Midwife

Report on Opinion - Case 98HDC21478

Complaint

The Commissioner received a complaint from the consumer's partner about services provided to the consumer by a midwife. The complaint was summarised as:

- *The provider did not respond appropriately to telephone calls for assistance made by the consumer and her partner. The calls were made at about 8 p.m., 11.12 p.m. in early September 1998 and 12.13 a.m. the following morning.*
- *On arrival at the consumer's and her partner's residence, the provider verbally attacked the ambulance officers who were present and the consumer and her partner for calling ambulance services.*

Investigation Process

The complaint was received through the Nursing Council of New Zealand on 4 December 1998 and an investigation was commenced on 10 February 1999. Information was obtained from:

The complainant/consumer's partner
The consumer
The provider/midwife
Two ambulance officers

Clinical records were obtained from the provider, and a copy of the ambulance officer's report was obtained from the ambulance service.

Information Gathered During Investigation

The provider had been the midwife for the birth of the consumer's daughter in 1994. The pregnancy and birth had gone well and the consumer decided to use the provider's services for her third pregnancy and planned for a home birth.

One morning in early September 1998, the consumer was assessed by the provider. The consumer was 41 weeks pregnant. The provider recorded that the baby's head was engaged, the cervix was "*firm*" and "*uneffaced*", and advised the use of evening primrose oil capsules to help ripen the cervix, two vaginally and one orally.

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Information Gathered During Investigation *continued*

The consumer took three evening primrose oil capsules at 2pm and 7pm. Regular contractions developed and by "*8pm they were of 45 seconds duration and 90 to 120 seconds apart".* At about 8pm the consumer telephoned the provider at her home, as she and her partner were "*becoming concerned*"

The provider disputes the consumer's and her partner's reporting of the content of that conversation. The consumer's partner reported that "[the provider] *informed* [the consumer] *that the contractions were a normal reaction to the internal exam and that they would subside and be gone by 1.00am".* The consumer said that the provider "*told me they wouldn't be contractions but only a reaction to the internal she had given me earlier that day. She told me to try & get some sleep & if I was having the pains still at 1 o'clock in the morning to ring her back then".* The provider advised the Commissioner she "*discussed with her* [the consumer] *that contractions may have been a reaction to the oil or to the vaginal examination that I performed earlier in the day. Alternatively I told* [the consumer] *that she could be going into labour but not to be too disappointed if things 'petered out'. I said that I would go and sleep in preparation for a night up with* [the consumer] *should she progress into labour and I suggested that she do the same. I asked* [the consumer] *to call me when she felt that there was more happening and the contractions were regular, more frequent and stronger".*

The consumer's contractions increased and she began to vomit. By 11pm "*she had vomited seven or eight times".* The consumer said "*I was vomiting & I told* [the consumer's partner] *I was sure I was in labour".* The consumer's partner telephoned the provider at 11:12pm. The consumer's partner reports the conversation as, "*I introduced myself as '*[the consumer's] *partner' – she replied & she has a distinctive voice which I recognised as* [the provider's] *voice – there appears to be a trace of an English accent. The response was very brief – she sounded sleepy. I told her that the contractions were running into each other, that* [the consumer] *was distressed & that she was vomiting & crying. Her exact reply to that was 'There's nothing wrong – there's nothing to worry about'. I said 'So I do nothing' – she said 'Yes, do nothing'. That was the extent of the call."* The provider denies this call occurred.

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Information Gathered During Investigation *continued*

The consumer advised the Commissioner that she dismissed her feelings that the pains she experienced were contractions after she contacted the provider. The consumer advised the Commissioner that the provider stated emphatically that what she [the consumer] was experiencing could not be labour.

The provider advised the Commissioner that it puzzled her as to why the consumer and her partner did not contact her midwifery partner if they were unhappy with her advice. The consumer said she and her partner did not consider contacting the provider's partner for a second opinion because of the understanding they had about the partner's role in the birth. The consumer said she was aware that the midwifery partner was in a partnership arrangement with the provider, but that the provider was the primary caregiver. The consumer understood that the midwifery partner would attend the birth as the provider's assistant as the midwifery partner had never attended a home birth before. The consumer said that all instructions and information were given to her by the provider, and any questions or phone calls made were directed to the provider. The consumer reported that her relationship was with the provider, who had been her midwife for a previous child.

The consumer's partner rang the provider again at 12:13am when the consumer's "*contractions were rolling into one another, the vomiting was coming with every second contraction*", and the consumer's partner "*was by now very scared and panicky"* when *"*[the consumer's] *waters broke"*. The provider said she would come over.

The consumer's partner then immediately rang his sister to come and collect the consumer's two children when the consumer *"cried out that the baby was coming".* The consumer's partner *"could see the top of the baby's head appearing [and] dropped the phone and ran across to* [his partner]. *The rest of the baby's head came out within a few seconds – because* [the consumer] *was kneeling I had to hold the baby as it appeared. Assuming my sister was still on the other end of the phone, I yelled 'Call an ambulance'.*" The consumer said *"*[Her partner's] *sister rang the ambulance as we didn't know what to do with the cord or placenta.* [The provider] *lives at* [another town some distance away] *& we knew it would be some time before she got here."*

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Information Gathered During Investigation *continued*

The consumer's partner telephoned the provider again at 12:19am to notify her that the baby had been born. The consumer's partner advised that the provider said "*she would be right over*" and that "*Neither* [the consumer] *nor I knew what to do about the cord".* The provider advised the Commissioner that she "*asked if the baby was crying*" and gave instructions to the consumer's partner about keeping the baby warm and leaving the cord attached. The consumer remained on her hands and knees from delivery until the arrival of the ambulance officers. Her partner placed "*the baby between* [the consumer's] *legs while* [she was] *still kneeling, she was able to turn around and see the baby*".

Two ambulance officers arrived at 12:29am and the consumer's partner let them inside. The consumer was on her hands and knees in the position she had delivered in and one of the ambulance officers checked her for bleeding while the other checked the baby. The ambulance officers cut the umbilical cord and informed the consumer she could reposition herself for comfort and warmth. The ambulance officers ascertained that the midwife had been called, assisted the consumer and wrapped her warmly for the arrival of the midwife to deliver the placenta.

The provider arrived ten to twenty minutes later and let herself into the house. She questioned the presence of the ambulance officers, questioned why they had been called and then left the house. Both ambulance officers present confirm that the provider questioned their presence. The provider returned about a minute later. The provider disputes she entered the house without asking, and states she "*asked* [the consumer's partner] *if she could come into the house and was told that I could".* One ambulance officer recalled that the provider entered the house herself.

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Information Gathered During Investigation *continued*

The ambulance officer advised the Commissioner that the provider demanded to know what the ambulance officers were doing at the scene. She commented that she tried "*to bring her* [the provider] *up to date with events surrounding the birth, but she then went into the 'Am I needed here or not' attitude, and left"*. The ambulance officer advised the Commissioner that the provider "*was hostile, definitely, to me and my partner. To everyone actually".* The ambulance officer said, "*I was embarrassed really, on behalf of all health professionals. I thought she was giving us all a bad name really, carrying on like that".* The ambulance officer advised the Commissioner that the provider "*was extremely abrupt and defensive. She was horrible actually. She came in there with no thought for the parents, the baby, or us for that matter, and ruined the whole mood of the birth. The atmosphere really went down after she arrived. She was only concerned with herself. It was obvious to everyone there that her behaviour was a bit off, we were all quite shocked actually"*.

The consumer and her partner advised the Commissioner that "*At no stage did she* [the provider] *enquire as to our welfare".* The provider disputes this when she says "*I did question the presence of the ambulance as I was concerned that something was wrong with* [the consumer] *or the Baby and I wanted to ascertain what this might be so I could immediately assist"*. The ambulance officer advised that she asked the provider to check the baby as she was concerned about it's snuffly breathing, and that the provider did not specifically ask about the mother or baby's welfare at any stage.

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Information Gathered During Investigation *continued*

An argument ensued between the provider and the consumer's partner about whether the telephone call at 11:12pm occurred. The second ambulance officer described this as stern speaking lasting about 2 minutes. He reported that the consumer's partner was saying he had called the provider, and the provider was saying "*no you didn't".* The first ambulance officer recollected the incident as, "*He* [the consumer's partner] *said they had called her and she* [the provider] *hadn't come. She denied it. He would say he'd rung her, and she would say 'No you haven't', 'why is the ambulance here', 'what time did you ring me', 'you must have rung the wrong number'. She was very intimidating, and kept questioning his integrity, suggesting he had never made the calls at all. She just dismissed him and brushed him off. You could see he was getting frustrated with her, she just wouldn't listen to him. The midwife upset the father so much, he had to leave the room to collect himself, for his wife's sake. The Mum* [the consumer] *was being upset by the atmosphere deteriorating in the room. Things were very heated and voices were raised."*

The provider advised the Commissioner that *"The atmosphere was one of considerable hostility towards me from* [the consumer's partner]*"* and *"This made me feel quite upset but I was certainly not aggressive or verbally abusive". "*[The consumer's partner] *was very angry and questioned me about the phone calls he had supposedly made. I said that I had come in response to his call and he said that I had not, because he had rang at 11pm and that I had said there was nothing that I could do. I was stunned as I did not receive this call and there is no way that a midwife, who is waiting for a call to attend a woman once she establishes in labour, would say there is nothing she can do and just stay home. It is certainly possible that if* [the consumer's partner] *rang someone else inadvertently that they would say that there was nothing they could do. I must emphasise that I did not receive this call." "The situation seems bizarre to say the least and the only explanation other than a call to another number is that there was a telephone fault."* The consumer's partner left the room angry. He advised that he chose to leave the room because he did not want his *"ensuing anger to make a highly charged atmosphere even worse".* The provider delivered the placenta, and the ambulance officers left. The provider assisted the consumer to have a shower and with feeding the baby. The provider left.

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Information Gathered During Investigation *continued*

The provider returned later that morning to check on the consumer and her baby. The disputed phone call was discussed again, and the provider said "*neither my son nor husband had heard the phone at that time".* Later that day the consumer's partner contacted the Telecom Call Investigation Centre and arranged for a call trace of outward calls made from their home on the evening in question. The call trace confirmed that calls were made from the consumer and her partner's phone to the provider's phone at 11:12pm, and at 12:14am and 12:19am the following morning.

The provider acknowledges her failure to respond to the 11:12pm telephone call in a letter to the consumer and her partner dated mid-September 1998, but in her response to the Commissioner, the provider advised "*I did not receive the call that* [the consumer's partner] *claims he made at 11.00pm and I am at a loss to understand what occurred"*. The consumer also advised the Commissioner that the provider has seen the Telecom records, and her letter of mid-September was written in response to this.

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Independent Advice to Commissioner

An independent midwife advised the Commissioner as follows:

The provider should have expected the consumer to enter into labour for the following reasons:

- being 41 weeks pregnant
- having had a vaginal examination
- having prescribed evening primrose oil

Evening primrose oil contains a precursor of prostaglandins (hormones acting on uterine muscle to cause contractions), and in the adviser's experience is associated with "*violent"* results. "*She should have been looking out for this."*

For the above reasons, the provider should have taken more notice of the consumer's first telephone call as representing the onset of labour. The consumer's condition as outlined by her partner at 11:12pm was a typical description of someone in severe labour. "*The midwife should have gone to their home at this point as the client was in hard labour."*

When the consumer's partner called again at 12:19am to inform the provider that the baby had been born it would have been appropriate at this time as a minimum, given that the midwife lived some distance away, to have given some information regarding keeping the mother and baby warm. Additionally, information could have been given about leaving the umbilical cord intact, placing the baby to the mother's breast to assist the delivery of the placenta, making themselves comfortable, and providing some calming reassurance.

In the adviser's opinion the provider behaved with unprofessional conduct when she argued with the consumer's partner, and questioned the presence of the ambulance staff in an aggressive manner.

Midwife

Report on Opinion – Case 98HDC21478, continued

Code of Health and Disability Services Consumers' Rights

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.

3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

RIGHT 5
Right to Effective Communication

2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

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.

RIGHT 10
Right to Complain

5) Every provider must comply with all the other relevant rights in this Code when dealing with complaints.

6) Every provider, unless an employee of a provider, must have a complaints procedure that ensures that -

b) The consumer is informed of any relevant internal and external complaints procedures, including the availability of–

i. Independent advocates provided under the Health and Disability Commissioner Act 1994; and

ii. The Health and Disability Commissioner; and

c) The consumer's complaint and the actions of the provider regarding that complaint are documented.

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Midwife

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Nursing Council of New Zealand Code of Conduct for Nurses and Midwives

PRINCIPLE TWO
The nurse or midwife acts ethically and maintains standards of practice.
Criteria
The nurse or midwife:
2.1 is guided by a recognised professional code of ethics applied to nursing or midwifery;
2.5 upholds established standards of professional nursing or midwifery practice;

PRINCIPLE FOUR
The nurse or midwife justifies public trust and confidence.
Criteria
The nurse or midwife:
4.3 uses professional knowledge and skills to promote patient/client safety and wellbeing;
4.6 takes care that a professional act or any omission does not have an adverse effect on the safety or wellbeing of patients/clients;
4.7 respects the trust implicit in the professional nursing relationship or midwifery partnership;
4.9 acts in ways which contribute to the good standing of the nursing and midwifery professions.

Opinion: Breach

In my opinion the provider breached Rights 4(2), 4(3), 4(4) and 4(5), Right 5(2), Right 6(1) and Rights 10(5), 10(6)(b), and 10(6)(c) of the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(2)

Labour
In my opinion the provider failed to recognise that the consumer was in labour when the consumer telephoned at 8pm. The provider should have been expecting the consumer to proceed into established labour at that time particularly in view of her instructions to the consumer to use Evening Primrose Oil. I am satisfied that the consumer was in labour at this time.

The provider should have ensured more dialogue with the consumer rather than advising her that she was not in labour. This was the consumer's third pregnancy and her own knowledge and experience of labour was given no weight by the provider.

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Opinion: Breach *continued*

Telephone Calls

I am satisfied by the Telecom records that the calls were placed by the consumer's partner to the provider that night. When the provider was telephoned at 11:12pm this time by the consumer's partner, who reported the consumer's increased contractions, distress and vomiting, the provider dismissed the symptoms of labour and advised no action. Although the provider acknowledges her failure to respond to the 11:12pm telephone call in a letter to the consumer and her partner dated mid-September 1998, she does not in her response to me.

Argument with the consumer's partner

The provider is required by the Nursing Council of New Zealand Code of Conduct for Nurses and Midwives, Principle 4.9, to act in a way which contributes to the good standing of the midwifery profession. It is clear that the provider's conduct fell below this level. The first ambulance officer's comments about the provider's behaviour reflecting negatively upon the reputation of all health professionals, is a strong indicator of how poorly the provider chose to handle the situation she was faced with.

It was not appropriate for the provider to participate in an argument with the consumer's partner regarding telephone calls in front of the consumer, nor was it appropriate to conduct herself in a verbally aggressive manner. The consumer was upset by this and asked for it to stop and for attention to be directed towards the delivery of the placenta.

As a registered midwife, the provider is also required to act ethically and maintain minimum standards of practice. In my opinion the provider's actions on this occasion did not meet these requirements and she therefore breached Right 4(2) of the Code.

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Opinion: Breach *continued*

Right 4(3)

The provider had a duty to exercise her professional knowledge and skills to both listen effectively to, and thoroughly assess, the consumer. Clearly the consumer was in labour that evening. The provider was contacted twice and provided with two descriptions of a labour in progress. On both occasions she failed to recognise and respond to these facts. In my opinion the provider did not provide services in a manner consistent with the needs of the consumer or her baby. Further, the consumer did not receive emotional support from the provider following the sudden delivery of the consumer's baby.

Right 4(4)

In my opinion the provider did not provide services in a manner that minimised the potential harm to the consumer and her newborn baby when she failed to attend the consumer in labour as requested and when she did not check the consumer or her baby on her arrival at the scene, until requested to do so by the first ambulance officer. The consumer's baby was born without medical attendance despite her parents' efforts to obtain it. Although a good outcome resulted, in my opinion the provider's failure to attend as requested placed the consumer and her baby at risk.

Right 4(5)

In my opinion, when the provider questioned the presence of the ambulance officers and subsequently left the room after saying, "*I can see I'm not wanted here"*, she did not co-operate with other providers to ensure quality and continuity of services to the consumer.

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Opinion: Breach *continued*

Right 5(2)

In my opinion the provider did not provide the consumer with an environment which enabled her to communicate openly, honestly, and effectively, following the sudden birth of the consumer's baby or during the post-natal period. It is agreed by both parties that the atmosphere was tense and hostile on the morning of the birth, neither of which is conducive to effective communication or a positive birth experience. As observed by the first ambulance officer, the consumer and her partner were experiencing the elation of the birth safely, despite having to manage the birth alone, but the happiness they were feeling was "*ruined"* by the provider's conduct on arrival.

The onus was upon the provider to maintain a professional manner by managing her own feelings in an appropriate way and to facilitate a trusting relationship with the consumer. She clearly did not do this.

Right 6(1)

I am satisfied that there is sufficient evidence to demonstrate that the provider did not advise the consumer's partner what immediate measures to take when told of the baby's delivery. In my opinion the provider breached the Code when she did not provide information to the consumer about how they might manage her unexpected labour, or deal with the immediate situation of the baby being born on the floor, especially important given that there would be a time delay before the provider's arrival.

Right 10(5)

As detailed above, in my opinion, the provider did not uphold the other relevant Rights of the Code when dealing with the complaint against her from the consumer and her partner.

Right 10(6)(b)

The provider did not advise the consumer or her partner how to complain. She did not inform the Commissioner of her complaints procedure, nor did the provider inform them about the Health and Disability Commissioner or the Commissioner's free advocacy service, as she is obliged to do under the Health and Disability Commissioner Act 1994.

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Report on Opinion – Case 98HDC21478, continued

Opinion: Breach ***continued***

Right 10(6)(c)

The provider has not provided any evidence to the Commissioner to demonstrate she documented the consumer's and her partner's complaint as she is required. A copy of a letter the provider wrote to the consumer and her partner, dated mid-September 1998, acknowledging responsibility for her failure to attend the consumer as requested was forwarded to the Commissioner. The provider does not refer to this letter in her response to the Commissioner. Additionally, she did not advise any changes to her practice which she had informed the consumer and her partner were made as a result of this incident.

Actions

I recommend the provider takes the following actions:

- Apologises in writing to the consumer and her partner for breaching the Code. This apology is to be sent to the Commissioner who will forward it to the consumer and her partner.
- Reads the Code of Health and Disability Consumers' Rights and views a copy of the provider video available from the Commissioner.
- Refunds the cost of the Telecom call trace of $14 and the ambulance service's callout fee of $54.
- Establishes a complaint's procedure which allows consumers to exercise their right to complain directly to her without repercussions.
- Provides the Commissioner with a written assurance within 14 days that she will attend a communication skills course within six months to ensure all future contact with other health professionals and consumers will be conducted in a non-confrontational manner.

Other Actions

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