BUDDLEFINDLAY

Legal update - Maternity care under scrutiny

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Maternity services have encountered a flurry of media attention following the release of a University of Otago study which compared birth outcomes for babies born to mothers registered with medical lead maternity carers (LMCs) (such as obstetricians or GPs) with those who had midwives as LMCs. The study found comparatively higher rates of adverse birth events in midwifery-led versus medical-led deliveries, but did not show that the model of care, or the carer, was the cause of the difference. The Ministry of Health's Chief Medical Officer has said that "The study and its findings require further investigation, and the Ministry has already referred it to the National Maternity Monitoring Group for consideration".

Independently of that study, the Health and Disability Commissioner has recently released two breach decisions relating to maternity care: one against a midwife who failed to refer to specialist care despite clear policy guidance, and another involving private maternity care. These decisions are summarised below.

Midwifery care

In a decision released last week, the Commissioner was 'highly critical' of aspects of the midwifery care provided to a woman whose baby was stillborn in April 2015. The patient was a 27 year old with clear risk factors including a high BMI of 44.6. The Commissioner considered that the midwife failed to provide services with reasonable care and skill (breaching Right 4(1) of the Code of Rights) and failed to provide the patient with information regarding a recommended transfer of care (breaching Right 6(1)).

Failure to follow guidelines
Ministry of Health guidelines clearly require that where a pregnant woman's BMI is above 40 the LMC must recommend transferring responsibility for care to a specialist obstetrician, and the District Health Board (DHB) guidelines applicable in this case suggest the same approach. The midwife did not discuss this option with the patient or refer her for specialist review on the basis that, in her experience, it was difficult to transfer women in this category unless they had additional medical issues, and she believed that the patient was unlikely to attend additional appointments given her poor clinic attendance to date. The Commissioner was highly critical of this decision, in view of the patient's 'clear risk factors'. Further, by neglecting to offer an opportunity to discuss the option, the midwife failed to provide essential information that a reasonable consumer in these circumstances would expect.

During labour, the midwife again failed to follow guidelines recommending continuous fetal heart rate monitoring. Additionally, when unusual tracing was identified, she requested assistance from the ward midwives but did not follow the DHB's obstetric emergency guidelines to utilise the emergency call bell and pager system. The Commissioner considered the midwife's management of this situation did not follow the appropriate process.

"Suboptimal" documentation and inadequate postnatal care
The Commissioner made additional comments regarding the midwife's suboptimal documentation in relation to telephone assessments and the advice given during labour. Following the stillbirth the midwife did not complete a minimum of seven postnatal visits as required by the Ministry guidelines, and the Commissioner criticised the "insensitive and inappropriate" manner in which the limited postnatal contact was conducted.

The Commissioner recommended that the midwife provide an apology to the patient and directed a competency review prior to any return to practice. The midwife has also been referred to the Director of Proceedings.

Obstetric and midwifery care

In August 2016, the Commissioner issued breach findings in respect of both a midwife and an obstetrician involved in the provision of private maternity care. The case involved the mismanagement of a syntocinon infusion resulting in irregular contractions, a difficult ventouse delivery, infant deterioration and subsequent diagnosis of severe dystonic cerebral palsy.

The prescribing doctor was found in breach of the Code for her clinical decisions involving the syntocinon infusion and failure to recognise the link between the infusion and the abnormal fetal heart rate. The responsible midwife was also found to have breached the Code as, although the Commissioner acknowledged that it was not the midwife's decision to commence syntocinon, she failed to comply with the current DHB policy when administering the syntocinon infusion and

she had a "responsibility to be familiar with, and comply with, the DHB policies and guidelines". The Commissioner also considered that the midwife failed to fulfil her professional responsibility as she did not recognise clinical concerns, discontinue the infusion, or request the clinician's assessment of the patient in person. Further, she did not document any discussions or the rationale for stopping and restarting the infusion.

Both decisions highlight the importance of following relevant guidelines and policies. For organisations, it is crucial to ensure that staff are made aware of guidelines and policies, and that any changes to such documents are clearly communicated to staff.

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