Midwife, Ms B

Obstetrician, Dr C

A District Health Board

A Report by the

Health and Disability Commissioner

(Case 03HDC15081)

Parties involved

Ms A	Consumer
Mr A	Ms A's partner
Ms B	Provider/independent midwife
Dr C	Provider/Obstetrician
Mrs D	Mother of Ms A's partner
Dr E	Obstetrician
Ms F	Midwife

Complaint

On 9 December 2003 the Commissioner received a complaint from Ms A about the services provided to her by Ms B, independent midwife. The following issues were identified for investigation:

Whether Ms B, independent midwife, provided services of an appropriate standard to Ms A, in particular:

- *whether Ms B appropriately managed Ms A's symptoms on 26 August 2003.*

An investigation was commenced on 23 January 2004. On 30 August 2004, as a result of independent expert advice, the investigation was extended to include Dr C, obstetrician, and his employer, a District Health board. Dr C was notified that:

> "Professor Westgate [the Commissioner's expert] advised that [Ms A] was not appropriately managed. … [S]he stated that when the severity of [Ms A's] hypertension was identified she should have been immediately admitted to hospital for a full medical assessment and treatment.
>
> In light of Professor Westgate's advice the Commissioner has decided to extend his investigation to include the service you provided to [Ms A] on 26 August 2003, in particular your decision not to admit [Ms A] to hospital."

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Information reviewed

- Information from:
  - Ms A
  - Mrs D
  - Ms B
  - Dr C
  - Dr E
- Ms A's clinical records from Ms B and the public hospital
- Independent expert advice was obtained from Professor Jenny Westgate, obstetrician, and Ms Elizabeth Brunton, independent midwife.

Information gathered during investigation

Background information – antenatal history and delivery by Caesarean section

On 9 January 2003, when Ms A was five and a half weeks pregnant, she engaged Ms B as her Lead Maternity Carer (LMC). Ms B saw Ms A four weekly during the first 25 weeks of the pregnancy, and two weekly after that. At 34 weeks Ms A complained of a headache and swelling of her feet. Ms B (who had previously taken a full family history, which included a paternal grandfather suffering from hypertension) checked Ms A's blood pressure, which was 114/60. Ms B tested Ms A's urine for protein, which was negative and, as a precaution, took blood for liver function tests. The blood test results were normal.

On 29 July Ms A (then 35.1 weeks pregnant) telephoned Ms B to inform her that her hands and feet were more swollen, and that she had had a headache that morning, but this had resolved without pain relief. Ms B visited Ms A and found that her blood pressure was 110/72, and there was no protein in her urine.

Ms B reviewed Ms A the following day. She found that there was no change in her condition, advised her to call if she had further concerns, and arranged to see her in one week if there was no further change.

On 6 August Ms B reviewed Ms A prior to going on holiday, and advised her how to contact the back-up midwife, Ms F.

On 20 August Ms A went into labour and was admitted at 3.45am to the public hospital by Ms F. Ms A was fully dilated at 11am. At 1.06pm Dr E, obstetrician, diagnosed a failure to progress owing to cephalopelvic disproportion, and mild foetal distress. He performed a Caesarean section and an alert baby boy was delivered. Ms A's blood pressure was recorded throughout the perinatal and postnatal periods. The highest recording was 140/80. Ms B resumed care of Ms A and her baby on 25 August, the date they were discharged from hospital.

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Events of 26 August 2003
At 6.45am on 26 August Ms A telephoned Ms B to inform her that the baby had been unsettled during the night. Ms B visited at 11am and found that Ms A had a persistent headache, which had eased only after she had taken three doses of Panadol and taken a shower. Ms B took Ms A's blood pressure, which was elevated at 200/120. Ms B advised Ms A to rest and rechecked her blood pressure after an hour. Ms A's blood pressure was 180/110 at the second recording. Ms B decided to take a blood sample, and left Ms A briefly to get some blood tubes. While away, she discussed Ms A's case with her colleague, Ms F. Ms F advised Ms B that she should take a blood sample. Ms B did so on her return to Ms A, requesting an urgent full blood count, to assess Ms A's renal and liver function.

Ms B remained with Ms A until 3pm when she received the results of the blood tests. The results showed an elevated alkaline phosphatase but were otherwise normal. At this time Ms A's blood pressure was 190/80. Ms B remained concerned and, at 3.30pm, she telephoned Dr C, the on-call obstetrician at the public hospital, to discuss Ms A's condition. Dr C advised Ms B that as he was about to go into theatre for an emergency, if it could wait, he would be free to speak with her in about 30 minutes. Ms B advised me:

> "I was anticipating [Dr C] would want to see [Ms A] so I started a referral however did not complete or send the referral because of my subsequent telephone call with [Dr C]."

Ms B's and Dr C's telephone conversation
Ms B spoke with Dr C again at 4.10pm. There are differences in Ms B's and Dr C's recollection of the conversation.

Ms B advised me that she told Dr C of Ms A's blood pressure recordings, urine and blood results, and headaches. Dr C advised her that he did not consider Ms A to be suffering from fulminating pre-eclamptic toxaemia, and recommended that Ms B check Ms A's blood pressure in the morning and refer her to her GP if the hypertension had not resolved. Ms B suggested prescribing a sedative for Ms A because she was tired, having had little sleep the previous night with the baby. Dr C agreed to this plan.

Ms B's record of her conversation with Dr C stated:

> "[4.10pm] Spoke with [Dr C] re[garding] [Mrs A's] BP – he felt it wasn't fulminating PET and to give as I suggested sedative Temazepam 10-20mg so as to get some sleep and check BP and refer to GP in [morning] if BP not settled …"

Dr C did not make a record of his discussion with Ms B but recalled the conversation taking place. He advised me that to the best of his recollection (approximately 7 months later) Ms B had called him because she was concerned that Ms A's blood pressure was significantly elevated. She was one week post partum, and had had a seemingly uncomplicated recovery from a Caesarean section. There was no prior history of hypertension either before or during her pregnancy and delivery. Dr C understood Ms A's clinical condition to be good, that blood test results were normal and there was no

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proteinuria. Ms B reported to him that Ms A was anxious and she thought this anxiety might be contributing to her elevated blood pressure. Dr C stated:

> "I advised on the basis of the information received that I believed the risk of pre-eclampsia or eclampsia was extremely low and that urgent admission into hospital that evening was not necessary. I suggested bed rest overnight and asked [Ms B] to assess [Ms A's] clinical condition and blood pressure the following morning."

Dr C later clarified that he was not aware that Ms A had a severe and unrelenting headache. He has a clear recollection that Ms A's general clinical condition was said to be good. With regard to the blood pressure readings, Dr C noted that at the time of his second conversation with Ms B, Ms A's blood pressure reading was 190/80. Dr C advised that while a reading of 200/120 constitutes an emergency, and his usual practice with such a case would be to admit for investigation and treatment, a reading of 190/80 was less worrying and would not necessarily require urgent admission to hospital. With regard to his knowledge of the initial reading of 200/120, Dr C advised:

> "It is possible that in the course of my telephone conversation with [Ms B] that I failed to appreciate the severity of [Ms A's] hypertension. It is also possible that [Ms B] failed to accurately inform me as to the severity of the hypertension."

Subsequent events

After Ms B's conversation with Dr C, Ms A had something to eat, took the prescribed temazepam and settled to sleep. Before she left Ms A's house, Ms B advised Ms A, her partner, Mr A, and Mr A's mother – who had arrived at the house – to contact her if there were any problems overnight.

Ms A was anxious about her condition and, shortly after Ms B left, she, Mr A and the baby went to Mr A's mother's house to stay the night.

At 7am on 27 August Ms A had a convulsion. An ambulance was called and Ms A had three further seizures on the way to hospital. On arrival at the public hospital, she was transferred to the intensive care unit with a diagnosis of pre-eclamptic toxaemia. She remained in intensive care for three days before being transferred to the postnatal ward, and was discharged from hospital a further two days later.

Dr C stated:

> "At the time of [Ms A's] seizure she was day 7 post partum. The rate of all eclamptic seizures in New Zealand seems less than 1 in 4000 deliveries. If late post partum seizures account for one quarter of this number then the numerical risk of an eclamptic seizure in a woman day 7 post partum would seem to be in the order of 1 in 16,000 births or less.
>
> I apologise for labouring this point, but the unlikelihood of a seizure at the time of my telephone advice to [Ms B] was fundamental to my decision not to advise transfer to hospital [on 26 August]".

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Dr E, the obstetric consultant responsible for Ms A's care during her admission, provided the following information about her condition:

"… My initial diagnosis was status 'eclampticus'. This is a condition where there is multiple fitting associated with pregnancy.

The text books generally tell us that eclampsia does not occur 48 hours after delivery and is always associated with hypertension, oedema and proteinuria ie: the signs of pre-eclampsia toxaemia.

In [Ms A's] case she had a straight forward pregnancy and delivery by Caesarean Section and at no stage was she regarded as being hypertensive or having signs of toxaemia of pregnancy.

I enclose an article for your perusal regarding delayed peri-partum eclampsia. This explains why some women with certain organ systems or vascular beds may be especially susceptible to eclampsia. The one important feature that is present is hypertension of a significant degree.

[Ms A] was managed in our intensive care unit until her condition was stable which allowed us to transfer her to a hospital ward."

Independent advice to Commissioner

The following preliminary expert advice was obtained from Professor Jenny Westgate, obstetrician:

"Thank you for asking me to advise the Commissioner on several aspects of this case. I have read the material provided:

- Letter of complaint and accompanying document, from [Mrs D] to the Commissioner, dated 9 October 2003, marked with an 'A'. (Pages 1 to 3)
- Letter of complaint and accompanying documents from [Ms A] to the Commissioner, dated 19 December 2003, marked with a 'B'. (Pages 4-9)
- Record of telephone interview with [Ms A] dated 19 February 2003, marked with a 'C'. (Page 10)
- Record of telephone interview with [Mrs D] dated 19 February 2003, marked with a 'D'. (Pages 11)
- Letter of response and supporting documentation, from [Ms B] to the Commissioner, received 19 February 2004, marked with an 'E'. (Pages 12 to 47)
- Letter of response from [Dr C], dated 8 March 2004, marked with an 'F'. (Pages 48 to 49)

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- [Ms A's] clinical records received from [the District Health Board] on 15 April 2004, marked with a 'G'. (Pages 50 to 100)
- Letter of response and accompanying reference document about post-partum eclampsia from [Dr E], obstetrician, to the Commissioner, dated 5 July 2004, marked with an 'H'. (Pages 101 – 106)

The events surrounding [Ms A's] pregnancy, delivery and immediate postpartum period have been well summarised already. This complaint relates to the Midwife's management of [Ms A] on 26 August 2003. The summary of the events of that day is as follows:

At 6.45am on 26 August [Ms A] telephoned [Ms B] to inform her that the baby was unsettled during the night. [Ms B] visited at 11am and found that [Ms A] had a persistent headache, which had eased only after she had taken three doses of Panadol and taken a shower. [Ms B] took [Ms A's] blood pressure which was elevated at 200/120. [Ms B] advised [Ms A] to rest and rechecked her blood pressure after an hour. [Ms A's] blood pressure was 180/110 at the second recording. [Ms B] took blood for an urgent full blood count, to assess her liver function and for signs of renal complication.

[Ms B] remained with [Ms A] until 3pm when she received the results of the blood tests. The results showed that [Ms A] had an elevated alkaline phosphatase but was otherwise normal. At this time [Ms A's] blood pressure was 190/80. [Ms B] remained concerned and contacted [Dr C], the on-call obstetrician, to discuss [Ms A's] condition. [Dr C] was due in theatre and unavailable to discuss [Ms A] at that time, so [Ms B] called him again at 4.10pm, and advised him of [Ms A's] blood pressure recordings, urine and blood results and headaches. [Dr C] advised her that he did not consider [Ms A] to be suffering from fulminating pre-eclamptic toxaemia and recommended that [Ms B] check [Ms A's] blood pressure in the morning and refer her to her GP if the hypertension had not resolved. [Ms B] suggested prescribing a sedative for [Ms A] because she was tired, having little sleep the previous night with the baby. [Dr C] agreed to this plan.

[Ms A] had something to eat, took the prescribed Temazepam and settled to sleep. Before she left the house, [Ms B] advised [Ms A], her partner, [Mr A] and [Mr A's] mother – who had arrived at the house – to contact her if there were any problems overnight.

[Ms A] was anxious about her condition and, shortly after [Ms B] left, she and [Mr A] and the baby went to [Mr A's] mother's house to stay the night.

At 7am on 27 August [Ms A] started to have convulsions and was admitted by ambulance to [the public hospital] where she was transferred to ICU with a diagnosis of pre-eclamptic toxaemia.

You have asked me to advise on the following:

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- How does post-partum eclampsia usually present?
- Would you expect a woman presenting with post-partum eclampsia to have shown signs of pre-eclampsia?
- Was the management of [Ms A's] symptoms on 26 August appropriate in the circumstances?
- If not, what else should have been done?

1. Postpartum eclampsia is broadly viewed as the onset of seizures in the postnatal period (first 6 weeks after delivery). It is most commonly preceded by headache. Recent studies have described this symptom occurring in 62%[1] and 87%[2] of women with late onset pre-eclampsia. Visual symptoms occurred in 19% and 43% and epigastric pain in less than 10%.

2. The vast majority of women who present with late postnatal (>48 hours post delivery) seizures do not have a history of pre-eclampsia or hypertension in the pregnancy. Matthys et al found less than 10% had a history of chronic hypertension and Chames et al found that only 22% had a history of pre-eclampsia in the pregnancy and most had no identifiable risk factors for pre-eclampsia or eclampsia. Prior to the seizure occurring 91% of women had at least one symptom, the most common of which was severe headache.

3. I do not believe that [Ms A] was managed appropriately on 26 August. A blood pressure of 200/120 mmHg is a severe and potentially dangerous degree of hypertension, particularly in someone who has not been hypertensive before. Hypertension of this level is associated with a significant risk of cerebral vascular crisis as the perfusion pressure to the brain is simply too high for the brain blood vessels to cope with. The possible consequences are many and include fitting, as occurred here or even cortical blindness or stroke. The fact that [Ms A] had a severe and unrelenting headache as well as this degree of hypertension was even more alarming.

4. I believe the Midwife should have consulted with a medical practitioner immediately she identified the degree of hypertension and arranged urgent admission to hospital. Irrespective of its cause and the results of any blood tests, this degree of hypertension is dangerous and needs emergency treatment. I ran this scenario past several specialists, registrars and independent midwives today (in an anonymised form obviously) and each and every one was immediately concerned at the level of hypertension and would have wanted immediate admission to hospital for full medical assessment and treatment. This remained the case even after they were told her blood tests were normal and there was no protein in her urine. Unfortunately, in this case, I think the focus was too much on whether or not [Ms

[1] Delayed postpartum preeclampsia: an experience of 151 cases. Matthys LA, Coppage KH, Lambers DS et al, American Journal of Obstetrics and Gynecology 2004:190;1464-6.
[2] Late postpartum eclampsia: a preventable disease? Chames MC, Livingston JC, Ivester TS et al, American Journal of Obstetrics and Gynecology 2002:186;1174-7.

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A] had biochemical evidence of pre-eclampsia and this rather diminished the attention paid to both the severity of her hypertension and her symptoms."

A further report was obtained from independent peer midwifery advisor, Ms Liz Brunton. Ms Brunton's report is as follows:

"Thank you for asking me to provide expert advice to the Commissioner on the above claim.

I have read and I agree to follow the Commissioner's Guidelines for Independent Advisors.

I am a Registered Midwife and a Registered General and Obstetric Nurse and have a Bachelor Degree in Psychology/Nursing. I have worked as a midwife for 24 years.

I worked for 4 years in a hospital setting (post-natal and delivery suite) as a staff midwife and charge-nurse, 6 years in a polytechnic institution tutoring student midwives and for the last 14 years I have worked as a self-employed independent midwife.

Purpose To provide independent expert advice about whether [Ms A] received an appropriate standard of care from [Ms B].

Background On 9 January 2003, when [Ms A] was 5.5 weeks pregnant, she engaged [Ms B] as her LMC. [Ms B] saw [Ms A] four weekly during the first 25 weeks of the pregnancy and two weekly after that. At 34 weeks [Ms A] complained of a headache and swelling of her feet. [Ms B] (who had previously taken a full family history which included a paternal grandfather suffering from hypertension) checked [Ms A's] blood pressure which was 114/60. [Ms B] tested [Ms A's] urine for protein, which was negative and, as a precaution, took blood for liver function tests. The blood test results were normal.

On 29 July [Ms A] (who was 35.1 weeks pregnant) telephoned [Ms B] to inform her that her hands and feet were more swollen, and that she had had a headache that morning, but this had resolved without pain relief. [Ms B] visited [Ms A] and found that her blood pressure was 110/72, and there was no protein in her urine.

[Ms B] reviewed [Ms A] the following day. She found that there was no change in her condition, advised her to call if she had further concerns, and arranged to see her in one week if there was no further change.

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On 6 August [Ms B] reviewed [Ms A] prior to going on holiday, and advised her how to contact the back-up midwife, [Ms F].

On 20 August [Ms A] went into labour and was admitted at 3.45am to [the public hospital] by [Ms F]. [Ms A] was fully dilated at 11am. At 1.06pm [Dr E], obstetrician, diagnosed a failure to progress due to cephalopelvic disproportion, and mild foetal distress, and performed a Caesarean section. [Ms A's] blood pressure was recorded throughout the peri and post natal periods. The highest recording was 140/80.

[Ms B] resumed care of [Ms A] on 25 August and organised her discharge from hospital. Her temperature and blood pressure were within normal range, and her Caesarean section wound was healing.

At 6.45am on 26 August [Ms A] telephoned [Ms B] to inform her that the baby was unsettled during the night. [Ms B] visited at 11am and found that [Ms A] had a persistent headache, which had eased only after she had taken three doses of Panadol and taken a shower. [Ms B] took [Ms A's] blood pressure which was elevated at 200/120. [Ms B] advised [Ms A] to rest and rechecked her blood pressure after an hour.

[Ms A's] blood pressure was 180/110 at the second recording. [Ms B] took blood for an urgent full blood count, to assess her liver function and for signs of renal complication.

[Ms B] remained with [Ms A] until 3pm when she received the results of the blood tests. The results showed that [Ms A] had an elevated alkaline phosphatase but was otherwise normal. At this time [Ms A's] blood pressure was 190/80. [Ms B] remained concerned and contacted [Dr C], the on-call obstetrician, to discuss [Ms A's] condition. [Dr C] was due in theatre and unavailable to discuss [Ms A] at that time, so [Ms B] called him again at 4.10pm, and advised him of [Ms A's] blood pressure recordings, urine and blood results and headaches. [Dr C] advised her that he considered the risk of [Ms A] suffering from eclampsia to be relatively low. He recommended that [Ms B] check [Ms A's] blood pressure in the morning and refer her to her GP if the hypertension had not resolved. [Ms B] suggested prescribing a sedative for [Ms A] because she was tired, having little sleep the previous night with the baby. [Dr C] agreed to this plan.

[Ms A] had something to eat, took the prescribed Temazepam and settled to sleep. Before she left the house, [Ms B] advised [Ms A], her partner, [Mr A], and [Mr A's] mother – who had arrived at the house – to contact her if there were any problems overnight.

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[Ms A] was anxious about her condition and, shortly after [Ms B] left, she and [Mr A] and the baby went to [Mr A's] mother's house to stay the night.

At 7am on 27 August [Ms A] started to have convulsions and was admitted by ambulance to [the public hospital] where she was transferred to ICU with a diagnosis of pre-eclamptic toxaemia.

Complaint

Whether [Ms B], independent midwife, provided services of an appropriate standard to [Ms A], in particular:

- *whether [Ms B] appropriately managed [Ms A's] symptoms on 26 August 2003.*

Supporting Information

- Letter of complaint and accompanying document, from [Mrs D] to the Commissioner, dated 9 October 2003, marked with an 'A'. (Pages 1 to 3)
- Notes taken during a telephone conversation with [Mrs D] (complainant) on 19 February 2004, marked with a 'D'. (Page 11)
- Letter of response and supporting documentation, from [Ms B] to the Commissioner, received 19 February 2004, marked with an 'E'. (Pages 12 to 47)
- Letter of response from [Dr C], dated 8 March 2004, marked with an 'F'. (Pages 48 and 49)
- [Ms A's] clinical records received from [the District Health Board] on 15 April 2004, marked with a 'G'. (Pages 50 to 100)
- Letter of response and accompanying reference document about post-partum eclampsia from [Dr E], obstetrician, to the Commissioner, dated 5 July 2004, marked with an 'H'. (Pages 101 – 106)
- Copy of independent advice received on 30 July 2004 from Professor Jenny Westgate, marked with an 'I'. (Pages 107 – 116)
- Letter of response from [Dr C] to Professor Westgate's advice, dated 28 September 2004, marked with a 'J'. (Pages 117 – 119)
- Further advice from Professor Westgate, dated 30 October 2004, marked with a 'K'. (Page 120).

Expert advice Required

To advise the Commissioner whether in your expert opinion [Ms B] provided [Ms A] with services of an appropriate standard. In particular:

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1) Was [Ms B's] assessment of [Ms A], when she reported persistent headache and was found to have an elevated blood pressure on 26 August 2003, appropriate?
2) If not, why not?
3) Were [Ms B's] actions in relation to [Ms A's] condition on 26 August appropriate?
4) If not, what else should she have done?
5) To assist him in deciding what action to take on this complaint, the Commissioner obtained some preliminary advice from Professor Jenny Westgate (pages 107 to 117). Professor Westgate advised that in her view 'the midwife should have consulted with a medical practitioner immediately she identified the degree of hypertension and arranged urgent admission to hospital'. Do you agree with this comment? If so, could you please comment on the expected midwifery practice in these circumstances.
In addition:

Any other comments you consider relevant that may be of assistance?

Midwifery comment:

1) Was [Ms B's] assessment of [Ms A], when she reported persistent headache and was found to have an elevated blood pressure on 26 August 2003, appropriate?

I believe that [Ms B's] initial assessment of [Ms A], when she reported persistent headache and was found to have an elevated blood pressure, was not appropriate.

2) If not, why not?

Midwives practice in an environment of 'Normal' Midwifery/Obstetrics. The severity of the initial blood pressure recording, accompanied by symptoms of persistent headache which had been unrelieved by 3 doses of Panadol, and leg oedema, were outside the range of a 'normal' definition.

It was at this stage that Specialist consultation should have been made and preparations for transfer to a medical facility considered.

Regardless of her previous history of stable blood pressure and episodes of headache resolution and normal blood picture during pregnancy, the initial blood pressure taken on the 26th August, in a 22 year old woman, was in a pathological range and required medical consultation.

3) Were [Ms B's] actions in relation to [Ms A's] condition on 26 August appropriate?

[Ms B's] initial actions were not appropriate as the initial blood pressure demanded specialist consultation and further assessment would have been done under medical supervision.

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Her subsequent actions were appropriate for assessment and monitoring of [Ms A's] condition considering consultation and transfer were not the chosen option.

4) If not, what else should she have done?

[Ms B] should have consulted earlier than she did and arranged for [Ms A] to be transferred to a hospital.

[Ms B] showed appropriate concern in regard to [Ms A's] condition, demonstrated by the time spent assessing [Ms A's] condition, reassessment of her blood pressure, completing a blood analysis, consulting an obstetric specialist and advice for future contact by the family.

Her interpretation of the blood analysis, urinalysis, lowering of the blood pressure over the day and eventual consultation with [Dr C], would have persuaded [Ms B] that [Ms A] was probably not toxaemic.

Clinically [Ms A] showed some potential symptoms of 'toxaemia' during pregnancy and [Ms B] assessed this appropriately, her blood pressure and blood picture all being within acceptable limits. Her blood pressure on discharge from hospital was slightly elevated (135/85).

Post-Birth Toxaemia is not a common event, as commented on by Professor Westgate and [Dr C] though it is within the range of possible diagnoses when presented with hypertension post-partum. [Ms B] was alert to this potential but was eventually advised otherwise.

There appears to have been either a lack of accurate reporting of the clinical details by [Ms B] to [Dr C] or a misunderstanding/interpretation of these details by [Dr C].

5) To assist him in deciding what action to take on this complaint, the Commissioner obtained some preliminary advice from Professor Jenny Westgate (pages 107 to 117). Professor Westgate advised that in her view 'the midwife should have consulted with a medical practitioner immediately she identified the degree of hypertension and arranged urgent admission to hospital'. Do you agree with this comment? If so, could you please comment on the expected midwifery practice in these circumstances.

I agree with this comment.

Expected midwifery practice in these circumstances would be one of consultation in the first instance. The initial blood pressure was severe enough, in such a young person, to necessitate consultation and anticipate transfer of care.

From consultation to transfer to tertiary care, an independent midwife would be expected to stay with her client, assess the client's condition and render care and support as necessary.

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Continued care by an independent midwife following transfer to a tertiary institution is outside the range of accepted/expected independent midwifery practice.

In addition:

Any other comments you consider relevant that may be of assistance?

Apart from not consulting initially, I believe [Ms B's] actions were of a caring and concerned practitioner. She was aware of the potential for post-birth eclampsia and carried out assessments appropriate for this diagnosis.

I believe that decisions in rural practice differ to city practice in that transfer to hospital is of a more dramatic nature. This can influence the decisions made in an effort to reduce the amount of disruption to the client.

[Ms B] did consult with her peer midwife and this did not seem to be helpful in retrospect.

It also appears that the discussion with the consultant obstetrician was not clear and thus the advice was not appropriate in this instance."

Further comment was sought from Professor Westgate in relation to the services provided by Dr C. In particular, Professor Westgate was asked to comment on [Dr C's] letter of response to the complaint. Professor Westgate's comments are as follows:

"Thank you for asking me to comment on [Dr C's] letter dated 28 September, 2004 (Document A).

[Dr C] states early in his letter that he agrees that any patient with a blood pressure of 200/120 mmHg should be admitted acutely for investigation and treatment. However, [Dr C] raises the possibility that in his telephone discussion with [Ms B] he was not cognisant of two important pieces of information, the first being that [Ms A] had a severe headache which had been present all day and that her blood pressure earlier in the day had been 200/120 mmHg. As a result he believes that he was giving advice on a patient who was seven days postpartum with a blood pressure of 190/80 mmHg, who was otherwise well and had normal blood test results and no proteinuria. He believes that the risk of eclampsia in such a setting is extremely low and I agree with him. The level of systolic hypertension is still rather high, particularly for a woman who had never been hypertensive. Hopefully, [Dr C] would have enquired as to [Ms A's] general condition and the presence of any symptoms. In his letter he states that he has a clear recollection that [Ms A's] general condition was said to be good. Under these circumstances, his decision not to advise that [Ms A] should be admitted is understandable.

Given the circumstances, it is impossible to know exactly what facts were or were not communicated in the telephone conversation between [Dr C] and [Ms B]. I am very reassured by the fact that [Dr C] agrees without question that a patient with a blood

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pressure of 200/120 with severe headaches should be admitted immediately for investigation and treatment.

I hope this information is helpful. If you have any further questions please contact me."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) *Every consumer has the right to have services provided with reasonable care and skill.*
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.*

Professional Standards

The following professional standards from the Nursing Council's 'Code of Conduct for Nurses and Midwives' are applicable in this case:

"Principle Two

The nurse or midwife acts ethically and maintains standards of practice.

Criteria

…

2.3 [The nurse or midwife] is accountable for practising safely within her/his scope of practice;"

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Opinion: Breach – Ms B

Delay in seeking specialist consultation and considering transfer
Pursuant to Right 4(1) of the Code of Health and Disability Services Consumers' Rights (the Code), Ms A had the right to have services provided by Ms B with reasonable care and skill. In accordance with Right 4(2), those services were also to be provided in accordance with relevant standards, including those set out in the Nursing Council's Code of Conduct.

Ms A telephoned Ms B at 6.45am on 26 August 2003, the day after discharge from hospital following her Caesarean delivery on 20 August. Ms B visited Ms A at 11.00am, and found that she had a persistent headache behind her left eye, which had not abated despite repeat analgesia, and an elevated blood pressure reading of 200/120. Ms B advised Ms A to rest for an hour before repeating the reading (then 180/110) and taking a blood sample. Ms B stayed with Ms A while awaiting the blood test results, which were received at 3.00pm and within the normal range, apart from an elevated alkaline phosphatase. Ms A's blood pressure had reduced to 190/80 by this time. However, Ms B remained concerned about Ms A and, at 3.30pm, attempted to contact the on-call obstetrician, Dr C, who was not immediately available, and asked Ms B to call again in half an hour. Ms B then spoke to Dr C again at 4.10pm. In the meantime she had prepared a hospital admission form.

Professor Jenny Westgate advised me that Ms B's management of Ms A's condition was not appropriate, particularly as a blood pressure reading of 200/120 mm Hg is "a severe and potentially dangerous degree of hypertension, particularly in someone who has not been hypertensive before …" and should be treated as a medical emergency requiring immediate admission to hospital. Professor Westgate further advised: "The fact that [Ms A] had a severe and unrelenting headache as well as this degree of hypertension was even more alarming", and Ms B should have consulted with a medical practitioner immediately after taking the first blood pressure reading at 11am.

Expert midwifery advisor, Ms Elizabeth Brunton agreed with Professor Westgate that Ms B's initial actions in response to Ms A's headache and blood pressure reading of 200/120 were not appropriate. Ms Brunton advised that midwives practise in an environment of "normal" midwifery/obstetrics and as Ms A's blood pressure reading and symptoms were severely outside the range of "normal" definition, specialist consultation, along with preparation for transfer, should have been considered at that early stage, ie, around 11am. Ms Brunton further advised:

> "Regardless of her previous history … the initial blood pressure taken on the 26th August, in a 22 year old woman, was in a pathological range and required medical consultation."

Considering that Ms B did not choose the option of early specialist consultation, her subsequent level of assessment and monitoring between 11am and 4.10 pm were appropriate. It was vital that Ms B stay with Ms A and continue to monitor her, check her blood pressure, and await blood test results. It was also appropriate that she ensured contact was made with Dr C (although with hindsight it is regrettable that she failed to

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realise, or emphasise to him at 3.30pm that his advice was in fact required as a matter of urgency). Ms Brunton also acknowledged that transfer of a patient to hospital from her home in a rural location, as in this case, "is of a more dramatic nature" and can influence decision-making. Ms B was apparently alert to the potential for Ms A's symptoms to amount to post-birth toxaemia requiring hospital care, but did not pursue this differential diagnosis, despite consulting with a midwifery colleague and Dr C.

I accept the advice of both Ms Brunton and Professor Westgate that overall it was necessary for Ms B to take immediate further action in response to Ms A's initial blood pressure reading and symptoms. I accept that late onset pre-eclampsia is a rare condition in community practice and one that Ms B may never have seen previously. I note that she was likely to have been reassured by the fact that Ms A had not been hypertensive during her pregnancy, and that after 11am on 26 August her blood pressure did reduce slightly. Nevertheless, in my opinion, faced with a blood pressure reading of 200/120, Ms B should immediately have consulted with an obstetrician and considered preparations for transfer to a medical facility. Her failure to seek specialist consultation at that time and arrange transfer of Ms A's care to hospital specialists constitutes a failure to provide services with reasonable care and skill, and therefore is a breach of Right 4(1) of the Code. In my opinion, Ms B also failed to meet the requirement of her profession to practise safely within her scope of practice and accordingly she breached Right 4(2) of the Code.

Ms B's communication with Dr C

Pursuant to Right 4(5) of the Code, Ms A had the right to co-operation among providers to ensure quality and continuity of services. In terms of Right 4(5), Ms B was obliged to ensure that her patient's clinical condition was fully and appropriately discussed with Dr C so that appropriate decisions could be made and quality and continuity of care maintained. Factors relevant to consideration of this issue are Ms B's role as LMC; Ms A's location in a rural area (such that admission to the regional hospital was slightly more "dramatic" in nature); and Dr C's role as a telephone advisor only, with no opportunity to physically assess the patient's needs. Ms B advised me that at 4.00pm she advised Dr C of Ms A's blood pressure recordings, blood test results, the headaches and the negative proteinuria. Ms B's record of her conversation states that she spoke with Dr C "re[garding] [Ms A's] [blood pressure]". It provides no further detail of what information was conveyed to Dr C, ie, which readings were reported to him, or whether Ms A's severe and unrelenting headache was discussed.

Dr C acknowledged that "it is possible that … I failed to appreciate the severity of [Ms A's] hypertension. It is also possible that Ms B failed to accurately inform me as to [the] severity of the hypertension." Dr C specifically stated that he did not believe that he was made aware of Ms A's severe and unrelenting headache, and that he had "a clear recollection that Ms A's clinical condition was said to be good".

As there were no independent witnesses to Ms B's discussion with Dr C, it is impossible to know exactly what was said. However, Ms B's notes are brief, and Dr C made no notes of the call. On balance I am satisfied that if Ms B had mentioned to Dr C that the 11am blood pressure was 200/120, combined with severe headache and pitting oedema, Dr C would have insisted on hospital transfer. Instead, on the information he appears to have been

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given, Dr C was reassured and did not advise transfer. Accordingly, I do not believe that Ms B adequately or clearly conveyed Ms A's condition to Dr C and, therefore, she failed to ensure quality and continuity of services could be maintained, and breached Right 4(5) of the Code.

No Breach – Dr C

On the basis of the advice that he received from Ms B, Dr C advised Ms B that he believed the risk of pre-eclampsia or eclampsia to be extremely low, and that urgent hospital admission was not warranted. He suggested bed rest, and advised Ms B to assess Ms A's blood pressure and clinical condition in the morning. I note that Dr C did not make a record of his conversation with Ms B. I accept the absence of a record by Dr C in the context of a busy on-call day, and the fact that he had just been in attendance at an emergency operation.

Dr C's response to the Commissioner raised the possibility that when he provided advice to Ms B, he was not cognisant of two important pieces of information, ie, the initial blood pressure reading of 200/120 mmHg, and the presence of a severe unrelenting headache. Professor Westgate advised:

> "… As a result [Dr C] believes that he was giving advice on a patient who was seven days post-partum with a blood pressure of 190/80mm Hg, who was otherwise well and had normal blood test results and no proteinuria. He believes that the risk of eclampsia in such a setting is extremely low and I agree with him … Under these circumstances, his decision not to advise that [Ms A] should be admitted that day is understandable."

Conversely, Professor Westgate was reassured by Dr C's advice that if he had been consulted about a patient with a blood pressure of 200/120, he would "without question" admit her immediately for investigation and treatment.

I have noted Professor Westgate's comment that it would have been appropriate for Dr C to have enquired about Ms A's general condition and the presence of any symptoms. With regard to this point, Dr C advised me that he has a clear recollection that Ms A's general condition was said to be good.

I accept Professor Westgate's advice. I am also mindful of the fact that in his telephone advisory role, Dr C could not examine Ms A for himself. He was only able to provide advice on the basis of the information conveyed to him over the telephone by Ms B. In this situation, the final decision regarding treatment or admission rested with the midwife as the Lead Maternity Carer. If Ms B had remained concerned, despite reassurance, she was still free to insist (within reason) that she believed her patient should be seen and assessed in the emergency department of the hospital. However, she did not do so and, based on his understanding of Ms A's symptoms and clinical condition at the time, as it appears to have

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been conveyed to him by Ms B, Dr C's advice was appropriate. Accordingly, in my view Dr C acted with reasonable care and skill and did not breach Right 4(1) of the Code.

Opinion: No Breach – The District Health Board

Vicarious liability
Dr C is employed as an obstetric and gynaecology consultant by the District Health Board. Employers may be vicariously liable for an employee's breach of the Code, pursuant to s 72(2) of the Health and Disability Commissioner Act 1994.

As Dr C did not breach the Code, it follows that the question of vicarious liability on the part of the District Health Board does not arise in this case.

Actions

Ms B has confirmed that she will review her practice, and has provided a written apology to Ms A in response to my provisional opinion.

Further actions

- A copy of my final report will be sent to the Midwifery Council and the Medical Council of New Zealand.
- A copy of my final report, with details identifying the parties removed, will be sent to the New Zealand College of Midwives, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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