Midwife, Ms B

Opinion – Case 98HDC11371

Complaint

The Commissioner received a complaint from Mrs A that her midwife, Ms B:

- *did not advise Mrs A of the option of shared care with a doctor and advised Mrs A that no doctor would be involved in her care during the pregnancy because doctors did not know any more than midwives.*
- *was constantly late, was rushed or did not arrive for arranged appointments with Mrs A.*
- *did not ring Mrs A to report the results of blood and swab tests and that Mrs A had to wait up to three weeks for results to be given at the next visit.*
- *did not respond appropriately to a request from Mrs A on her due date of 17 November 1997 to induce the birth of her baby.*
- *did not arrange for a scan to be done when requested on 20 November 1997 until six days later, even though Mrs A was worried about the health of her baby.*

Investigation

The complaint was received on 27 January 1998 from Mrs A and an investigation was commenced. Information was obtained from:

Mrs A	Consumer
Ms B	Midwife
Dr C	Obstetrician
Dr D	Pathologist

The Commissioner also received advice from a midwife.

Outcome of Investigation

When Mrs A discovered she was pregnant, her GP advised her on 25 March 1997 that he did not undertake obstetric cases and he discussed lead maternity care options with her. He advised her to see another GP to discuss these options further.

On 20 May 1997, Mrs A met with Ms B, midwife to discuss her maternity care arrangements. Mrs A said she was not given the option of having a doctor share care during the pregnancy.

Continued on next page

Midwife, Ms B

Opinion – Case 98HDC11371, continued

Outcome of Investigation *continued*

Ms B stated she discussed the options with Mrs A and gave her the Health Funding Authority brochure, "*Your Choices in Childbirth*". Ms B reported Mrs A opted for the "midwife only" care arrangement and chose her as lead maternity carer.

Mrs A stated that Ms B informed her that she would not be having a doctor as well as a midwife, and that doctors do not know anything more than midwives. In response, Ms B stated that she advised Mrs A that if there were problems in the pregnancy Ms B would consult a specialist, rather than a GP. She advised that, as GPs and midwives deal with normal pregnancies and birth, if there were problems the appropriate action would be to refer to a Consultant Obstetrician.

Ms B was aware that Mrs A had suffered from toxaemia during her first pregnancy and her baby had been induced two weeks early. Ms B considered that she managed the second pregnancy appropriately and with the knowledge of this history. She advised that Mrs A's HOP screens were normal, as was her blood pressure and urinalysis.

During the midwife's visits, Mrs A complained that Ms B was constantly late, was rushed or did not arrive for arranged appointments. Ms B agreed she was late for some appointments due to traffic congestion or other appointments taking longer than expected. Also, one appointment was missed due to another patient who was giving birth. However in total Mrs A was seen 14 times during her pregnancy. Ms B also stated that she had the use of a cell phone and that Mrs A was given a business card with her cell phone and home contact number. Appointments are scheduled at 60 minute intervals and patients are told that if Ms B does not arrive 30 minutes into the scheduled time, then they are not to wait for her.

Ms B also denied it is her practice to have rushed appointments and denied rushing any appointments with Mrs A.

Continued on next page

Midwife, Ms B

Opinion – Case 98HDC11371, continued

Outcome of Investigation *continued*

Mrs A commented she was never contacted about the results of her laboratory tests. Ms B reported her usual practice is to inform women that they will not be contacted about results unless abnormal and in Mrs A's case there were no abnormalities. Ms B stated Mrs A would most likely have been informed of this but she cannot recall specifically telling her this.

Mrs A stated that on the due date of 17 November, she contacted Ms B to ask whether the baby could be induced as her baby was of good size and she was sure of her dates. Ms B advised her not to be concerned as an earlier scan done on 16 June 1997 suggested the baby may be due later than expected.

On 20 November 1997, Mrs A saw Ms B for a routine antenatal check when Mrs A reported that she had less movements than usual that day. Ms B reported that she arranged to see her at the local maternity unit to do a cardiotocogram (CTG) reading which is a monitoring of the fetal heart. This CTG reading was normal. Ms B also spoke to the Obstetric Consultant about the request for an induction and was advised that the induction should take place the following week using her last menstrual period date as a guide for estimating postmaturity.

Ms B considered that on the consultation of 20 November 1997 the CTG was normal and there was no clinical indication of a problem with the health of Mrs A or her baby. There was no need, therefore, to arrange an urgent scan. Nor were there abnormal clinical features to indicate the need for specialist referral. Ms B stated that is it accepted practice that Induction of Labour consultations may be in the form of a telephone call, an antenatal visit or a day-ward assessment, depending on the clinical situation. Ms B enclosed a copy of Hospital and Health Services' policy in regard to this matter.

A scan was arranged for Tuesday 25 November 1997 to assess liquor volume and a kick chart started. The scan done on 25 November 1997 showed the baby had died.

Continued on next page

Midwife, Ms B

Opinion – Case 98HDC11371, continued

Outcome of Investigation ***continued***

Dr C advised the Commissioner that a public women's hospital case review of the situation concluded there were no indicators for Ms B that something was wrong with the baby and the care Ms B gave was found to be exemplary.

Dr D, the pathologist who conducted the post mortem examination, advised the Commissioner the baby's death was inexplicable. Dr D considered that Ms B was correct in not arranging the induction at an earlier time because there were no clinical indications that it was necessary. Dr D remarked that if inductions were undertaken because of maternal anxiety at term then they would be inundated with cases to deal with. In most situations an episode of reduced fetal movements on its own is not enough to indicate an urgent induction is required.

Midwife, Ms B

Opinion – Case 98HDC11371, continued

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

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 –

…

b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option

…

f) The results of tests.

Midwife, Ms B

Opinion – Case 98HDC11371, continued

Opinion: Breach Midwife, Ms B

In my opinion Ms B breached Right 4(2) of the Code of Health and Disability Services Consumers' Rights as follows:

Appointments

In my opinion, Ms B did not give adequate advice of delays and appeared rushed in her appointments. I consider Ms B's actions demonstrate a need to improve her time management and organisational skills. My midwifery advisor states:

> "*The nature of the midwifery profession is that a labour will have priority.* [Ms B] *should have rung* [Mrs A] *to change the appointment. ...* [Ms B] *should acknowledge this weakness in her practice* [late rushed visits] *and take measures to improve it.*"

In my opinion, Ms B breached Right 4(2) of the Code for not only being late for appointments but also for appearing rushed to the consumer.

Opinion: No Breach Midwife, Ms B

In my opinion Ms B did not breach Rights 4(2) and 6(1) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(2)

Induction Request 17 November 1997

Ms B responded appropriately to the request to induce the birth of the baby on 17 November 1997 and did not breach Right 4(2) of the Code. My midwifery advisor states:

> "[While] *the weight gain was excessive, other tests were normal. Because of* [Mrs A's] *previous obstetric history,* [Ms B] *has repeated the blood tests which were also normal. The care given is within expected standards of practice.*
>
> *It is normal to wait 7-14 days past the due date before considering an induction if no complications exist.*"

Continued on next page

Midwife, Ms B

Opinion – Case 98HDC11371, continued

Opinion: No Breach Midwife, Ms B *continued*

Ms B's reasons for not organising an induction immediately were based on the fact that it is not unusual for a woman to wait 7 to 14 days past their due date before an induction is considered, provided there are no complications. At the time of this consultation Mrs A did not present with any apparent complications. These reasons were given to Mrs A when the induction was requested and Mrs A was reassured by Ms B.

Induction Request 20 November 1997
In my opinion, Ms B did not breach Right 4(2) of the Code. She responded appropriately at the time Mrs A' requested an induction and reported reduced fetal movements.

After sighting the results of the CTG, Ms B appropriately arranged a scan for Mrs A five days after the appointment of 20 November 1997. My midwifery advisor states:

> "*It would have been better for* [Mrs A] *to see the specialist, a corridor or phone consultation is not as good as a clinic consultation. There is no guarantee that all the information is passed on. It is possible that advice may have been different if she had seen* [Mrs A] *in person, eg more CTG's, earlier scan, earlier induction.*
>
> *A reduction in movements should always be taken seriously*. [As Mrs A] *was anxious it would have been worthwhile repeating the CTG's on Saturday and Monday. The kick chart appeared to reassure* [Ms B] *that all was well.*"

Ms B made this decision on the basis of Mrs A's presenting clinical features and an informal discussion with an obstetric specialist. In my opinion, while Ms B could have made a formal referral to a specialist obstetrician so that the specialist could assist with the decision about the scan and the induction, Mrs A' clinical features were not causes for alarm in themselves. Furthermore Ms B followed up by calling Mrs A at home and received advice that everything was fine.

Continued on next page

Midwife, Ms B

Opinion – Case 98HDC11371, continued

Opinion: No Breach Midwife, Ms B *Continued*

Right 6(1)

Options

Mrs A was given information about her lead maternity care options from both her GP and Ms B. Mrs A was able to choose the option most suitable to her needs at the time. Ms B had provided information about her choices, and by Mrs A signing the Lead Maternity Care document, it was reasonable for Ms B to believe that Mrs A had made a choice for her to be the Lead Maternity Carer.

Test Results

Ms B's practice is to inform consumers of the results of tests at the next visit unless results are abnormal and require action before then. However, Ms B should advise her consumers more explicitly about these arrangements for advice of test results to comply more fully with Right 6(1)(f) of the Code. This information could usefully be included in a brochure or information sheet provided to consumers by Ms B.

Actions

I recommend that Ms B:

- apologises in writing for her breach of the Code. This apology is to be sent to the Commissioner who will forward it to Mrs A.
- re-schedules appointments rather than arrive late or be rushed.
- gives clients a copy of clear written instructions on what to do if she does not attend scheduled appointments.

Other Actions

A copy of this opinion will be sent to the Nursing Council of New Zealand and the New Zealand College of Midwives.