Midwifery Practice - Learning from Complaints

Media spotlight on midwives

Attention-grabbing headlines in daily newspapers highlight cases where births go badly. The nightmare journey for the expectant parents — the search for a cause or explanation — and whether the midwife did the right thing at the right time — are laid out in black and white for public scrutiny and comment: "Mother warns of home-birth risks" (*The Press* 23/10/07); "Midwife is a serious risk" (*Sunday Star Times* 17/6/07); "Midwife brought discredit to job Tribunal decides in stillbirth case" (*New Zealand Herald* 18/9/2007). It must be difficult for midwives to remain unaffected by the public response to the actual and potential problems that surround the bringing of a baby into the world, and by the possibility that they may be involved in the care of a patient where something goes wrong and a complaint is made against them.

Complaints

In New Zealand, the quality and safety of health care is upheld under a law called the Health and Disability Commissioner Act 1994. Under this legislation, everyone using a health or disability service has the protection of a Code of Rights — 10 rights including the right to respect, appropriate standards of practice, effective communication, adequate information and informed consent. The legislation provides for people who feel unhappy about the service they have received, and believe their rights under the Code have been breached, to make a complaint. They can complain to the provider directly, to the provider's registration body (Midwifery Council), or to the Health and Disability Commissioner (HDC). Any complaint made to the Midwifery Council must be referred to the Commissioner.

There is an increasing number of complaints made about the care provided by midwives; 53 such complaints were made to HDC in the two years to 30 June 2007. Complaints may involve a bad outcome (such as a neonatal death) or an experience where a consumer felt the standard of care was inadequate or inappropriate. This article discusses the obligations of midwives under the HDC Act, what happens when a complaint is made about a midwife, how to respond to a complaint, examples of where problems arise, and themes from complaints.

Responsibilities

Under the HDC legislation, midwives have a responsibility to practise in a way that gives effect to the 10 consumer rights in the Code. These are the right to:

- be treated with respect and privacy
- fair treatment
- dignity and independence
- be treated with care and skill
- effective communication
- all the information they need
- make their own decisions
- a support person at most times
- rights during teaching and research
- have a complaint taken seriously.

Rights in practice

The underlying philosophy of the Code is that provision of care should be consumer-centred. In rights-based practice, consideration of consumer rights is intrinsic to the delivery of care. This obligation on providers relates not only to knowledge, skills and expertise — but also to attitude and respect for consumers. The responsibility of midwives to maintain competence, adhere to practice standards, cooperate with other providers to ensure quality and continuity of service, communicate effectively with patients, provide explanations, information and options, and ensure consent is properly informed and freely given, may all be compromised where a midwife is not taking a consumer-centred approach or treating the consumer with the level of respect the midwife herself would expect to receive.

Complaints process

Complaints to HDC are resolved at the lowest appropriate level. An initial assessment, including preliminary enquiries if necessary, will be undertaken to decide what action to take. Options available to the Commissioner include referral to the nationwide Advocacy Service, calling a mediation conference, or referral to the Midwifery Council — for example, where there are competence concerns. In some circumstances the Commissioner may take no action, for example, where a thorough investigation has already been undertaken by a provider (such as a DHB) and an adequate response provided. Some complaints about midwives proceed to a formal investigation. Investigations staff work on behalf of the Commissioner and are required under the act to be objective and impartial. A midwife has the opportunity to tell her side of the story. Advice on accepted standards of practice is obtained from one of the Commissioner's independent experts (midwives nominated by the Midwifery Council). The Commissioner will consider all the evidence before reaching a decision and making a report. A midwife has the opportunity to respond to any proposed breach finding or adverse comment before the Commissioner's report is finalised.

After investigating a complaint against a provider, the Commissioner may decide to take no further action, arrange for mediation, or issue a report stating whether the provider has breached the Code; if so, recommendations may be included (eg, make an apology, review practice). Sometimes the midwife may be referred to the Midwifery Council for consideration of a competence review. In serious cases, the midwife found in breach may be referred to the Director of Proceedings, who can decide whether to commence disciplinary proceedings before the Health Practitioners Disciplinary Tribunal, or civil proceedings (for a declaration or damages before the Human Rights Review Tribunal).

Responding to a complaint

A complaint made directly to a midwife presents an opportunity for the midwife to address the consumer's concerns herself, without the need for third party or HDC involvement. Taking a consumer-centred approach is key. When consumers complain, they want an explanation about what happened, answers to questions about the care received, acknowledgement of their concerns, accountability for what went wrong, and, where necessary, review and rehabilitation of a substandard practice or system so that others will not have to go through a similar experience. However, what matters to complainants as much as any of these factors is an acknowledgement of, and apology for, any inadequacies in the care they received.

A genuine apology, whether made immediately in response to a complaint from the consumer, or at a face-to-face meeting, will convey a sense that the midwife is truly sorry for what happened. It should also express recognition and acceptance of responsibility for any care deficiencies, and an indication of how the incident has resulted in changes in practice.

A midwife responding to a complaint made to HDC needs to provide a written explanation about what happened. This should include all the relevant background information and documentation. Some time may have elapsed since the events complained about, and memory is not a reliable form of evidence of past events. Comprehensive contemporaneous notes are required. The general rule of thumb is: if it isn't documented, it didn't happen. However, a provider can still explain events that happened but, through oversight, were not documented.

While most investigations are concluded within 6 to 12 months, complex cases where there are multiple providers may take longer. Midwives may wish to seek support from peers or through the College during the process.

Themes from complaints
Recurring issues that lead to breaches of the Code are:

- failure to conduct tests, examine/monitor vital signs
- failure to appropriately consult/refer to specialist in a timely manner
- failure to act on test results/abnormal symptoms in a timely manner
- failure to keep adequate/accurate records
- failure to adequately plan/manage labour and/or delivery
- failure to communicate
- failure to practise with reasonable care and skill, according to guidelines.

The case summarised below is an example of the way such deficiencies in care may arise in practice, and the potential tragic outcomes that may result (Opinion 05HDC17106, www.hdc.org.nz). It provides an opportunity for midwives to reflect on the quality and safety of their practice.

Case example – a breach of the Code
This case involved the care provided by an LMC to a 31-year-old woman during the birth of her first baby. When the LMC arrived at the major public hospital maternity unit at 8.30am the woman was in active and rapid labour and 7cm dilated. The midwife performed an ARM (artificial rupture of membranes) and noted an episode of marked fetal bradycardia on the CTG trace. The obstetric team was advised and reviewed the woman at 8.30am.

After 1½ hours of minimal progress and apparently normal fetal heart recordings, the midwife contacted the obstetrician on call to discuss commencing Syntocinon to augment the labour. The consultant understood this to be a preliminary enquiry only, so saw no need to review the woman at this time; the midwife, however, took this conversation as permission to start the medication. The CTG trace at this time was non-reassuring, but the midwife did not recognise this and commenced the Syntocinon at 10.50am, increasing the dose at 11.15am, 11.25am and 11.35am, noting "contractions still not increasing despite Syntocinon", and again at 11.45am and 11.55am. Despite monitoring the CTG trace continuously, the midwife failed to

recognise the changes in the baseline heart rate, some late decelerations and loss of variability. Two hours later (12.12pm) the baby's head was delivered but the delivery was impeded by shoulder dystocia. The midwife performed the appropriate manoeuvres to attempt to deliver the baby, but delayed nine minutes in calling for back-up when she was unsuccessful. The obstetrician delivered the baby within two minutes (12.23pm); the baby had no heartbeat and made no attempt to breathe, and was provided with advanced resuscitation by the neonatal paediatrician. The baby was diagnosed as having Grade II hypoxic ischaemic encephalopathy.

Several aspects of Ms B's care during the latter stage of labour are of concern. The first is the way in which the Syntocinon infusions were instigated and continued. The Commissioner's independent midwife advised that it would be usual practice for the obstetric team to assess the patient personally before a final decision is made. The authority to commence Syntocinon is not within the scope of midwifery practice. In addition, the midwife failed to consult the obstetric team after Syntocinon was commenced, despite direction in the Hospital Syntocinon Policy that the doctor must clearly chart the dose and rate of increase on the second stage management plan, and conduct a vaginal assessment after an hour of augmentation. The midwife needed to remain within her scope of practice and to adhere to the hospital policy in all respects.

Secondly, although the midwife assessed and recorded the fetal heart rate at regular intervals, she failed to identify and act on signs of fetal distress; fetal heart decelerations were evident on the CTG from 0900-1210. The tracing has been described as "ominous" and "pre-terminal". Accurate assessment of the CTG should have triggered closer surveillance, including actions (such as fetal blood sampling) that would have assisted the midwife in her decision-making about whether the baby needed to be delivered earlier. The midwife needed to exercise reasonable care and skill in assessing, interpreting and acting on the information provided by the CTG trace — and to maintain a high level of suspicion as to what it might indicate.

Thirdly, the midwife delayed for too long when it became apparent that the baby's shoulders were stuck. It is usual practice for a midwife encountering a suspected or actual shoulder dystocia to try to facilitate the birth and to call for assistance at the same time. Calling for assistance in a timely manner is crucial.

Finally, the midwife's documentation was inadequate. There was no mention of discussion regarding consent for procedures, such as the Syntocinon infusion, minimal information about the woman's physical or emotional well-being in the later stages of labour, and no comment about the decelerations evident on the CTG trace. Even if it is not possible to complete clinical notes during a rapid or complicated delivery, notes should be completed as soon as possible after the event, and annotated to show when the record was made.

In summary, the midwife did not exercise reasonable care and skill in the care she provided, and also failed to comply with professional midwifery standards and professional standards for documentation. She therefore breached Rights 4(1) and 4(2) of the Code. The midwife's omissions contributed to the tragic outcome for this mother and child.

Case example – no further action taken on complaint
Mrs A, who wanted a home birth, engaged an LMC based in a town 1½ hours distant from her home because there were no independent midwives (for lead or back-up care) in her home town. The woman had previously delivered a 9lbs baby at 42 weeks after a long labour. Mr A called the midwife at 8.40pm when labour was established, and by the time the midwife arrived at the rural town at 10.25pm, the baby's head had been "born to the brow".

The second stage was complicated by a shoulder dystocia. The midwife requested an ambulance, traction was applied, and at 10.32pm the baby was born flat. The midwife began mouth-to-mouth resuscitation and chest compressions. The ambulance arrived at 10.39pm but, as the baby had responded well to the resuscitation measures and staff were reassured by their observations, the ambulance left again at 10.50pm. At this stage, the placenta 'fell out' with the loss of 400ml of blood. Mrs A declined administration of vitamin K to the baby, and sutures to her second degree perineal laceration.

At 2.20am Mrs A passed a large clot of blood amounting to 400-500ml. The midwife administered Syntocinon in an attempt to prevent a postpartum haemorrhage; however as Mrs A became pale and symptomatic with a blood pressure of 80/50mmHg she administered IV fluids and arranged ambulance transfer to hospital. Mrs A's family travelled with her in the ambulance. The midwife travelled in her car with Mrs M's mother, following closely behind the ambulance, having instructed the ambulance officers to stop if problems arose.

The on-call duty obstetrician, with the assistance of the midwife, administered bi-manual uterine compressions to stabilise Mrs A's condition. She then conducted an examination under anaesthetic, noting the laceration, which she sutured. Matching blood was obtained and transfused. Mrs A was discharged 4 days later.

The obstetrician complained to HDC about several aspects of the midwife's care: that a home birth may not have been prudent given the baby's size; there was no Syntocinon infusion in place and no ergometrine had been administered; no second large bore cannula had been sited to allow rapid volume replacement; that no attempt had been made to perform bimanual uterine compression prior to admission; and, in the circumstances, administration of vitamin K would have been appropriate. The matter was investigated.

The Commissioner, who received advice from an independent midwifery expert, was satisfied that the midwife provided adequate antenatal care. Despite Mrs A 'looking big' from the time she was 24 weeks pregnant, the size of the fundus was not outside the norm, and there did not appear to be any basis to suggest that Mrs A was at greater risk of complications in relation to the birth. The expert noted that although it was 'not optimal' to have a home birth without the support of a back-up midwife, and this arrangement was out of line with requirements under the section 88 notice, the midwife made appropriate contingency plans. She was quite explicit about the possible risks of a home birth, raised the issues several times, and was willing to support Mrs A in her choice of a distant home birth.

The midwife faced three serious emergencies at this birth: shoulder dystocia, the baby needing resuscitation, and post-partum haemorrhage. The Commissioner's view was that the midwife handled the baby's delivery extremely well and appropriately. The expert commented that there is ongoing debate on the benefit of suturing tears, and advised that the decision to refrain from suturing was appropriate.

Regarding the post-partum haemorrhage, the expert commented that Mrs A deteriorated quite suddenly after passing a large blood clot, and that the midwife generally managed this appropriately, contacting an ambulance, requesting an urgent transfer to hospital and inserting a drip. A second IV line with an ergometrine/syntocinion infusion would have been helpful; however, since the bleeding had settled, the uterus was well contracted and one IV line was running, it was more important to effect a prompt transfer to hospital. Although it would have been prudent for the midwife to have travelled with Mrs A in the ambulance, her rationale for taking her own car was understandable.

The Commissioner's decision was that, despite the adverse outcome for Mrs A, the midwife dealt with a series of difficult and unexpected situations promptly and appropriately. He decided to take no further action on the complaint.

Elizabeth Finn
Education Manager