from Ms B's perspective this was clearly not the case. Ms B felt left out of the communication loop and disempowered throughout her labour. There is no evidence of systematic attempts to engage Ms B collaboratively in the decision-making process or to keep her informed about the progress of the labour, or the respective ongoing roles of midwife and specialist, as the management decisions unfolded.

In my opinion, Ms A breached Right 5(1) of the Code in not effectively communicating with Ms B and keeping her well informed throughout her labour.

Other comment

Following the release of my provisional opinion, I received a letter from a Senior Lecturer in Paediatrics expressing concern at some aspects of my provisional opinion, and commented as follows:

> "I have been sent a copy of the provisional opinion that your team has provided on the above case by [Ms B], who I understand is the complainant against the midwife who cared for her during labour. [Ms B] has sought my advice as I was the neonatal paediatrician who cared for her baby when she was in the neonatal

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intensive care unit at the Public Hospital. [Ms B] expressed some concern to me about the provisional opinion and asked me to look at it for her and comment on it.

I feel concerned looking at the report that there is very little mention of the morbidity to the baby in this case and I was certainly never asked for an opinion as to the severity of the neonatal illness. I realise that the complaint is against the management of labour but I don't think that the outcome for the baby can be divorced from this. Also I feel concern that the opinion of a midwife appears to be considered expert on the management of a baby exposed to meconium stained liquor at delivery when I would consider this is specialist neonatology territory.

I would like therefore to fill in a few details about the baby who was under my care.

As outlined in the report there was meconium staining noted in liquor at 1000 hours on the day of delivery and yet the baby did not deliver for another 8 hours at least. As far as I can gather it was reasonably significant meconium – not just thin meconium. Meconium passage is an indication of foetal asphyxia. The meconium is passed because when the fetus is compromised the blood flow is diverted away from the gut to protect other organs, particularly the brain, from asphyxial injury. It is a clinical sign that should not be taken lightly.

The usual protocol in any centre I have ever worked in has been that when there is meconium in the liquor, somebody from the paediatric team should be in attendance at delivery to assist in care of the infant. (I have spent many hours of my clinical training waiting for such deliveries to happen so I would be there AT the time of birth.) They would take responsibility for ensuring that the nasopharynx is suctioned while the head is on the perineum, before the infant takes his / her first breath and sucks the meconium into the lungs. If the baby is not breathing then the trachea should be suctioned under direct vision prior to resuscitation.

Failure to suction on the perineum may have been very important in this case and seems to have occurred because nobody was called to attend the delivery with the purpose of looking after the baby. Certainly once the infant cries the meconium may enter the lower airways but there appears to have been time when the infant was on the perineum to suction prior to the baby's first real breath. The midwife should never have to decide whether to cut the cord or suction because there should be somebody there for the baby and somebody there for the mother so that both things can be done at the same time.

If the meconium is already in the airways prior to delivery of the head this implies that the infant has been gasping *in utero* and this indicates significant foetal asphyxia.

This baby suffered significant morbidity. She had moderately severe respiratory distress soon after birth and again there was nobody able to give undivided attention to her immediately. She quickly developed a high oxygen requirement and the retrieval team were called. When they arrived she was being ineffectually

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> bagged after a failed intubation attempt. She was desaturated and bradycardiac. She picked up with effective bagging and intubation but initially required 100% oxygen. Clinically she had severe meconium aspiration syndrome and was ventilated for 4 days and then transferred to nasal CPAP which she was on in 30-40% oxygen when she was transferred for ongoing care to another neonatal unit so the family could be closer to home.
>
> Luckily she appeared to not have any hypoxic ischaemic encephalopathy and I was pleased to hear from her mother that she has done well since.
>
> I feel compelled to comment also that I have never known that it was usual obstetric practice to consider a woman and her baby need delivery, attempt induction and then when it fails to send the woman home for 10 days. In fact when trying to protect neonatal beds locally this weekend by asking the obstetricians to halt the induction process on a women with a baby with foetal anomalies (we had no beds for the baby) I was told very clearly by the obstetrician on call that once an induction is started it must be carried through to completion.
>
> I realise I run the risk of being seen as butting in here but feel I need to advocate not only for the care of this baby but the next one who may be born in these circumstances. That is of course the point of review, to ensure an appropriate standard of care. …"

I note the doctor's constructive comments, but in the circumstances of this case I am not persuaded to alter my conclusions about the reasonableness of the clinical care provided by Ms A.

In determining that the clinical management of the labour by the midwife was reasonable, I am guided by my expert advice from an independent expert midwifery advisor. In order to assess whether a breach of the Code has occurred, I am generally reliant on expert peer opinion as to the standards expected within the relevant profession. That is the legal standard. While the comments of clinicians from related but different disciplines may be relevant, in legal terms they are not as persuasive as direct peer evidence of standards expected within a profession.

In the present case, the advice from my expert midwifery advisor was clear and appropriate. While on some issues the doctor takes a different view, I am not persuaded that this creates any material concern that my midwifery advice does not reflect standards expected within the midwifery profession.

Nevertheless, I acknowledge that he raises two matters of general importance. First, the desirability of having another person present at the delivery who is able to assist the lead maternity carer, so as to avoid a situation where actions have to be prioritised. Secondly, where meconium is noted in the liquor during labour, a member of the paediatric team should attend the delivery. In the present case another pair of hands would have allowed immediate suctioning of the baby, although I note my advisor's comments that it is unlikely in this case that such suctioning would have made any difference.

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I bring these comments to the attention of Ms A for her future reference. I also intend to forward a copy of this opinion, with identifying details removed, to the New Zealand College of Midwives as well as the Paediatric Society of New Zealand, and specifically recommend to these organisations that they note the concerns expressed by the above doctor in relation to this case.

Proposed recommendations

I recommend that Ms A apologise to Ms B for her breach of the Code. The apology should be sent to the Office of the Health and Disability Commissioner and will be forwarded to Ms B. I note that in her response to my provisional opinion, Ms A indicated her willingness to provide such an apology.

I recommend that Ms A review her practice in light of this report, and in particular review the Ministry of Health's *Maternity Services* document, especially Appendix 1, which sets out the Guidelines for Consultation with Obstetric and Related Specialist Medical Services. (This document, effective from July 2002, replaced the previous Health Funding Authority Guidelines.) I draw Ms A's attention to paragraph 5.0 of Appendix 1, which makes explicit the requirement of establishing the woman's wishes in determining the ongoing roles and responsibilities of midwife and specialist.

Further actions

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

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