Use of saline as placebo pain relief during labour
18HDC01578, 13 May 2019

Registered midwife ~ Lead maternity carer ~ Pethidine ~Placebo ~ Informed consent ~Rights 7(1), 4(2)

A pregnant woman engaged a registered midwife as her lead maternity carer (LMC), and the pregnancy proceeded uneventfully. The LMC recorded in the woman's birth plan that the woman would use "gas" and pethidine for pain relief in labour if needed.

At 40+2 weeks' gestation, the woman began having irregular contractions, and at around 8am she arrived at the public hospital. A student midwife assisted the LMC to care for the woman.

At 12.35pm, the woman was assessed by an obstetrician, who recorded that the woman had "[p]ain in [her] back ++". At 12.55pm, the obstetrician conducted a vaginal examination and ascertained that the woman was 8cm dilated, and the baby's position was occiput posterior. The obstetrician recorded that the woman was requesting analgesia, and suggested trying fentanyl or pethidine.

The woman asked for pethidine. The LMC drew up a syringe of either water or normal saline, and told the student midwife and a core midwife that she was going to give the woman some of the intravenous (IV) fluid via a syringe, but would tell the woman that it was pethidine. The LMC said that she believed in the placebo effect.

A total of 10ml of saline was administered to the woman over approximately 2.5 hours. The woman continued to be in pain. The LMC subsequently left and came back with real pethidine, which the student midwife administered. The medication chart, signed by the LMC, records that the woman was administered 50mg of pethidine intramuscularly at 1.15pm.

At 4.15pm, the LMC discussed the woman's lack of progress with the obstetrician. The LMC noted that the woman was "distressed ++". The obstetrician was present at 4.30pm, and recorded that the woman had been pushing for 75 minutes with slow progress, and that the CTG was reassuring.

The obstetrician conducted a bedside scan, and obtained verbal consent for a ventouse delivery. The obstetrician recorded that there was good descent of the head with three contractions, and that the baby was rotated and delivered occiput anterior.

After the woman left the hospital, the LMC told her that she had not given her pethidine, and explained that the reason for this was for the safety of the baby.

Findings

The principle of informed consent is at the heart of the Code. Pursuant to Right 7(1), services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent. It is the consumer's right to decide and, in the absence of an emergency or certain other legal requirements, clinical judgement regarding best interests does not apply.

The LMC's conduct was considered to have been disgraceful. The birth plan included the use of pethidine, and the LMC told the woman that she was being administered pethidine when

in fact she was being administered saline. The woman's pain continued, and by not providing her with the medication she had requested and agreed to receive, the LMC ignored the fundamental importance of consent. It was the woman's right to make an informed choice about the pain relief she was to receive, and not to be given IV saline when she had not consented to this. Consequently, the LMC breached Right 7(1).

The LMC's conduct in misleading her client during labour by administering saline and telling her that it was pethidine was not only dishonest, but also showed a concerning degree of paternalism. This was demonstrated by the LMC having told the student midwife that she views her relationship with her clients as being that of parent and child, and that her clients will believe anything she (the LMC) tells them. Such behaviour by a midwife is an abrogation of the essential partnership between the midwife and her client, which lies at the heart of the midwifery model in New Zealand.

The LMC was referred to the Director of Proceedings, who decided to take disciplinary proceedings in the HPDT. Her decision as to HRRT proceedings is on hold pending the outcome of any HPDT proceeding.

The LMC again misled the woman when she told her after she had left the hospital that she had not administered pethidine when in fact she had administered 50mg pethidine. The Midwifery Council of New Zealand publication "Code of Conduct" states that midwives are expected to work in partnership with women, to act with integrity, and to be open and honest. By her paternalistic treatment of the woman and by deliberately misleading her during the labour and after the birth, the LMC contravened those standards. Accordingly, the LMC also breached Right 4(2).

Recommendations

It was recommended that the LMC undergo further training with regard to the Code of Rights, informed consent, and communication with clients, and that the Midwifery Council of New Zealand consider whether the LMC should undertake a competency review.

It was also recommended that the LMC provide a written apology to the woman.