Registered Midwife, RM A

A Report by the
Health and Disability Commissioner

(Case 18HDC01578)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. Ms B became pregnant in 2017. Her lead maternity carer (LMC) was registered midwife (RM) RM A.

2. Ms B's pregnancy proceeded uneventfully. RM A recorded in Ms B's birth plan that Ms B would use "gas" and pethidine for pain relief in labour if needed.

3. At 40+2 weeks' gestation, Ms B began having irregular contractions, and at around 8am she arrived at the public hospital. Student midwife Ms D assisted RM A to care for Ms B.

4. At 12.35pm, Ms B was assessed by an obstetrician and gynaecologist, Dr E, who recorded that Ms B had "Pain in back ++". At 12.55pm, Dr E conducted a vaginal examination (VE) and ascertained that Ms B was 8cm dilated, and the baby's position was occiput posterior (OP).[1] Dr E recorded that Ms B was requesting analgesia, and suggested trying fentanyl or pethidine.

5. Ms B asked for pethidine. RM A drew up a syringe of either water or normal saline and told Ms D and RM C, a core midwife, that she was going to give Ms B some of the intravenous (IV) fluid via a syringe, but would tell Ms B that it was pethidine. RM A said she believed in the placebo effect.

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

7. At 4.15pm, RM A discussed Ms B's lack of progress with Dr E. RM A noted that Ms B was "distressed ++". Dr E was present at 4.30pm, and recorded that Ms B had been pushing for 75 minutes with slow progress, and that the CTG was reassuring.

8. Dr E conducted a bedside scan, and obtained verbal consent for a ventouse delivery.[2] Ms B was placed in the lithotomy position,[3] and a pudendal block[4] was administered. Dr E recorded that there was good descent of the head with three contractions, and the baby was rotated and delivered occiput anterior (OA).[5]

9. After Ms B left the hospital, RM A told her that she had not given her pethidine, and explained that the reason for this was for the safety of the baby.

[1] The OP position (occiput posterior fetal position) is when the back of the baby's head is against the mother's back.
[2] A ventouse is an assisted delivery of a baby using a vacuum device.
[3] Lying on the back with the legs flexed 90 degrees at the hips.
[4] A local anaesthetic injected into the pudendal canal, where the pudendal nerve is located, to provide rapid pain relief to the perineum, vulva, and vagina.
[5] An occiput anterior fetal position is when the back of the baby's head is facing the mother's spine.

Findings

10. The principle of informed consent is at the heart of the Code of Health and Disability Services Consumers' Rights (the Code). Pursuant to Right 7(1) of the Code,[6] 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.

11. RM A's conduct was disgraceful. Ms B's birth plan included the use of pethidine, and RM A told Ms B that she was being administered pethidine when in fact she was being administered saline. Ms B's pain continued, and by not providing her with the medication she had requested and agreed to receive, RM A ignored the fundamental importance of consent. It was Ms B's right to make an informed choice about the pain relief she was to receive, and not to be given IV normal saline when she had not consented to this. Consequently, RM A breached Right 7(1) of the Code.

12. RM A'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 RM A having told Ms D that she views her relationship with her clients as being that of parent and child, and that her clients will believe anything she (RM A) 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.

13. RM A again misled Ms B 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 Ms B and by deliberately misleading her during the labour and after the birth, RM A contravened those standards. Accordingly, RM A also breached Right 4(2) of the Code.[7]

Recommendations

14. It is recommended that RM A undergo further training with regard to the Code of Rights, informed consent, and communication with clients.

15. It is recommended that the Midwifery Council of New Zealand consider whether RM A should undertake a competency review.

16. It is recommended that RM A provide a written apology to Ms B.

[6] Right 7(1) of the Code states: "Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise."
[7] Right 4(2) of the Code states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

17. RM A will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994, for the purpose of deciding whether any proceedings should be taken.

Complaint and investigation

18. The Health and Disability Commissioner (HDC) received a complaint about the services provided to Ms B by RM A.[8] An investigation was commenced, and the following issue was identified for investigation:

- *Whether RM A provided Ms B with an appropriate standard of care in 2018, including whether Ms B was fully informed, and gave informed consent.*

19. The parties directly involved in the investigation were:

RM A	Provider/midwife
Ms B	Consumer
RM C	Provider/midwife
Ms D	Provider/student midwife

Also mentioned in this report:

Dr E	Obstetrician and gynaecologist

20. Information from the district health board (DHB) and the Midwifery Council of New Zealand was also reviewed.

Information gathered during investigation

Background

21. Ms B had her first child in 2008. In 2017, Ms A became pregnant again. Her pregnancy proceeded uneventfully.

22. RM A assumed responsibility as LMC when Ms B was at 37+3 weeks' gestation. RM A said that at this time she had an in-depth conversation with Ms B about pain relief, including that pethidine can cross the placenta and cause adverse outcomes for the baby. However, there is no record of this conversation. RM A stated that there is a section on the maternity programme EXPECT where she documents the various subjects she has

[8] The DHB informed the Midwifery Council of New Zealand (MCNZ) of these events. MCNZ then notified HDC under section 64 of the Health Practitioners Competence Assurance Act 2003.

discussed with women, including pain relief. She said she also has a pamphlet on pain relief that she gives to the women, and stated that she gave Ms B the pamphlet and discussed it, but did not document the pain relief as she usually does.

23. RM A recorded a birth plan. Ms B's plan to use "gas" and pethidine if needed is noted under "coping strategies". A week later, RM A recorded that she had discussed with Ms B when to "come in" when she was in labour.

Labour

24. At 40+2 weeks' gestation, Ms B began having irregular contractions.

25. At around 8am, Ms B arrived at the public hospital. She was contracting three times in 10 minutes, with contractions lasting 45 seconds. RM A arrived shortly thereafter.

26. The clinical notes state that a student midwife, Ms D, palpated Ms B's abdomen and queried whether the baby's position was OP.

27. RM A undertook a vaginal examination (VE) and found the cervix to be 4–5cm dilated. At 9am, RM A recorded that Ms B's contractions had become much stronger, and that she was using Entonox gas[9] for pain relief, but wanted something stronger.

28. At 9.15am, Ms D inserted an intravenous (IV) luer. At 10.45am, Ms D recorded that Ms B had said that she was finding that the Entonox gas was making her feel nauseous.

29. At 12.15pm, RM A conducted a further VE and found the cervix to be 6–7cm dilated. She discussed with Ms B and her family that the baby might be OP, and gained consent to have input from an obstetrician.

Obstetric review

30. At 12.35pm, Ms B was assessed by an obstetrician and gynaecologist, Dr E, who recorded that she had "Pain in back ++". At 12.55pm, Dr E conducted a VE and ascertained that Ms B was 8cm dilated, and the baby's position was OP. Dr E recorded that Ms B was requesting analgesia, and suggested trying fentanyl or pethidine. He noted that Ms B was to have a continuous CTG[10] and a further VE in two hours' time. He further noted that if, at that stage, the head was not descending, or the cervix was not dilated, he would be concerned, and that Ms B might need a Caesarean section. He requested the insertion of an IV line, and for blood to be taken for testing.

31. At 1pm, RM A recorded that Ms B was distressed and was using Entonox gas "++". RM A recorded: "Already has an IV in but bloods not taken."

[9] Entonox is a gas mixture consisting of 50% nitrous oxide and 50% oxygen. It is used for rapid onset and offset of analgesia and sedation.
[10] A cardiotocograph (CTG) (also known as an electronic fetal monitor (EFM)) records the fetal heartbeat and uterine contractions.

Pethidine

32. Ms D told the DHB that Ms B told her that her first birth had been a natural birth, without pain relief, because her midwife had refused pain relief. Ms D said that Ms B asked for pethidine.

33. Ms D said that she told RM A that Ms B had requested pethidine, and RM A asked her to insert another IV luer for the pethidine. There is no record of the insertion of a second IV line. In response to the provisional opinion, RM A said that she did not ask Ms D to insert another IV luer, as a second one was not required because there was already a patent IV line in place.

34. Ms D stated:

> "The LMC and myself went to dispensary to get the pethidine. The LMC told me about the placebo effect. Pethidine — 0.9% normal saline with a medication label on the syringe. I asked if she tells the woman afterwards, and she said no. Sometimes if the client is a good friend and can laugh about it afterwards she tells them."

35. Ms D said that a DHB midwife came into the dispensary, and RM A also told her about the plan.

36. RM C, a core midwife, told the DHB that when she entered the "treatment room" some time between 12.00 and 1pm, RM A was drawing up a syringe of either water or normal saline, and was chatting to the student about the "amazing effect" of placebo. RM C said that RM A explained to her that she was going to give her lady in labour some of the IV fluid via a syringe, but would tell the patient that it was pethidine. RM C said that RM A appeared to be proud of the fact that she had done this previously on several occasions, and stated that she believed she had had good results from it. RM C said that RM A said things like "placebo effect is awesome" and "bullshit rocks", and that RM A "seemed to enjoy the fact that you can tell people anything and they will believe you".

37. In response to the provisional opinion, RM A said that she does not "totally recall this conversation". She said that it is not her usual practice to administer saline as a placebo, and she "[has] not had to deal with telling women this in the past". She said that she never looks after a friend as an LMC or DHB midwife.

38. Ms D said that RM A described her relationship with her clients as being that she, RM A, was the parent, and the woman was a child. Ms D stated that RM A told her that women look up to you and listen to what you say, and if you tell them it is pethidine, they will believe you.

39. Ms D said that she administered the IV saline to Ms B, and RM A told Ms B that it was pethidine. Ms D stated that Ms B felt instant pain relief, but kept saying that she had a sore back, so RM A instructed Ms D to get more "pethidine". Ms D said that Ms B requested half doses of the "pethidine" because she did not want to harm her baby.

40. Ms D stated that Ms B received four 10ml syringes of saline, three of which were given in half doses. Ms D said that she did not document the administration of the saline because it was not real pethidine.

41. In response the provisional opinion, RM A said that she does not recall the exact time when Ms B had her first dose of IV saline, but she thinks it was after 9.30am. RM A stated that between 9.30am and 12.00pm Ms B would have received 2ml increments approximately every 30 minutes, which would have been a total of five administrations of IV saline. RM A said that a total of 10ml saline would have been administered over approximately 2.5 hours.

42. Ms D said that there was another core midwife in the dispensary, and when she told her what was happening the core midwife told her that it was illegal.

43. Ms B continued to be in pain. Ms D said that RM A left and came back with real pethidine, which she (Ms D) administered intramuscularly. The medication chart, signed by RM A, records that Ms B was administered 50mg of pethidine intramuscularly at 1.15pm. RM A stated that Dr E had assessed Ms B and agreed with the administration of pethidine. RM A told HDC that the reason for the administration was that Ms B was not progressing, and needed analgesia because she had a posterior presentation resulting in prolonged distress.

44. At 2.15pm, RM A recorded: "Pethidine not as effective now."

Delivery

45. At 3pm, RM A recorded that she had conducted a VE and no cervix had been felt. Ms B began pushing, but with little effect. At 3.45pm, the fetal heart rate was 135 beats per minute (bpm). RM A recorded that there were decelerations to below 70bpm, with good recovery.

46. At 4.15pm, RM A discussed Ms B's lack of progress with Dr E. RM A noted that Ms B was "distressed ++". Dr E was present at 4.30pm, and noted in his retrospective notes that Ms B had been pushing for 75 minutes with slow progress, and that the CTG was reassuring.

47. Dr E conducted a bedside scan, and obtained verbal consent for a ventouse delivery. Ms B was placed in the lithotomy position, and a pudendal block was administered. Dr E recorded that there was good descent of the head with three contractions, and the baby was rotated and delivered occiput anterior (OA).

48. Ms B and her baby boy remained well, and at 8.30pm RM A recorded that Ms B had been handed over to the hospital midwives. At 9.20pm, Ms B and her baby were discharged home with her whānau.

Incident management

49. Ms D and RM C expressed concerns about these events to their shift colleague. They decided that the matter should be raised with their manager.

50. RM C completed an incident management form, and a review was undertaken. The review was completed on 16 February 2018, and states that because the LMC was an independent practitioner, no internal formal investigation of her practice occurred. It notes that the incident was considered to be in breach of the Midwifery Council Code of Conduct, and would be reported to the Midwifery Council of New Zealand.

Further information

RM A

51. RM A stated:

> "The way [Ms B] was presenting led me to believe that she was transitional.[11] Knowing this, I felt it was in the best interests of the baby not to give Pethidine. However, in the best interests of [Ms B], I was to give her a sense of support and help in a difficult time, therefore I administered normal Saline, leading her to believe it was Pethidine. I knew it would do no harm, and that Pethidine could still be administered at any stage going forward, if required."

52. RM A told HDC that she later told Ms B that she had provided water instead of pethidine and apologised to her. She said that Ms B commented that she was grateful that she had not been given pethidine.

53. RM A said that she accepts that she "messed up", and accepts responsibility for what she did.

54. RM A told HDC that she had been registered as a midwife for 23 years, and that she was deeply regretful of this situation. She stated that she has seen a psychologist for emotional support and clinical supervision, which has given her the opportunity to reflect on her role as a midwife in her community, and to work on her problem-solving and decision-making skills. She stated that she has had regular discussions with a rural mentor, who has recommended that she engage in further education. In addition, she has requested a special circumstances midwifery review.

55. RM A said that she views her relationship with her clients as caring and professional, and uses metaphors for better understanding, for example: "Labour is like baking a cake. The Latent phase (pre-labour) is like buying the ingredients and preparing for baking." RM A stated that it is important to her that clients have a clear understanding of what is happening to their body, and to that of their unborn baby.

56. RM A said that the use of placebos was not usual for her, and that the only other time she used saline rather than pethidine was over ten years ago. She stated that she has never provided midwifery care for a friend, as that would be a conflict of interest and unwise.

[11] Transition is the final phase of the first stage of labour, following early and active labour.

57. RM A stated that she remembers feeling quite stressed that day, and for that reason she may not have been professional in the manner in which she communicated with the student and the DHB midwife while in the dispensary.

Information subsequently given to Ms B

58. Ms B told HDC that when she left the hospital, RM A told her that she had not given her pethidine, and explained that the reason for this was for the safety of the baby. Ms B said that she was glad that RM A had not administered pethidine.

59. In response the provisional opinion, RM A said that she told Ms B that she did not give her IV pethidine during her labour but instead administered saline, and apologised for misleading her. RM A stated: "I believe I had told her that she did have pethidine via injection, once the obstetrician had been to assess her. My intention was to relay that I had not given her **IV pethidine** and that I was very sorry for not getting her consent [emphasis in original]."

60. There is no record of what Ms B was told.

Responses to provisional opinion

61. Responses have been incorporated into the "information gathered" section as appropriate.

62. In addition, RM A said that she viewed her relationship with Ms B as a nurturing and positive adult. RM A stated:

> "We had an adult to adult relationship. At NO stage, did I view her as a child. Our relationship was complimentary and stable. A controlling parental role seeks to judge and manipulate. Nurturing wants to care for people [emphasis in original]."

63. RM A also stated: "In retrospect, I am deeply regretful of this situation and this will never be repeated again."

64. Ms B said that she had nothing further to add.

Relevant professional standards

65. The Midwifery Council of New Zealand publication "Code of Conduct" (December 2010) states that midwives are expected to work in partnership with women, and conduct themselves personally and professionally in a way that maintains public trust and confidence in the midwifery profession. It also states that midwives:

"
- act with integrity
- are open and honest

…

- do not abuse the woman's trust in themselves or in the midwifery profession …"

66. With regard to professional relationships, the Code of Conduct states:

> "16. They provide impartial, honest and accurate information in relation to midwifery care and health care products … any information that they provide about their midwifery services is factual and verifiable …"

Opinion: RM A — breach

67. Ms B arranged for RM A to take over as her LMC. RM A said that she discussed pain relief with Ms B and told her that pethidine can cross the placenta and cause adverse outcomes for the baby. However, the birth plan states under "coping strategies" that Ms B planned to use "gas" and pethidine if needed.

68. Ms B went into labour. At 12.55pm, Dr E confirmed that Ms B was 8cm dilated and the baby's position was OP. He recorded that Ms B was requesting analgesia, and that fentanyl or pethidine should be tried.

69. Ms B was using Entonox gas "++". She was distressed with the pain, and asked for pethidine. RM A administered 0.9% normal saline with a medication label on the syringe, and told Ms B that the normal saline was pethidine.

70. Ms B was concerned that pethidine might harm her baby, so requested half doses of the "pethidine". Ms B told RM A and Ms D that she felt some immediate relief after the saline was first administered, but then her pain continued. Ms B said that she had pain in her back, so RM A instructed Ms D to get more saline. Ms D said that overall, Ms B received four 10ml syringes of saline, three of which were given in half doses. In contrast, RM A recalls that a total of 10ml saline would have been administered over approximately 2.5 hours.

71. As the administration is not recorded, I am unable to determine exactly how much saline was administered. However, the period of time during which the administration occurred was at least 2.5 hours.

72. Ms B required analgesia because her labour was not progressing and the baby was OP. Dr E instructed that Ms B be administered pethidine or fentanyl for the pain. Eventually, at around 1.15pm, RM A administered 50mg of pethidine IM. Ms B said that after the birth, RM A told her that she had administered water instead of pethidine, and had not given her pethidine because of the need to ensure the safety of the baby. In response to the provisional opinion, RM A said that she intended to convey to Ms B that after the obstetrician had been to assess her, she was administered pethidine via injection, but not IV pethidine. The information given to Ms B is not recorded. In light of Ms B's account that

she was glad that RM A had not given her pethidine to ensure the safety of the baby, I remain of the view that RM A did not tell Ms B that she did, in fact, administer pethidine.

Conclusions

73. The principle of informed consent is at the heart of the Code. Pursuant to Right 7(1) of the Code, 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.

74. RM A's conduct was disgraceful. Ms B's birth plan included the use of pethidine, and RM A told Ms B that she was being administered pethidine when in fact she was being administered saline. Ms B's pain continued, and by not providing her with the medication she had requested and agreed to receive, RM A ignored the fundamental importance of consent. It was Ms B's right to make an informed choice about the pain relief she was to receive, and not to be given IV normal saline when she had not consented to this. Consequently, RM A breached Right 7(1) of the Code.

75. RM A's conduct in misleading her client during labour by administering saline and telling her that it was pethidine was not only dishonest, but also shows a concerning degree of paternalism. This is demonstrated by RM A having told Ms D that she views her relationship with her clients as being that of parent and child, and that her clients will believe anything she (RM A) 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.

76. RM A again misled Ms B when she told Ms B after she had left the hospital that she had not administered pethidine when in fact she had administered 50mg pethidine IM. 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. In my view, by her paternalistic treatment of Ms B and by deliberately misleading her during the labour and after the birth, RM A contravened those standards. Accordingly, I find that RM A also breached Right 4(2) of the Code.

Recommendations

77. I recommend that RM A undergo further training with regard to the Code of Rights, informed consent, and also communication with clients. RM A is to report back to HDC within three months of the date of this opinion, with evidence of having attended such training, or enrolment in such training.

78. I recommend that the Midwifery Council of New Zealand consider whether RM A should undertake a competency review.

79. I recommend that RM A provide a written apology to Ms B. The apology is to be sent to HDC within three weeks of the date of this opinion, for forwarding.

Follow-up actions

80. RM A will be referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994, for the purpose of deciding whether any proceedings should be taken.

81. A copy of this report with details identifying the parties removed will be sent to the Midwifery Council of New Zealand, and it will be advised of RM A's name.

82. A copy of this report with details identifying the parties removed will be sent to the district health board, and it will be advised of RM A's name.

83. A copy of this 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.

Addendum

84. The Director of Proceedings decided to take disciplinary proceedings in the Health Practitioners Disciplinary Tribunal. In October 2021, the Tribunal found RM A was guilty of professional misconduct. RM A was censured, ordered to pay a fine, ordered to undergo a Midwifery Standards Review annually for two years, and was prohibited from supervising student midwives for a period of one year.