Failure to arrange hospital admission for post-partum woman with hypertension, who later suffered eclamptic seizures (03HDC15081, 24 March 2005)

Midwife ~ Lead maternity carer ~ Obstetrician ~ District health board ~ Hypertension ~ Headache ~ Assessment ~ Monitoring ~ Consultation with specialist ~ Communication ~ Referral ~ Rural practice ~ Standard of care ~ Professional standards ~ Vicarious liability ~ Rights 4(1), 4(2), 4(5)

A 22-year-old woman complained about the care provided by her midwife after the delivery of her baby. Seven days after the delivery, the woman told her midwife that she had a persistent headache, which had not abated despite taking pain relief. The midwife took the woman's blood pressure, which was elevated at 200/120. She told the woman to rest, and an hour later her blood pressure had dropped to 180/110, which was still high. The midwife consulted with another midwife and arranged for an urgent full blood count to assess renal and liver function. The midwife stayed with the woman until the test results arrived. Although the results were within the normal range, the midwife remained concerned. She took another reading (190/80) and decided to seek specialist advice.

The hospital's on-call obstetrician was due in theatre for an emergency procedure and asked the midwife to call back in half an hour. There is some disparity between the parties as to what information was relayed to the obstetrician. The midwife says she told the obstetrician of the woman's blood pressure recordings, blood test results, headaches and negative proteinuria. The obstetrician does not recall the headaches being mentioned; the midwife's notes refer only to the blood pressure. The obstetrician says that either he failed to appreciate the severity of the hypertension or it was not communicated accurately to him. He suggested bed rest overnight, agreed to the midwife giving the woman a sedative, and instructed the midwife to assess the woman's blood pressure and clinical condition in the morning. The next morning the woman began to have seizures.

It was held that the midwife's duty of care went beyond identifying and communicating causes for concern. As lead maternity carer (LMC), she was ultimately responsible for the woman's care, and should have insisted upon the woman's admission to hospital. By not doing so, she breached Rights 4(1) and 4(2).

The midwife was also ultimately responsible for making sure the obstetrician received adequate information about the woman's condition and that this was communicated clearly. This is especially important when advice is sought over the telephone, as the doctor is not able to conduct an examination. Regardless of what was actually said, the misunderstanding indicates that this standard was not met, and the midwife was held to have breached Right 4(5) by failing to ensure that quality and continuity of care was maintained.