Midwives, Ms B and Ms C / General Practitioner/Obstetrician, Dr D

Opinion - Case 98HDC11631

Complaint

The Commissioner received a complaint from the consumer, Ms A, and her husband, Mr F, about midwives, Ms B, and Ms C.

The complaint is that midwife, Ms B:

- *did not facilitate any arrangements for shared care as requested by Ms A*
- *repeatedly stated to Ms A that she did not need the care of a doctor, although she was aware that Ms A had anaemia and a specialist's recommendation that she deliver in the public hospital*
- *did not check Ms A's weight and only carried out one routine urine test during Ms A's pregnancy*
- *was unable to locate the foetal heart beat on three occasions and took no further action.*

In addition the complaint is that midwife, Ms C:

- *did not attend an appointment with Ms A at 9:30am on 12 January 1998*
- *did not take action in response to Ms A reporting, by telephone on 12 January 1998, that the baby was not moving, beyond instructing Ms A to drink more cold water*
- *did not visit or contact Ms A on 13 January 1998 after having been advised on the previous day that the baby was not moving*
- *was unable to be contacted on her mobile telephone or at her home on Ms A's due date, 13 January 1998.*

The complaint was extended to include general practitioner/obstetrician, Dr D:

- *During December 1997 and January 1998 Dr D did not ensure Ms A received continuity of care during the latter part of her pregnancy when lead maternity carer.*

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Midwives, Ms B and Ms C / General Practitioner/Obstetrician, Dr D

Opinion - Case 98HDC11631, continued

Investigation

The complaint was received on 4 February 1998 and an investigation commenced. Information was obtained from:

Ms A	Consumer
Ms B	Provider / midwife
Ms C	Provider / midwife
Dr D	Provider / general practitioner/obstetrician
Ms E	Midwife

Ms A's antenatal notes and the postmortem report were viewed. Health Benefits reports were also obtained and reviewed. The Commissioner received advice from two independent midwives.

Outcome of Investigation

In October 1997, the consumer, Ms A, and her husband, Mr F, moved to a town from the city. Mr F was of Syrian origin and both he and his New Zealand-born wife are Muslim. At this time Ms A was 27 weeks pregnant and was seeking shared maternity care with a midwife and a female GP. Ms A telephoned the health centre and spoke to Ms B who said she would be available to be her midwife and would find a female general practitioner to share her maternity care.

Ms B, who belongs to the maternity carer's organisation MATPRO, first met Ms A on 30 October 1997 when she was 29 weeks pregnant. Ms A's options were outlined and she was given the pamphlet *Choices in Childbirth* and the MATPRO booklet, *Maternity Guide*. Ms B stated that she had copies of Ms A's antenatal notes from her former lead maternity carer.

Ms A stated that Ms B did not respond to her request for shared care arrangements. Ms B replied that she made several attempts to find a female doctor, including contacting three women doctors in the area and then telephoning three doctors in the city. These attempts met with no success because all were either booked, on leave at that time or not registered to perform deliveries. The request for a female doctor is documented in the Obstetric Care Plan by Ms B.

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Midwives, Ms B and Ms C / General Practitioner/Obstetrician, Dr D

Opinion - Case 98HDC11631, continued

Outcome of Investigation *continued*

Ms B referred Ms A to a specialist obstetrician on 20 November 1997 because Ms A's haemoglobin was low. The specialist recommended that Ms A deliver at the public hospital but was concerned with the couple's request for only women to be present at her delivery. The specialist considered this might cause a life-threatening delay during labour. The specialist recommended the couple contact a private obstetrician to ensure their needs were met and wrote a referral letter to the obstetrician she suggested. Ms A reported they followed this up but were told by the obstetrician's receptionist that there were no vacancies at this time.

Ms A reported Ms B repeatedly said to her she did not need the care of a doctor, although Ms B was aware that Ms A had anaemia and a specialist's recommendation that she deliver in the public hospital. In reply to the Commissioner, Ms B stated she told the couple they were free to look for an appropriate doctor at any time especially when her own attempts proved unsuccessful. Ms B stated she prefers her patients to have a doctor, therefore at no stage discouraged them from finding one. When Ms A came under the care of a specialist obstetrician, Ms B stated she advised the couple after initial attempts at finding a doctor were unsuccessful, that it would be of little help having a doctor in the town as this doctor might not be able to attend the birth now that this was likely to occur at the public hospital. Ms B further advised the couple that when labour started they could consult with the public hospital team to see if a female obstetrician would be available.

Ms B stated she arranged for them to go to the public hospital and meet with the midwife Ms E who would be responsible for the labour and delivery if she was away at this time. Ms A reported they visited the hospital and midwife the week before the baby was due. However Ms E recalls they visited her earlier than that, possibly in November and on one occasion only. Ms E reported that she also assisted in the couple's search for a female doctor and approached a female Muslim doctor in the city to see if she would be available to look after the couple but this doctor refused.

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Midwives, Ms B and Ms C / General Practitioner/Obstetrician, Dr D

Opinion - Case 98HDC11631, continued

Outcome of Investigation *continued*

Ms A reported Ms B did not check her weight. In reply to the Commissioner, Ms B stated Ms A was weighed twice at the private clinic when she visited the specialist and there was no reason do so more regularly. Her weight at the first visit was also recorded on the Obstetric Care Plan.

Ms A further reported Ms B only carried out one routine urine test during Ms A's pregnancy. In reply to the Commissioner, Ms B stated that Ms A's first urine test was normal and there was no indication for more frequent urine testing as she had normal blood pressure and no diabetes present. In addition, on two visits, urine specimens were not available and on the last visit the couple declined a check of any kind.

Ms A reported on three occasions Ms B was unable to locate the foetal heart beat and took no further action. In reply to the Commissioner, Ms B stated she had trouble getting the foetal heart on one occasion only on 22 December 1997, but noted that the baby was actively moving at this time. Ms B further stated on 15 December 1997 when Ms A reported reduced movements, she arranged for her to be taken to the private clinic for a cardiotocogram (CTG) reading. The reading at this time was normal.

Then on 16 December Ms B made a second referral to the specialist because she thought Ms A might be small for her dates. The specialist who saw Ms A on 18 December 1999 stated in a letter to Ms B, "*I am comfortable this pregnancy at this stage is progressing normally and I have no concerns about the foetal welfare*". The specialist also documented that Ms A was given instructions on how to observe foetal movements, including measuring movements after drinking cold sweet water, and to contact a midwife if she had any concerns.

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Midwives, Ms B and Ms C / General Practitioner/Obstetrician, Dr D

Opinion - Case 98HDC11631, continued

Outcome of Investigation *continued*

Between 30 October and 30 December 1997, Ms B saw Ms A a total of six times and made two referrals to a specialist during this time. Ms B stated she made home visits for the couple in order to accommodate their needs. In addition, although she is only funded for four visits during this period, Ms B made an extra visit at their request to ensure Ms A was making satisfactory progress. At one of her routine visits on 9 December 1997, Ms B reported although she undertook an assessment, she omitted to record the results on the Care Plan as the visit was made difficult by Mr F. In a referral note to the specialist on 16 December, Ms B had written, "*I am finding* [Mr F] *and his dogmatic manner (for which he always apologises afterward) difficult to cope with*".

On 19 December 1997, Mr F and Ms A found a woman doctor in the city, general practitioner/obstetrician, Dr D, who agreed to be their lead maternity carer. When they informed Ms B, the couple reported she had an unfavourable reaction. In response to the Commissioner, Ms B stated she had no problem with the city doctor being their obstetrician and said to the couple this was fine.

Dr D stated that Ms A and Mr F first came to see her on 23 December 1997 and explained they had been trying to find a female doctor for shared care and asked if she would consider looking after her. Dr D agreed but said that the proper arrangements for a transfer must be made. Dr D stated she had a long discussion with Ms B on the same day where Dr D and Ms B agreed that Ms B would continue to provide midwifery care in the town because of the long distances involved in travelling to the city. At this visit on 23 December 1997, Ms A had brought her antenatal records, blood tests and scan reports to the appointment. Dr D was aware of the specialist's involvement with Ms A during her antenatal period.

At the last visit on 30 December 1997, the couple informed Ms B they no longer wished her to act as their midwife. Ms B reported Mr F verbally assaulted her and was so threatening that Ms B "backed out of the house". Mr F also insisted on taking the original case-notes.

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Midwives, Ms B and Ms C / General Practitioner/Obstetrician, Dr D

Opinion - Case 98HDC11631, continued

Outcome of Investigation *continued*

Some weeks before the abrupt termination of her contract, Ms B had arranged for Ms C to provide postnatal care during the period of her leave. Now that the contract was finished Ms B' understanding was that Dr D would be the lead maternity carer and a midwife in the city, Ms E would conduct the delivery at the public hospital. This was also Ms A's understanding.

Dr D stated she did not have any concerns about Ms A's pregnancy. On Ms A's second visit on 5 January 1998, a scan confirmed the foetal well-being.

Dr D stated she gave Ms A explicit details on how to contact her, including her home phone number and the public women's hospital delivery suite, who could contact her if necessary on her mobile phone.

Dr D was unaware of the arrangements made with Ms C until Ms A phoned her in a frantic state on 13 January 1998 saying that the baby had not moved for the last day or so. Ms A said she had been trying to contact Ms C whom she believed was replacing Ms B for midwifery care.

Ms C stated she was asked by Ms B to provide postnatal care. She visited the couple on 31 December for the purpose of becoming more acquainted with Ms A before the baby was born, and to do the antenatal check that Ms B was unable to do the day before. Ms C also stated she did not contact the lead maternity carer who had replaced Ms B as she did not think it necessary, having been briefed by Ms B. In addition, Ms C stated at that time the usual practice was for the city lead maternity carer general practitioner to contact the local midwife regarding postnatal care, because they (the general practitioner) are not in a position to provide such care. Ms B stated that when Ms C visited the couple on 31 December, Ms C retrieved the original notes that were left with Mr F the day before, returning the originals to Ms B and retaining a copy for herself.

During this visit on 31 December 1997, Ms A asked Ms C if she would visit her once more on 12 January 1998.

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Midwives, Ms B and Ms C / General Practitioner/Obstetrician, Dr D

Opinion - Case 98HDC11631, continued

Outcome of Investigation *continued*

Ms C stated Ms A wanted this visit so that Ms C could answer further questions and assess whether she was in labour prior to travelling to the city. Ms C agreed to do this as a gesture of goodwill, but explained to Ms A she had women who might be in labour at this time and so might not be able to attend as scheduled. Ms A voiced no concerns about this at the time.

Ms A stated when Ms C performed the check and wrote this up in the notes on 31 December, as well as agreeing to visit her on 12 January and giving her contact details, she was given the impression that Ms C was available to her for quick checks that would avoid the need to travel in to the city.

Ms A further stated while she knew who her new lead maternity carer was, she was not told specifically Ms C would not be delivering antenatal as well as postnatal care.

On 12 January 1998, Ms C could not attend their appointment at 9.30am because she was in the city all day with a labouring woman. Ms A reported that there was a message on their answerphone in the afternoon from Ms C stating her reason for the missed appointment and that she would call later that evening. When Ms C telephoned that evening she apologised and explained why the appointment was missed. During this conversation, Ms A reported she told Ms C her baby was not moving and Ms C instructed her to drink more cold water.

In reply Ms C stated Ms A did not appear to be overly concerned about reduced foetal movements at this time and the purpose of the call, initiated by Ms C, was to discuss the missed appointment. Ms A appeared to want to discuss in general terms foetal movements before labour and in the middle of another topic of conversation, Ms A said the baby was now moving. Ms C also denied advising her to drink cold water but stated this was an instruction given by the specialist and not herself, to test for movements if they appeared reduced. Ms C stated that Ms A did not convey to her that she was concerned about the baby's movements during the phone call of 12 January 1998. If concerns had been communicated, Ms C would have arranged for a CTG that same day.

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Midwives, Ms B and Ms C / General Practitioner/Obstetrician, Dr D

Opinion - Case 98HDC11631, continued

Outcome of Investigation ***continued***

Ms A stated Ms C did not visit or contact Ms A on 13 January 1998, after having been advised on the previous day that the baby was not moving. Ms A reported Ms C said she would not be able to visit that evening or the following day but would try to come the day after. In reply Ms C stated she arranged to see her the following day only if it were possible.

Ms A reported she could not contact Ms C on her mobile telephone or at her home on Ms A's due date of 13 January 1998 despite several attempts. Ms C explained the reason for her non-attendance on this day was that a second client had gone into labour that night and needed attending from 5.30am to 9.00pm that day. As on the day before, Ms C had made arrangements for another midwife to provide cover with contact details on her answerphone. In addition Ms C's husband was at home and able to pass on messages. Ms C further reported that both the covering midwife and her husband said no one tried to contact her during this time. Ms C further explained that while at the public hospital, her cellphone was switched off according to hospital policy.

Further to this, while Ms A reported the baby was due on 13 January 1998, Ms B and Ms C both report the expected date of delivery was 18 January 1998 and this was recorded on the Obstetric Care Plan.

Ms A reported that she woke on 13 January 1999 concerned that she had not felt any foetal movements during the night. After drinking a glass of cold water and feeling no movements she immediately telephoned Ms C. After about an hour of trying with no response they contacted Dr D who advised they come to the surgery as soon as possible. The couple were subsequently referred to the public hospital where a scan showed the baby was dead. Ms A reported the baby had died because the umbilical cord had formed a knot around its neck and this was confirmed in the death certificate. No post-mortem was requested. Dr D reported the baby was found to have the cord around his neck and a knot in the umbilical cord as well.

The midwives, including Ms E all state that this death could not have been foreseen or prevented in the circumstances.

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Midwives, Ms B and Ms C / General Practitioner/Obstetrician, Dr D

Opinion - Case 98HDC11631, continued

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disabiltiy 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.*

…

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

Clause 3 ***Provider Compliance***

1) *A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.*
2) *The onus is on the provider to prove that it took reasonable actions.*
3) *For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.*

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Midwives, Ms B and Ms C / General Practitioner/Obstetrician, Dr D

Opinion - Case 98HDC11631, continued

Opinion: No Breach Midwife, Ms B

Right 4(2)

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

I am advised that one instance of not hearing a feotal heart beat when all other signs such as the baby's movements are normal, is neither unusual nor cause for concern when the midwife is familiar with the patient and her history. In this instance the consumer, Ms A, had a normal cardiotocogram and had seen a specialist the week before who considered that the pregnancy was progressing normally. There were no other features at the time of the appointment on 22 December 1998 that would give Ms B cause for concern.

Further in my opinion Ms B attempted to facilitate shared care arrangements with a general practitioner. Ms B did what she could but was unsuccessful because of the time of the year and short notice with which to make these arrangements. There is evidence also that Ms B supported and co-operated with medical doctors in her midwifery practice. Ms B also arranged early on in her care for backup midwives to cover for the period of 1 January until 15 January 1998.

In my opinion Ms B undertook an adequate number of weight and urine screens which were required for the antenatal assessments by herself and the specialist. Ms A was weighed at least twice and I am advised that weight gain is not a requirement to assess, nor is it a reliable measure of the baby's growth.

Finally in future I suggest Ms B takes care to document all her findings in the Obstetric Care Plan. The results of examinations and observations must be written down to provide a clear picture of the woman's obstetric progress.

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Midwives, Ms B and Ms C / General Practitioner/Obstetrician, Dr D

Opinion - Case 98HDC11631, continued

Opinion: No Breach Midwife, Ms C

Right 4(5)

In my opinion midwife, Ms C, did not breach Right 4(5) of the Code of Health and Disability Services Consumers' Rights. I accept Ms C's statement that the purpose of her contact with the consumer, Ms A, was to answer questions and assess whether Ms A was in labour before travelling to the public hospital's Delivery Suite. While there was some confusion on the part of Ms A about Ms C's role, in my view Ms C fulfilled her obligations to the best of her ability given her commitments to her existing patients. During the telephone conversation of 12 January 1998, Ms C did not pick up any concerns expressed by Ms A that would indicate action from Ms C was necessary. I accept that it was Ms C's expectation that Ms A would express concerns directly to her or else contact her lead maternity carer, Dr D (general practitioner/obstetrician) in the city for advice.

Further to this, in my opinion Ms C did not breach the Code of Rights when she was unable to see Ms A as planned on 12 and 13 January 1997. Ms C had two of her clients in labour and I am advised it is acceptable midwifery practice to prioritise these clients. Ms C had correctly informed Ms A she may not be available at these times for this reason and therefore it was up to Ms A to contact her lead maternity carer. It was the lead maternity carer's responsibility to ensure the provision of antenatal care and not Ms C's.

Ms C also did not breach the Code of Rights for not being contactable while attending her other clients who were in labour. Ms C had an answer-phone system in place and her husband was available at her home to take messages.

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Midwives, Ms B and Ms C / General Practitioner/Obstetrician, Dr D

Opinion - Case 98HDC11631, continued

Opinion: No Breach General Practitioner/ Obstetrician, Dr D

Right 4(5)

In my opinion the general practitioner/obstetrician, Dr D, did not breach Right 4(5) of the Code of Health and Disability Services Consumers' Rights. When Dr D took over from midwife, Ms B, as lead maternity carer for the consumer, Ms A, she obtained the relevant information and discussed the case with Ms B. There was nothing more that Dr D could have done to ensure continuity of services were maintained without added input from Ms A about her intentions to see Ms C for further antenatal care.

Other comments

I note that while the two midwives who are the subject of this complaint could have acted differently in hindsight, it is clear that neither contributed to, nor were responsible for, the tragic death of the consumer, Ms A, and her husband, Mr F's, son.

In this situation, it was difficult for the providers to ensure continuity. Ms A needed to keep her lead maternity carer Dr D (general practitioner/obstetrician) informed of her intentions when, for example, she requested an appointment from midwife, Ms C, for 11 January 1998.

Ms A was given instructions by a specialist obstetrician the previous month on what to do if she was concerned about reduced foetal movements. Ms A was advised on how to observe for movements and was guided on when it would be necessary to contact someone.

The family chose Dr D as lead maternity carer, and should have contacted Dr D first if they had concerns about the baby's movements, particularly when Ms C was not available for the January 12 appointment.

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