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SAFE DELIVERIES?

A REVIEW OF NEW ZEALAND'S MIDWIFERY REGULATION
THROUGH THE LENS OF THE HEALTH AND
DISABILITY COMMISSIONER

Laws 513 – Law and Medicine Research Paper

Faculty of Law

Victoria University of Wellington

2013

Abstract

Although birth is a fundamental part of the life process, competing factions within the health profession struggle to agree on the best way to deliver maternity services. Despite this long-standing tension, the midwifery-led model has dominated New Zealand's maternity system for more than two decades with the majority of consumers expressing satisfaction with the care provided. Unfortunately for a small number of mothers and babies the pregnancy and birth experience is not a positive one and families are left suffering life-long, and often tragic, consequences. As one of the main consumer watchdogs in New Zealand, the Health and Disability Commissioner is charged with investigating claims of poor quality healthcare. This paper examines the central themes in the Commissioner's reports on substandard midwifery practice and proposes a number of regulatory solutions to the issues involved. Working in unison, these amendments have the potential to ease the pressure placed on midwives; enhance interprofessional relationships; improve practitioner competence; and increase overall compliance with the Code of Health and Disability Services Consumers' Rights. By implementing these changes, the New Zealand Government could safeguard valuable midwifery-based principles whilst still ensuring that high quality maternity care is provided to all of the country's mothers and babies.

Key Words – Midwifery Regulation; Consumer Rights; Health and Disability Commissioner

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I Introduction

Although five new babies are welcomed into the world each second,¹ factions within the health profession continue to disagree on the best way to give birth. This ever-present tension between medical intervention and the ‘natural’² approach is well-illustrated by New Zealand’s regulatory history with state-funded maternity care passing back and forth between midwives and doctors since the early 1900s.³

The introduction of the Nurses Amendment Act 1990 established the existing midwifery-led maternity system with obstetric involvement restricted to high-risk pregnancies and those willing to pay for private care. Despite over 20 years of governmental support, the midwifery-led model has remained under fire with a spate of recent incidents threatening to bring the entire profession into disrepute. Media reports speak of inexperience;⁴ service delivery failures;⁵ and “loose arrangements”⁶ with opponents calling for a complete maternity shake-up⁷ and New Zealand First offering to co-ordinate a bipartisan review.⁸

Before considering the current state of midwifery practice in New Zealand, it is important to examine the path the profession has taken thus far and discuss why maternity services are worthy of further consideration. Part II of this paper provides a brief summary on the importance of birth whilst Part III contains an historical overview of New Zealand’s midwifery regulation since the introduction of the Midwives Act in 1904.

Part IV of the paper continues the overview of New Zealand’s midwifery regulation by providing an outline of the existing standards set down by the Health and Disability Commissioner (HDC); the Ministry of Health; the Midwifery Council of New Zealand (MCNZ); and the New Zealand College of Midwives (NZCOM). In order to evaluate

¹ “Population to Hit 7bn By the End of October With Five Babies Born Every Second” *The Daily Mail* (online ed, London, 19 July 2011).

² The term ‘natural’ in this paper refers to the belief that birth should be a natural experience without unnecessary medical intervention.

³ Halina Ogonowska-Coates *Born: Midwives and Women Celebrate 100 Years* (New Zealand College of Midwives, Christchurch, 2004) at 8-9.

⁴ James Ihaka “Baby Death: Midwife Blamed” *The New Zealand Herald* (online ed, Auckland, 9 May 2012).

⁵ Nicole Pryor “Midwife Fails in Baby Care” (24 June 2013) [Stuff.co.nz <www.stuff.co.nz>](http://www.stuff.co.nz); “Childbirth System Not Delivering” (24 February 2013) [Stuff.co.nz <www.stuff.co.nz>](http://www.stuff.co.nz).

⁶ “Midwife Found Guilty Over Loose Arrangement” *The New Zealand Herald* (online ed, Auckland, 23 May 2013).

⁷ Natalie Akoorie “Campaigners Seek Maternity Shake-Up” *The New Zealand Herald* (online ed, Auckland, 25 May 2012).

⁸ New Zealand First “Horrific Birth Highlights Need for Maternity Review” (press release, 19 February 2013).

potential regulatory solutions to the issues identified in Part VI, one must first appreciate the current framework regulating midwifery practice in New Zealand.

Part V of the paper addresses calls for a complete maternity shake-up by establishing why the midwifery-led model (set out on Part III and IV) remains the most appropriate approach to maternity care for New Zealand women. It would be futile to recommend areas of improvement if the entire system required an overhaul.

In order to identify suitable areas for improvement, Part VI explores the central themes in HDC reports on substandard midwifery care. As one of New Zealand's main consumer watchdogs, the HDC is charged with investigating claims of poor quality healthcare⁹ in accordance with the Code of Health and Disability Services Consumers' Rights (the Code).¹⁰ By publishing reports on the complaints they investigate, the HDC provides a unique opportunity to review existing midwifery practice and consider potential regulatory amendments to address the issues involved. These amendments are set out in Part VII and need to be applied in unison if problems with midwifery care in New Zealand are to be resolved effectively.

In an interview in 2011, the current Commissioner stated that recurring themes from HDC reports are more important than the number of complaints.¹¹ In light of this approach, only the most relevant midwifery-related HDC reports are examined in this paper - specifically those containing confirmed breaches of the Code and one or more of the eight central themes identified by the author.

Ideas for proposed regulatory amendments, on the other hand, originate from a wide range of sources including a number of overseas jurisdictions. It is important to remember, however, that New Zealand's midwifery profession is fairly unique by world standards and differs from that found in other Commonwealth countries like Australia;¹² Canada;¹³ and the United Kingdom.¹⁴ It can also be difficult to apply certain forms of guidance from the United States

⁹ Health and Disability Commissioner Act 1994, s 6.

¹⁰ Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

¹¹ Donna Chisholm "A Failure To Deliver" *North and South* (online ed, Auckland, August 2011) at 46.

¹² "So You Want To Be A Midwife" Australian College of Midwives <www.midwives.org.au>.

¹³ "Legal Status of Midwifery in Canada" (January 2012) Canadian Midwifery Regulators Consortium <www.cmrc-ccsof.ca>.

¹⁴ "So You Want To Be A Midwife" (14 June 2012) Midwives Information and Resource Service <www.midirs.org>.

where the legal status of non-nurse midwives varies from region to region and direct-entry midwifery is prohibited in 14 states.¹⁵

Finally, this paper concludes that the current regulatory framework for midwifery practice in New Zealand is fundamentally sound with the majority of women enjoying a safe and positive birth experience. The life-long effect on those who undergo substandard midwifery care, however, warrants attention and changes should be made to ensure that high quality maternity care is received by all of New Zealand's mothers and babies.

II Why Birth Matters

There are a number of life experiences that bind us as human beings – birth is one of these. Regardless of gender, race or religion, everyone must go through the birth process to arrive in this world, albeit in a variety of different settings and circumstances.

The way in which a child enters the world can shape their future and it is in every State's interest to provide quality healthcare for expectant mothers, not just for the woman's well-being but also for the health of her child. Gaskin believes that:¹⁶

A society that places a low value on its mothers and the process of birth will suffer an array of negative repercussions for doing so. Good beginnings make a positive difference in the world, so it is worth our while to provide the best possible care for mothers and babies throughout this extraordinarily influential part of life.

Birth is also a common entry point into the healthcare system for the entire family.¹⁷ Although maternity care is primarily focused on the mother and baby, health professionals acquire a unique opportunity to survey the well-being of the community that surrounds them. The effective “monitoring of maternal and newborn health constitutes an integral part of monitoring the health of the overall population.”¹⁸

¹⁵ American College of Nurse-Midwives *Information for Foreign Educated Midwives and Nurse-Midwives Who Seek to Practice in the United States* (March 2009) at 4.

¹⁶ Ina May Gaskin *Birth Matters: A Midwife's Manifesta* (Seven Stories Press, New York, 2011) at 1.

¹⁷ Ministry of Health *Report on Maternity 2010* (November 2012) at 1.

¹⁸ Ministry of Health *Hospital-Based Maternity Events 2007* (November 2010) at 1.

A Human Rights

The fundamental right to life is enshrined in the Universal Declaration of Human Rights (UDHR);¹⁹ the International Covenant on Civil and Political Rights;²⁰ and the United Nations Convention on the Rights of the Child.²¹ This right has also been recognised domestically via section 8 of the New Zealand Bill of Rights Act 1990 (NZBORA).

The right to life is most commonly associated with protection against arbitrary execution, but the World Health Organisation (WHO), the United Nations Population Fund and UNICEF have indicated that States should also foster conditions essential for life if they want to ensure this right is met.²² Their belief is based on the principle that:²³

Human rights are universal and must be applied without discrimination on any grounds whatsoever, including sex. For women, human rights include access to services that will ensure safe pregnancy and childbirth.

A number of international agreements also recognise specific rights relating to expectant mothers. The International Covenant on Economic, Social and Cultural Rights²⁴ and the UDHR²⁵ enshrine the right to special protection, care and assistance during pregnancy and birth whilst the Convention on the Elimination of All Forms of Discrimination Against Women²⁶ protects the right to appropriate maternity services.

B New Zealand Context

When the Treaty of Waitangi was signed in 1840, it marked an agreement between two peoples in the spirit of partnership.²⁷ A widely accepted interpretation of article II guarantees

¹⁹ Universal Declaration of Human Rights (adopted by the General Assembly of the United Nations 10 December 1948), art 3.

²⁰ International Covenant on Civil and Political Rights (opened for signature 16 December 1966, entered into force 23 March 1976), art 6.

²¹ *United Nations Convention on the Rights of the Child* GA Res 44/25, A/Res/44/25 (1989), art 6.

²² Office of the High Commissioner on Human Rights *New Zealand's Response to Operative Paragraph 6 of the Resolution Titled "Preventable Maternal Mortality and Morbidity and Human Rights"* (A/HRC/11/L.16, 2009).

²³ Office of the High Commissioner on Human Rights, above n 22.

²⁴ International Covenant on Economic, Social and Cultural Rights (opened for signature 16 December 1966, entered into force 3 January 1976), art 10(2).

²⁵ Universal Declaration of Human Rights, above n 19.

²⁶ Convention on the Elimination of All Forms of Discrimination Against Women (opened for signature 18 December 1979, entered into force 3 September 1981), art 12(2).

²⁷ Caroline McKinney and Naumai Smith "Te Tiriti o Waitangi or The Treaty of Waitangi: What is the Difference?" in Dianne Wepa (ed) *Cultural Safety in Aotearoa New Zealand* (Pearson Education New Zealand, Auckland, 2005) 39 at 48.

the Crown's protection of Māori taonga. These treasures include Māori health and well-being;²⁸ expectant mothers as 'te whare tangata';²⁹ and 'he mokopuna', the next generation.³⁰

Pregnancy and birth is a particularly significant time for Māori with the baby recognised as a member of the whānau from the moment of conception.³¹ The unborn baby represents the next link in the familial chain and the continuation of blood ties. For Māori, the continuation of whakapapa, and hence the continuation of the hapū and iwi, is not only central to the Māori way of life, but also central to life itself.³²

III The History of Midwifery Regulation in New Zealand

Turbulence and change are key themes permeating the history of New Zealand's maternity system with doctors and midwives unable to agree on the most appropriate way to provide childbirth services. Central pieces of midwifery regulation enacted since 1900 include the Midwives Act 1904; the Nurses Act 1971 and the Nurses Amendment Act 1990. These statutes have since been repealed and maternity care is now dominated by the lead maternity carer (LMC) scheme set out in the Primary Maternity Services Notice 2007 (the Notice).³³

A Midwives Act 1904

Prior to the introduction of maternity regulation, the majority of New Zealand women gave birth at home³⁴ with the assistance of a lay midwife whose skill base was acquired through experience rather than education.³⁵ In 1904, Parliament enacted the Midwives Act which established both a register of midwives and a series of formal training hospitals.³⁶ Although this statute gave legal recognition to the midwifery profession, it also granted a significant

²⁸ At 48.

²⁹ Mina Timu Timu in Halina Ogonowska-Coates *Born: Midwives and Women Celebrate 100 Years* (New Zealand College of Midwives, Christchurch, 2004) at 68.

³⁰ Christine Rimene, Connie Hassan and John Broughton *Ukaipo: The Place of Nurturing* (Te Roopu Rangahau Hauora Maori o Ngai Tahu, Dunedin, 1998) at 69.

³¹ At 49.

³² At 27.

³³ "Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000" (12 April 2007) 41 *New Zealand Gazette* 1025 [Primary Maternity Services Notice 2007].

³⁴ Jane Stojanovic "Midwifery in New Zealand 1904-1971" (2010) 5 *Birthspirit Midwifery Journal* 53 at 53.

³⁵ Elaine Papps and Mark Olssen *Doctoring Childbirth and Regulating Midwifery in New Zealand: A Foucauldian Perspective* (Dunmore Press, Palmerston North, 1997) at 83.

³⁶ Ogonowska-Coates, above n 3, at 8.

degree of control to those in the field of medicine;³⁷ and “began the introduction of nursing culture into midwifery by creating the nurse-midwife.”³⁸

The establishment of several training hospitals in New Zealand provided midwives with the formal education they were lacking in the past but meant more and more expectant mothers were forced to give birth away from home even if this was contrary to their wishes. The hospital environment was particularly advantageous for the medical profession because it provided access to many women in a single environment and allowed them to determine the type of care received during childbirth.³⁹

At a similar time, advancements were being made in science and technology, and the medical profession encouraged women to believe that hospital was the safest place to give birth.⁴⁰ As the medicalised model gained strength, the autonomy of midwives decreased and they gradually became subordinate to the medical profession.⁴¹ In 1920 only 35% of Pākehā (non-Māori) women gave birth in hospital with this figure increasing to 78% by 1935.⁴²

Māori women, despite resisting the medicalisation of childbirth for considerably longer than Pākehā mothers, eventually succumbed to societal pressure and abandoned their traditional birthing methods. A key contributory factor to this change was the enactment of the Tohunga Suppression Act in 1907 which prohibited the use of Māori forms of knowledge and expertise, and effectively outlawed Māori childbirth practices.⁴³

By 1962, approximately 95% of all New Zealand women laboured in hospital⁴⁴ “in a room similar to an operating theatre, under very similar conditions to a surgical operation.”⁴⁵ These conditions, albeit in line with the predominant approach to maternity care, were a far cry from the home environment, and a stark contrast to the state of affairs pre-1904.

³⁷ Papps and Olssen, above n 35, at 91.

³⁸ Stojanovic, above n 34, at 53.

³⁹ Papps and Olssen, above n 35, at 9.

⁴⁰ At 9.

⁴¹ At 9-10.

⁴² At 100.

⁴³ At 103.

⁴⁴ At 104.

⁴⁵ Stojanovic, above n 34, at 56.

B Nurses Act 1971

The continued pressure to give birth in hospital led to the enactment of new legislation which further altered the midwifery profession. By introducing the Nurses Act 1971, Parliament effectively ended any remaining autonomy enjoyed by midwives by making it an offence to carry out “obstetric nursing” unless a patient’s care was already under the responsibility of a medical practitioner.⁴⁶ All statutory reference to the midwifery profession disappeared with the new phenomenon of obstetric nursing emerging from the Act.⁴⁷

Under this hospitalised approach women received little to no continuity of care with maternity providers changing up to 50 times during the pregnancy, birth and postpartum period.⁴⁸ Midwives working within the medical model became entrenched in routine and ritual monitoring,⁴⁹ losing part of the ‘natural’ essence which defines midwifery practice.

C Nurses Amendment Act 1990

For a number of years prior to legislative change in 1990, women from consumer advocacy groups were voicing concerns about the impersonal, fragmented and hospital-controlled maternity care provided to expectant mothers in New Zealand.⁵⁰ Their calls for change were a major influence in the enactment of the Nurses Amendment Act, providing statutory recognition for midwives as “safe and competent practitioners in their own right.”⁵¹ At the time of its introduction, Helen Clark, the then Minister of Health, stated that:⁵²

The Act restores autonomy to midwives, who were previously limited by legislation which allowed medical practitioners only to take full responsibility for the care of women. Statistics reflect the benefit of a commitment to natural childbirth, of continuity of care of the client and the rejection of unnecessary intervention.

⁴⁶ Nurses Act 1971, s 52(1).

⁴⁷ Papps and Olssen, above n 35, at 95.

⁴⁸ Karen Guilliland, Sally K Tracy and Carol Thorogood “Australian and New Zealand Healthcare and Maternity Services” in Sally Pairman and others (eds) *Midwifery: Preparation for Practice* (2nd ed, Churchill Livingstone, Chatswood, 2010) 3 at 9-10.

⁴⁹ Papps and Olssen, above n 35, at 175.

⁵⁰ Barbara Crawford and others *Review of the Quality, Safety and Management of Maternity Services in the Wellington Area* (Ministry of Health, October 2008) at 101.

⁵¹ Papps and Olssen, above n 35, at 176.

⁵² Department of Health *Nurses Amendment Act 1990: Information for Health Providers* (October 1990) at 1.

In addition, midwives were given the statutory right to prescribe drugs;⁵³ order diagnostic tests;⁵⁴ and train without prior nursing qualifications.⁵⁵

D The Lead Maternity Carer Scheme

Under the current maternity system, New Zealand's expectant mothers must choose an LMC to manage their pregnancy, birth and postpartum period.⁵⁶ The concept of an LMC was first introduced in 1996 by section 51 of the Health and Disability Services Act 1993 and is now regulated by the Notice issued in accordance with section 88 of the New Zealand Public Health and Disability Act 2000.

Maternity services provided by midwives and general practitioners (GPs) are provided free of charge⁵⁷ but care from a specialist obstetrician is only state-funded if complications arise.⁵⁸ The provision of free maternity care to New Zealand women is in line with international law (as outlined in Part II) and based on the principle that every expectant mother should have the opportunity to enjoy a safe and fulfilling outcome to her pregnancy and birth.⁵⁹

IV The Current System of Midwifery Regulation

The midwifery profession of New Zealand is largely self-regulated (via the MCNZ and NZCOM) and practitioners enjoy a wide jurisdiction to make professional judgements on their own responsibility.⁶⁰ Statutory regulation via the Notice outlines the responsibilities of all LMCs and provides the payment structure for self-employed midwives⁶¹ whilst the Code comprises ten consumer rights which every health practitioner must uphold where possible.⁶²

⁵³ Papps and Olssen, above n 35, at 176.

⁵⁴ At 176.

⁵⁵ At 13.

⁵⁶ Ministry of Health *Your Pregnancy: A Guide to Pregnancy and Childbirth in New Zealand* (March 2013) at 4.

⁵⁷ At 4-5.

⁵⁸ At 8.

⁵⁹ Crawford and others, above n 50, at 102.

⁶⁰ Sally Pairman and Roslyn Donnellan-Fernandez "Professional Frameworks for Practice in Australia and New Zealand" in Sally Pairman and others (eds) *Midwifery: Preparation for Practice* (2nd ed, Churchill Livingstone, Chatswood, 2010) 227 at 238.

⁶¹ Primary Maternity Services Notice 2007.

⁶² Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

The Ministry of Health has also produced a set of LMC guidelines for consultation with obstetric and related medical services (Referral Guidelines).⁶³

In addition, midwives are required to comply with the following legislation:⁶⁴

- Medicines Act 1981
- Medicines Regulations 1984
- Misuse of Drugs Act 1975
- Misuse of Drugs Regulations 1977
- Privacy Act 1993
- Health Information Privacy Code 1994
- Accident Compensation Act 2001

A Midwifery Council of New Zealand

The MCNZ was established under section 114(3) of the Health Practitioners Competence Assurance Act 2003 (HPCAA) and is:⁶⁵

...responsible for the protection of the health and safety of women and babies during the childbirth process by providing mechanisms to ensure that midwives are competent and fit to practise midwifery.

In accordance with the HPCAA, the MCNZ must define the profession's scope of practice⁶⁶ and set out the qualifications required to work in the midwifery field.⁶⁷ The Council is also obliged to develop a Code of Conduct and specify the core competencies required to register as a midwife in New Zealand.⁶⁸

⁶³ Ministry of Health *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)* (February 2012).

⁶⁴ Midwifery Council of New Zealand *Recertification Programme: Competence-Based Practising Certificates for Midwives* (August 2010) at 12.

⁶⁵ Midwifery Council of New Zealand *Midwifery Workforce Report 2009* (March 2010) at 6.

⁶⁶ Health Practitioners Competence Assurance Act 2003, s 11.

⁶⁷ Section 12.

⁶⁸ Section 118.

1 Scope of Practice

The Midwifery Scope of Practice was developed in 2004 after a period of consultation with the profession⁶⁹ and provides a legal definition of midwifery practice in New Zealand.⁷⁰

For example, the first section states that:⁷¹

The midwife works in partnership with women, on her own professional responsibility, to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn.

It is important to note that midwives in New Zealand are not expected to practise across the entire Scope of Practice in their day to day work.⁷² They are permitted to concentrate on one area of care but must retain the ability to practise across the scope at all times.⁷³ The full Midwifery Scope of Practice is located in appendix 2.

2 Pre-registration education

In order to be deemed competent to practise across the Midwifery Scope of Practice, a student midwife must complete a MCNZ approved pre-registration programme and achieve a pass in the Midwifery Council National Examination.⁷⁴ During the three year programme, students must complete a minimum of 4800 hours with 50% in midwifery practice and at least 40% in midwifery theory.⁷⁵ The MCNZ recommends that the theoretical components of the programme decrease over time to allow for an increase in practical experience.⁷⁶

Each student midwife must undertake at least 100 antenatal assessments; 200 postnatal assessments (mothers and babies); and facilitate 40 births.⁷⁷ In order to facilitate a birth, a student must be “involved in the woman’s care throughout labour, taking a major part in all

⁶⁹ Midwifery Council of New Zealand *Standards for Approval of Pre-Registration Midwifery Education Programmes and Accreditation of Tertiary Education Organisations* (August 2007) at 2.

⁷⁰ Pairman and Donnellan-Fernandez, above n 60, at 243.

⁷¹ New Zealand College of Midwives *Midwives Handbook For Practice* (4th ed, New Zealand College of Midwives, Christchurch, 2008) at 4.

⁷² Pairman and Donnellan-Fernandez, above n 60, at 243.

⁷³ At 243.

⁷⁴ Midwifery Council of New Zealand *Standards for Approval of Pre-Registration Midwifery Education Programmes*, above n 69, at 1.

⁷⁵ At 12.

⁷⁶ At 15.

⁷⁷ At 16-17.

assessments and midwifery decision-making.”⁷⁸ Student midwives must also participate in the care of at least 40 women experiencing complications during pregnancy, birth or the postnatal period.⁷⁹

3 Code of Conduct

Section 118 of the HPCAA requires the MCNZ to create its own standards of conduct, providing a gauge by which practitioner behaviour can be measured.⁸⁰ These principles include practising in a non-discriminatory way; interacting with colleagues in a fair and respectful manner; and acting in a way that does not bring the midwifery profession into disrepute.⁸¹ The full Code of Conduct can be found in appendix 3.

4 Registration

Anyone wanting to practise as a midwife in New Zealand must be entered onto the public Register of Midwives available online as part of the MCNZ’s website.⁸² The Register “includes details of each midwife’s qualifications, practising status and any conditions on their practice.”⁸³ Midwives must also hold current practising certificates⁸⁴ and face penalties of up to \$10,000 if they work without one.⁸⁵

All applications for practising certificates need to be accompanied by declarations supporting the midwife’s competence to practise and participation in the Recertification Programme.⁸⁶ The Competencies for Entry to the Register specify the skills, knowledge and attitudes expected of midwives working within the Midwifery Scope of Practice.⁸⁷ They were initially established in 2004 but had to be updated in 2007 to encompass cultural competence

⁷⁸ At 17.

⁷⁹ At 17.

⁸⁰ Midwifery Council of New Zealand *Code of Conduct* (December 2010) at 1.

⁸¹ At 3-6.

⁸² Midwifery Council of New Zealand *Midwifery Workforce Report Updated 2010* (2011) at 8.

⁸³ At 8.

⁸⁴ At 8.

⁸⁵ Health Practitioners Competence Assurance Act 2003, s 7.

⁸⁶ Midwifery Council of New Zealand *Recertification Programme: Competence-Based Practising Certificates for Midwives*, above n 64, at 14.

⁸⁷ “Midwifery Competence” Midwifery Council of New Zealand <www.midwiferycouncil.health.nz>.

guidelines developed by the Māori Midwives' Collective, Ngā Maia o Aotearoa.⁸⁸ These cultural competence guidelines, entitled Turanga Kaupapa,⁸⁹ are located in appendix 4.

The Competencies for Entry to the Register are:⁹⁰

Competency One: The midwife works in partnership with the woman/wāhine throughout the maternity experience

Competency Two: The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care

Competency Three: The midwife promotes practices that enhance the health of the woman/wāhine and her family/whānau and which encourage their participation in her health care

Competency Four: The midwife upholds professional midwifery standards and uses professional judgment as a reflective and critical practitioner when providing midwifery care.

Although this paper sets out the basic details of the Competencies for Entry to the Register, the MCNZ has also developed a number of associated explanatory statements; and a list of key criteria to be met at each level of competency.⁹¹

5 Recertification

In accordance with section 41 of the HPCAA, the MCNZ requires all practising midwives to demonstrate their continued competence by partaking in the Recertification Programme.⁹²

Over a three year period participants are required to:

- Make a declaration of competence to practise within the Midwifery Scope of Practice⁹³

⁸⁸ Midwifery Council of New Zealand *Recertification Programme: Competence-Based Practising Certificates for Midwives*, above n 64, at 7.

⁸⁹ Midwifery Council of New Zealand *Statement on Cultural Competence for Midwives* (October 2011).

⁹⁰ New Zealand College of Midwives, above n 71, at 5-11.

⁹¹ At 5-11.

⁹² Midwifery Council of New Zealand *Recertification Programme: A Summary for Midwives* (2011) at 1.

⁹³ At 1.

- Competently practise across all areas of the Scope⁹⁴
- Maintain a professional portfolio⁹⁵
- Complete all compulsory education including:⁹⁶
 - A two hour adult CPR session annually
 - A two hour neonatal resuscitation session annually
 - A two day technical skills workshop once every three years
 - A four hour breastfeeding workshop once every three years
- Complete a minimum of 50 points of elective education and professional activity⁹⁷
- Participate in a Midwifery Standards Review (MSR)⁹⁸

New graduates partaking in the Midwifery First Year of Practice Programme (MFYPP) are required to complete the technical skills workshop and participate in a MSR a year after their initial certification.⁹⁹ Participation in the Recertification Programme also satisfies the Notice’s requirement that midwives partake in a professional review process recognised by the MCNZ.¹⁰⁰

B New Zealand College of Midwives

The NZCOM is the professional organisation for midwifery in New Zealand and represents over 90% of practising midwives.¹⁰¹ It supports the MCNZ in its regulatory role by publishing the *Midwives Handbook for Practice* containing the Council’s Scope of Practice and Competencies for Entry to the Register as well as the College’s own Code of Ethics, Standards of Midwifery Practice and a guide on key decision points in midwifery care.¹⁰² The NZCOM also administers the MSR process; the MFYPP; and a number of other professional education programmes.¹⁰³

⁹⁴ At 1.

⁹⁵ At 1.

⁹⁶ At 1 and 3.

⁹⁷ At 1.

⁹⁸ At 1.

⁹⁹ At 3 and 5.

¹⁰⁰ Midwifery Council of New Zealand *Recertification Programme: Competence-Based Practising Certificates for Midwives*, above n 64, at 13.

¹⁰¹ Pairman and Donnellan-Fernandez, above n 60, at 235.

¹⁰² New Zealand College of Midwives, above n 71.

¹⁰³ Celia P Grigg and Sally K Tracy “New Zealand’s Unique Maternity System” (2013) 26 *Women and Birth* e59 at e61.

Although the MCNZ and NZCOM are separate entities, their roles are complementary. This inter-relationship is reflected by the similarities which exist between the Midwifery Scope of Practice; the Code of Conduct; the Competencies for Entry to the Register; the Code of Ethics; and the Standards of Midwifery Practice. For example, the wording in Standard One practically mirrors that found in Competency One.

1 Standards of Midwifery Practice

The ten Standards of Midwifery Practice expand on the principles within the Code of Ethics by providing the benchmark for midwifery practice in New Zealand.¹⁰⁴ Like the core competencies established by the MCNZ, each standard of practice comprises a central statement followed by a list of criteria necessary to satisfy it. These central statements are:¹⁰⁵

Standard One: The midwife works in partnership with the woman

Standard Two: The midwife upholds each woman's right to free and informed choice and consent throughout the childbirth experience

Standard Three: The midwife collates and documents comprehensive assessments of the woman and/or baby's health and wellbeing

Standard Four: The midwife maintains purposeful, on-going, updated records and makes them available to the woman and other relevant persons

Standard Five: Midwifery care is planned with the woman

Standard Six: Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk

Standard Seven: The midwife is accountable to the woman, to herself, to the midwifery profession and to the wider community for her practice

Standard Eight: The midwife evaluates her practice

Standard Nine: The midwife negotiates the completion of the midwifery partnership with the woman

¹⁰⁴ New Zealand College of Midwives, above n 71, at 14.

¹⁰⁵ At 15-24.

Standard Ten: The midwife develops and shares midwifery knowledge and initiates and promotes research.

2 Code of Ethics

The NZCOM's Code of Ethics comprises a series of principles designed to explain the underlying philosophy of midwifery practice in New Zealand. These principles include working in partnership with women; upholding the right to informed consent; recognising Māori as tangata whenua; and sharing midwifery knowledge with others.¹⁰⁶ The full Code of Ethics can be found in appendix 5.

3 Midwifery Standards Review

On a biannual basis, a MSR committee meets with each individual midwife to “explore and discuss their midwifery practice through a supportive and educative process.”¹⁰⁷ The main purpose of these meetings is to create a Professional Development Plan designed to enhance the midwife's personal and professional development.¹⁰⁸ In order to promote frank and open discussion, the MSR is a confidential process with only a record of participation shared outside the NZCOM in line with the MCNZ's Recertification Programme.¹⁰⁹

4 Midwifery First Year of Practice Programme

The MFYPP was established in 2007 to provide graduates with a year of support from a named mentor.¹¹⁰ It is a government-funded scheme and includes paid education and professional development hours to assist new midwives in enhancing their midwifery knowledge and skill-base.¹¹¹

¹⁰⁶ New Zealand College of Midwives, above n 71, at 12-13.

¹⁰⁷ Pairman and Donnellan-Fernandez, above n 60, at 238.

¹⁰⁸ Midwifery Council of New Zealand *Recertification Programme: A Summary for Midwives*, above n 92, at 5.

¹⁰⁹ Midwifery Council of New Zealand *Recertification Programme: Competence-Based Practising Certificates for Midwives*, above n 64, at 18.

¹¹⁰ Pairman and Donnellan-Fernandez, above n 60, at 244.

¹¹¹ At 244.

The Programme's vision is for New Zealand's midwifery graduates to:¹¹²

...enthusiastically commence their careers...well-supported, safe, skilled and confident in their practice; meeting the needs of maternity service consumers, providers and communities; and building a sustainable base for the New Zealand registered midwives workforce into the future.

Although the MFYPP is not compulsory, the majority of new graduates recognise its merits and voluntarily enrol in the scheme.¹¹³

C Primary Maternity Services Notice

The Notice sets out "the terms and conditions on which the Crown will make a payment to a maternity provider for providing primary maternity services."¹¹⁴ It comprises an extensive list of requirements essentially based on complying with all the statutory, regulatory, legal and professional obligations relating to maternity providers.¹¹⁵ It also contains a schedule of payments covering specific services like first trimester care and birth.¹¹⁶ The full Notice can be accessed online via the Ministry of Health website.

D Referral Guidelines

The Referral Guidelines were updated by the Ministry of Health in February 2012 and now encompass four categories of referral based on a matrix of conditions. These categories are:

- Primary - The LMC discusses with the woman that a consultation may be warranted with a GP, midwife or other relevant primary health provider¹¹⁷
- Consultation - The LMC must recommend to the woman that a specialist consultation is warranted¹¹⁸

¹¹² "Midwifery First Year of Practice" New Zealand College of Midwives <www.midwife.org.nz>.

¹¹³ Midwifery Council of New Zealand *Annual Report 2012* (31 March 2012) at 19.

¹¹⁴ Primary Maternity Services Notice 2007, cl A3.

¹¹⁵ Clause CB1.

¹¹⁶ Primary Maternity Services Amendment Notice 2012, sch 1.

¹¹⁷ Ministry of Health *Guidelines for Consultation*, above n 63, at 3.

¹¹⁸ At 3.

- Transfer - The LMC must recommend to the woman that care is transferred to a specialist¹¹⁹
- Emergency - “An emergency necessitates the immediate transfer of clinical responsibility to the most appropriate practitioner available”¹²⁰

E Code of Health and Disability Services Consumers’ Rights

Although disciplinary aspects of midwifery regulation sit outside the scope of this paper, the following section will briefly consider the Code and the HDC Complaints Process. The Health and Disability Commissioner Act 1994 (HDCA) established the office of the HDC to promote and protect the rights of health and disability consumers, and “facilitate the fair, simple, speedy, and efficient resolution of complaints.”¹²¹ As part of developing the HDC role, the Commissioner was required to prepare a code of consumer rights¹²² which can be found in appendix 6.

When the Code is breached, a midwifery consumer can make a complaint to the NZCOM, the MCNZ or contact the HDC directly. Any complaints made to the MCNZ must be passed on to the Commissioner in accordance with section 64 of the HPCAA. It is important to note, however, that the rights contained within the Code are not absolute.¹²³ A midwife will only be in breach of the Code if they cannot prove that they took reasonable actions in the circumstances to give effect to the consumer’s rights, and comply with the corresponding duties.¹²⁴ It is the responsibility of the HDC to form an opinion on whether the Code was breached and what consequences the midwife should face.¹²⁵

Where appropriate, the HDC can refer the matter to the Director of Proceedings who can bring a case before the Human Rights Review Tribunal or Health Practitioners Disciplinary Tribunal (HPDT).¹²⁶ There is a small proportion of midwives who take safe practice to its

¹¹⁹ At 3.

¹²⁰ At 4.

¹²¹ Health and Disability Commissioner Act 1994, s 6.

¹²² Health and Disability Commissioner Act 1994, s 19.

¹²³ Sue Johnson “Rights” in Rebecca Keenan (ed) *Health Care and the Law* (4th ed, Brookers, Wellington, 2010) 67 at 81.

¹²⁴ Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996, sch, cl 3.

¹²⁵ Health and Disability Commissioner Act 1994, s 45(1).

¹²⁶ “Complaints Resolution Overview” Health and Disability Commissioner <www.hdc.org.nz>.

outermost limits¹²⁷ and the law must “send a very clear message...that under no circumstances will the midwifery profession and the public tolerate patient and public safety being compromised by the provision of poor care.”¹²⁸

It is important, however, to recognise that there is little justice in holding practitioners to account if they are forced to work within a flawed system.¹²⁹ It is also likely that health professionals will display greater willingness “to engage in full and frank discussion about adverse events, errors and near misses” where an inquiry examines the system as a whole rather than focusing on individual performance.¹³⁰

More commonly, the HDC makes a number of recommendations to the midwife without taking the matter further.¹³¹ These recommendations include upskilling; working under supervision; and apologising to the aggrieved consumer.¹³² The HDC may also forward the results of the investigation to the MCNZ and NZCOM.¹³³

V Why Retain Midwifery?

The midwifery-led model (set out in Parts III and IV) has dominated New Zealand’s maternity system for over 20 years, and despite recent calls for a comprehensive review, it continues to meet the needs of the vast majority of expectant mothers.¹³⁴ The retention of midwifery in New Zealand can be supported in a number of different ways but this section will focus on the beneficial aspects of midwifery care; the high levels of consumer satisfaction; and the correlation between midwifery and tikanga Māori.

¹²⁷ Health and Disability Commissioner *Case 04HDC05503* (28 November 2006) at 13.

¹²⁸ New Zealand Health Practitioners Disciplinary Tribunal (249/Mid08/103D, 2009) at 7.

¹²⁹ Ron Paterson “Inquiries into Health Care: Learning or Lynching?” (2008) 121 NZMJ 100 at 109.

¹³⁰ Anne O’Brien, Sue Johnson and Jackie Pearse “Accountability of Health Practitioners” in Rebecca Keenan (ed) *Health Care and the Law* (4th ed, Brookers, Wellington, 2010) 45 at 63.

¹³¹ At 59.

¹³² At 59.

¹³³ At 61.

¹³⁴ Ministry of Health *Submission to the Health Select Committee from the Ministry of Health on the Submission from Jennifer Maree Hooper* (28 October 2009) at 10.

A Beneficial Aspects of Midwifery Care

In 2008, a comprehensive review of maternity care research encompassing over 12,000 women established that midwifery-led care presents a number of benefits and has no identified adverse effects.¹³⁵ For example, women who receive midwifery care are more likely to experience spontaneous vaginal births; feel in control during labour; and initiate breastfeeding.¹³⁶ The authors concluded that “most women should be offered midwife-led models of care and...should be encouraged to ask for this option”.¹³⁷

As outlined in Part IV, the first section of the Midwifery Scope of Practice highlights three key principles within the midwifery-led model. Firstly, a midwife must work in partnership with a woman. The term ‘partnership’ infers empowerment and informed choice with mothers involved in all aspects of planning and care.¹³⁸ Since an expectant mother will be faced with the challenging task of rearing her child for the next twenty years, encouraging confidence in her decision-making abilities is vital to her future well-being and that of the child.¹³⁹

Midwifery care also tends to be much more transparent than the care provided by the medical profession.¹⁴⁰ Midwives work very closely with women, and this intimate level of service means that expectant mothers “are better able to see and understand what is going on.”¹⁴¹ Although a midwife provides essential support and advice, it is important that the woman remains in control of her own pregnancy and childbirth in line with right 7 of the Code and section 11 of NZBORA.

Secondly, midwives work as autonomous practitioners. Under Standard Seven, midwives are required to be accountable to themselves; the women they serve; the midwifery profession; and the wider community.¹⁴² Good quality maternity care relies on attentive, well-trained professionals who know a lot about the physiology of labour and birth.¹⁴³ No amount of

¹³⁵ Marie Hatem and others *Midwife-Led Versus Other Models of Care for Childbearing Women* (Wiley, Chichester, 2009) at 2.

¹³⁶ At 1-2.

¹³⁷ At 2.

¹³⁸ Irene Calvert *Birth in Focus: Midwifery in Aotearoa/New Zealand* (Dunmore Press, Palmerston North, 1998) at 10.

¹³⁹ Marsden Wagner *Born in the USA: How a Broken Maternity System Must Be Fixed to Put Women and Children First* (University of California Press, Berkeley, 2006) at 106.

¹⁴⁰ At 205.

¹⁴¹ At 205.

¹⁴² New Zealand College of Midwives, above n 71, at 21.

¹⁴³ Gaskin, above n 16, at 117-118.

elaborate medical equipment can ever fill this need¹⁴⁴ or provide that valuable human touch. A midwife's ability to work autonomously is particularly important in respect to birth location. Women receiving midwifery care have the ability to choose whether to birth at home or in one of New Zealand's many maternity facilities.¹⁴⁵

Lastly, a midwife provides a full spectrum of maternity services extending across pregnancy, labour and the postpartum period. When woman are offered continuity of care, they feel less anxious; are open to using different birthing positions; need less analgesia; and generally feel happier with the maternity services they receive.¹⁴⁶ Continuity of care also allows the midwife to act as a constant in the childbearing process, moving through the system with the woman and facilitating any additional services the baby or mother may need.¹⁴⁷

Such a philosophy honours the natural ability of women to give birth without intervention whilst recognising "that a pathological or dangerous complication can occasionally develop even in healthy women, and that the application of a powerful technology...can be lifesaving in these instances."¹⁴⁸ There is often a fine line between normalcy and risk in childbirth¹⁴⁹ and midwives must find the right balance for each woman they care for. There will always be a small proportion of mothers and babies who require specialist care and the ability to identify risk, and act on that knowledge, is likely to be as important as advocating for the normal childbirth process.

The pre-emptive use of technology, however, is not supported. The WHO states that the ultimate aim of maternity care should be "to achieve a healthy mother and child with the least possible level of intervention that is compatible with safety."¹⁵⁰ There is no reason to think that the human female is the only mammal on earth unable to birth without intervention - "we humans are not inferior to hamsters, rhinoceri, squirrels, or aardvarks in our reproductive design."¹⁵¹

¹⁴⁴ At 118.

¹⁴⁵ Ministry of Health *Report on Maternity 2010*, above n 17, at 70.

¹⁴⁶ Calvert, above n 138, at 11.

¹⁴⁷ Crawford and others, above n 50, at 103.

¹⁴⁸ Gaskin, above n 16, at 8.

¹⁴⁹ Joan Skinner "Being With Women With Risk: The Referral and Consultation Practices and Attitudes of New Zealand Midwives" (2011) 45 *New Zealand College of Midwives Journal* 17 at 20.

¹⁵⁰ World Health Organisation *Care in Normal Birth: A Practical Guide* (1996) at 4.

¹⁵¹ Gaskin, above n 16, at 23.

Beneficence and non-maleficence are two of the key ethical principles behind all forms of healthcare. They require practitioners to do good and to do no harm.¹⁵² Midwives, in particular, aim “to do the right thing for the right reason”¹⁵³ without being swayed by the pressures placed on them by the medical profession. The application of routine, and often risky, tests, procedures, drugs and restrictions is likely to contravene the principle of non-maleficence¹⁵⁴ where mothers and babies are essentially well and do not require such interventions.

As pregnancy and birth do not normally involve illness or disease, consumer expectation of safety is particularly high and the ethical obligation on midwives to do no harm is likely to be elevated above that imposed on the rest of the healthcare profession.¹⁵⁵ In recognition of this increased obligation, midwifery practice centres around evidence-based maternity care where the use of treatment is based solely on the needs and interests of the mother and baby.¹⁵⁶

Midwifery care during labour and birth also tends to be significantly cheaper than the “cascade of obstetric interventions” often employed by the medical profession.¹⁵⁷ In light of the current budgetary restraints on the New Zealand Government, it would be wise to retain the midwifery-led model purely for fiscal sustainability purposes.

B Consumer Satisfaction

As discussed in Part III, it was a consumer-led drive for change that pressured Parliament to enact the Nurses Amendment Act and restore professional autonomy to midwives in 1990.¹⁵⁸ New Zealand women wanted what midwives had to offer - the provision of primary maternity services without medical intervention.¹⁵⁹ This same desire for midwifery care exists today

¹⁵² Shirley R Jones *Ethics in Midwifery* (2nd ed, Mosby, Edinburgh, 2000) at 22.

¹⁵³ Joyce E Thompson and Henry O Thompson “Ethics and Midwifery Practice” (1997) 50 *World Health* 14 at 14.

¹⁵⁴ Gaskin, above n 16, at 224.

¹⁵⁵ Onora O’Neill and others *Safe Births: Everybody’s Business* (King’s Fund, 2008) at 19.

¹⁵⁶ Gaskin, above n 16, at 8.

¹⁵⁷ Sally K Tracy and Mark B Tracy “Costing the Cascade: Estimating the Cost of Increased Obstetric Intervention in Childbirth Using Population Data (2003) 110 *BJOG* 717 at 717.

¹⁵⁸ Grigg and Tracy, above n 103, at e59.

¹⁵⁹ At e60.

with over 90% of women choosing a midwife as their LMC in 2010¹⁶⁰ although options are arguably limited in areas where GPs no longer provide maternity care.¹⁶¹

Since the introduction of the midwifery-led model of maternity care, a considerable number of GPs have walked away from the provision of childbirth services.¹⁶² The main reasons offered for the exodus include a lack of professional recognition; limited financial viability; and a stressful working environment caused by the politics of maternity care and deteriorating relationships with midwives.¹⁶³

Despite media reports of systemic failures, the majority of New Zealand women are happy with the standard of maternity care they receive and fair well without access to the full range of providers proposed by the LMC scheme. A maternity consumer survey conducted in 2011 found that 89% of women were satisfied with the services they obtained from their LMC - 73% of the 'very satisfied' ratings going to self-employed midwives.¹⁶⁴

C Māori Approach to Birth

The current midwifery-led model is particularly appropriate for New Zealand women because it echoes the tikanga Māori approach to maternity care. Although contact with other cultures does produce outward change, it rarely produces a shift in the fundamental value system of the contacted culture¹⁶⁵ and Māori women should be able to birth in a manner akin with their ancestors if that is what they desire.

In pre-colonisation times, childbirth was viewed as a natural event which took place at home with whānau tautoko or family support.¹⁶⁶ The tapuhi (caregivers) would use a range of techniques to assist the mother during her labour including karakia (prayer), waiata (songs) and mirimiri (massage).¹⁶⁷ The flexibility of midwifery care allows mothers to retain

¹⁶⁰ Ministry of Health *Report on Maternity 2010*, above n 17, at xii.

¹⁶¹ Lynda Exton *The Baby Business: What's Happened to Maternity Care in New Zealand?* (Craig Potton Publishing, Nelson, 2008) at 89.

¹⁶² Royal New Zealand College of General Practitioners "GPs Continue To Walk Away From Childbirth Care" (press release, 21 June 2002).

¹⁶³ Royal New Zealand College of General Practitioners, above n 162.

¹⁶⁴ Ministry of Health *Summary of Findings of the Maternity Consumer Survey 2011* (March 2012) at 2.

¹⁶⁵ Law Commission *Maori Custom and Values in New Zealand Law* (NZLC SP9, 2001) at 28.

¹⁶⁶ Joan Donley *Birthing: Natural vs Unnatural Childbirth in New Zealand* (The Full Court Press, Auckland, 1998) at 122.

¹⁶⁷ Jean Te Huia "Midwifery" in Dianne Wepa (ed) *Cultural Safety in Aotearoa New Zealand* (Pearson Education New Zealand, Auckland, 2005) 114 at 117.

substantial control over where they give birth, and with whom. Specific customs like the retention of the placenta can also be more easily incorporated if birth occurs outside the hospital environment.

The philosophy behind the retention of the placenta is central to the spiritual connection that Māori have with the land.¹⁶⁸ By burying the placenta in the ground and returning it to the Earth Mother, it is hoped that Papatūānuku will “continue to feed and sustain the life of all humanity.”¹⁶⁹ The critical link between the land and the newborn’s placenta is further demonstrated by the use of the word ‘whenua’ to describe both elements.¹⁷⁰

Partnership, one of the key elements of midwifery care, also features in the Crown’s relationship with Māori.¹⁷¹ As employees or agents of the State, midwives have an obligation to honour the principles of the Treaty of Waitangi and affirm Māori as tangata whenua or people of the land.¹⁷²

The importance of partnership to Māori is recognised in a well-known proverb or whakataukī:¹⁷³

Nā tō rourou - With your food basket

Nā taku rourou - And my food basket

Ka ora ai te iwi - The people will thrive

This whakataukī is particularly relevant to maternity care because the midwife and expectant mother often bring substantially different knowledge-bases to the midwifery partnership. The woman is likely to be an expert in her own body and the baby that grows within. The midwife, on the other hand, will possess expert skills and knowledge about pregnancy, birth and the postpartum period, invaluable to the mother when guidance or assessment is required.

In a study dating back to 1994, Harris found that “Māori women are most attracted to services which provide continuous care from the same person with whom they are sufficiently familiar

¹⁶⁸ At 115.

¹⁶⁹ At 115.

¹⁷⁰ “Whenua” Maori Dictionary Online <www.maoridictionary.co.nz>.

¹⁷¹ Christine M Kenney “Midwives, Women and Their Families: A Maori Gaze” (2011) 7 *AlterNative: An International Journal of Indigenous People* 123 at 124.

¹⁷² At 124.

¹⁷³ “Whakataukī – Proverbs” Korero Maori <www.korero.maori.nz>.

to feel comfortable”.¹⁷⁴ As discussed above, continuity of care is a key element of the midwifery-led model and New Zealand’s current maternity system can easily accommodate this preference.

Unfortunately for Māori women, receiving continuity of care from a Māori midwife is rare in the 21st century. In a 2010 report prepared by the MCNZ, less than 8% of the midwifery workforce categorised themselves as Māori despite 20% of New Zealand mothers identifying as such.¹⁷⁵ New Zealand’s maternity system needs to actively accommodate aspects of tikanga if it wants to counter such imbalance and ensure that Māori mothers feel culturally safe during the childbearing process.

Midwifery practice is deemed to be culturally safe when practitioners recognise the impact of their own culture and beliefs; and acknowledge and incorporate the woman’s culture into the provision of individualised maternity care.¹⁷⁶ The MCNZ believes that women are more likely to experience satisfying birth outcomes and feel ‘safe’ when they receive care from a midwife who works in a culturally competent way.¹⁷⁷

VI Central Themes in HDC Reports on Substandard Midwifery Care

Although the midwifery-led model remains the most appropriate way to provide maternity services to New Zealand women, there are indications that service levels could be improved. In 2011, the Perinatal and Maternity Morality Review Committee (PMMRC) found that 35% of maternal deaths and 19% of perinatal-related deaths were potentially avoidable with personnel issues identified as a contributory factor.¹⁷⁸ There have also been a number of recent incidents where mothers and babies have suffered from serious but non-fatal health conditions after issues with their midwifery care.¹⁷⁹

¹⁷⁴ Aroha Harris *Measuring the Effectiveness of Health Services for Maori Consumers* (Ministry of Health, 1994) at 28.

¹⁷⁵ Midwifery Council of New Zealand *Midwifery Workforce Report Updated 2010*, above n 82, at 16.

¹⁷⁶ Midwifery Council of New Zealand *Statement on Cultural Competence for Midwives*, above n 89.

¹⁷⁷ Midwifery Council of New Zealand *Statement on Cultural Competence for Midwives*, above n 89.

¹⁷⁸ Perinatal and Maternal Mortality Review Committee *Seventh Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting Mortality 2011* (June 2013) at 4-5.

¹⁷⁹ Health and Disability Commissioner *Case 08HDC18402* (7 September 2010); Health and Disability Commissioner *Case 10HDC00267* (21 May 2012); Health and Disability Commissioner *Case 11HDC00098* (22 March 2013); Health and Disability Commissioner *Case 11HDC00957* (10 June 2013); Health and Disability Commissioner *Case 12HDC00301* (9 July 2013).

The HDC is charged with investigating claims of substandard midwifery practice. The following sections consider a number of central themes in HDC reports grouped under the headings: inadequate documentation; lack of informed choice and consent; issues with homebirthing; inadequate antenatal care; poor cardiotocograph (CTG) monitoring; poor infant resuscitation; inexperienced midwives; and conflict between doctors and the midwifery profession.

For the purposes of this paper, specific examples of substandard midwifery care are used to illustrate particular points. Although these examples will be considered in isolation, it is important to remember that incidents commonly involve a number of Code breaches and overlap will exist between the sections. For example, a midwife who fails to effectively document a mother's care may also fail to provide the woman with sufficient information to allow informed choice and consent.

A Inadequate Documentation

Issues around inadequate documentation appear to permeate HDC reports on substandard midwifery care. Of the 36 reports researched for this paper, more than 75% contained concerns about record-keeping.¹⁸⁰

The HDC believes that “documentation is a fundamental requirement of good care.”¹⁸¹ Without a record of what is said and done, it can be difficult to identify patterns and recognise if there is cause for concern.

Under right 4(2) of the Code, “every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.” Midwives are required to maintain comprehensive documentation under a number of different directives including the Notice;¹⁸² the Competencies for Entry to the Register;¹⁸³ the Code of Conduct;¹⁸⁴ the Standards of Midwifery Practice;¹⁸⁵ and the Referral Guidelines.¹⁸⁶ By failing to keep

¹⁸⁰ See bibliography.

¹⁸¹ Health and Disability Commissioner *Case 07HDC15908* (5 December 2008) at 12.

¹⁸² Primary Maternity Services Notice 2007, cls DA7, DA8, DA19, DA23 and DA29.

¹⁸³ Competencies One and Two - New Zealand College of Midwives, above n 71, at 6-9.

¹⁸⁴ Midwifery Council of New Zealand *Code of Conduct*, above n 80, at 7.

¹⁸⁵ Standards Three, Five and Seven - New Zealand College of Midwives, above n 71, at 16-21.

¹⁸⁶ Ministry of Health *Guidelines for Consultation*, above n 63, at 2-18.

adequate records, midwives are breaching both the Code and their professional and legal obligations.

Comprehensive record-keeping is one of the key aspects of effective documentation. The HDC has stated that “it is inadequate to write ‘well’ at each visit without further explanation”¹⁸⁷ and a midwife should keep detailed accounts of their appointments and assessments. One word comments are simply “too brief to be of value”.¹⁸⁸ The Commissioner has also investigated complaints where documentation was found to be inaccurate,¹⁸⁹ misleading,¹⁹⁰ and overly mechanistic.¹⁹¹ One particularly serious deviation from accepted standards involved a midwife who failed to document the fetal heart rate, the mother’s blood loss, the apgars of the baby¹⁹² and even whether the baby was born a boy or a girl.¹⁹³ An independent expert to the HDC advised that professional peers would view the midwife’s conduct with moderate to severe disapproval and the Commissioner determined that her poor documentation standards breached right 4(2) of the Code.¹⁹⁴

1 Care plans

The HDC believes that “documentation of a mother’s care must be illustrative of clear and specific planning between the mother and midwife.”¹⁹⁵ In line with this belief, preparation of a comprehensive care plan is one of the fundamental components of midwifery practice and is included in the requirements for Competency One;¹⁹⁶ Standard Five;¹⁹⁷ and the Notice.¹⁹⁸

¹⁸⁷ Health and Disability Commissioner *Case 05HDC18619* (27 July 2007) at 18.

¹⁸⁸ At 19.

¹⁸⁹ Health and Disability Commissioner *Case 07HDC08615* (17 September 2008) at 24.

¹⁹⁰ Health and Disability Commissioner *Case 12HDC00301* (9 July 2013) at 2.

¹⁹¹ Health and Disability Commissioner *Case 04HDC20394* (14 March 2006) at 16.

¹⁹² The apgar test is the very first assessment given to a newborn at birth to evaluate their physical condition and to determine any immediate need for extra medical or emergency care – “About the Apgar Score” KidsHealth <www.kidshealth.org>.

¹⁹³ Health and Disability Commissioner *Case 07HDC03243* (28 November 2007) at 17.

¹⁹⁴ At 18.

¹⁹⁵ Health and Disability Commissioner *Case 05HDC18619*, above n 187, at 40.

¹⁹⁶ New Zealand College of Midwives, above n 71, at 6.

¹⁹⁷ New Zealand College of Midwives, above n 71, at 19.

¹⁹⁸ Primary Maternity Services Notice 2007, cl DA19.

A care plan is legally defined as:¹⁹⁹

...the process by which the LMC and the woman develop a plan of care for the woman and her baby and the documentation of this plan throughout the individual clinical notes pertaining to this woman.

It encompasses all aspects of midwifery care including a schedule of visits; an assessment of risk; the mother's preferences for monitoring, intervention and treatment; and any cultural safety requirements.²⁰⁰ It would be extremely difficult for a midwife to recall the wishes of each individual mother without preparing and documenting such detailed arrangements.

Detailed care plans can also serve to remind midwives of issues still requiring attention and provide invaluable assistance in ensuring these important decisions are not missed.²⁰¹ In 2010, a baby suffered a cerebral haemorrhage after a midwife failed to administer a vitamin K injection due to a gap in her mother's care plan.²⁰² The administration of vitamin K is an important aspect of postnatal care and prevents the development of a serious bleeding condition linked with low vitamin K levels.²⁰³ Although the midwife's deviation from acceptable standards appears mild, the consequences of her departure were severe considering the baby suffered an avoidable and potentially life-threatening brain injury.²⁰⁴ After a thorough investigation, the HDC concluded that the midwife's care planning and documentation were not in accordance with professional standards and she breached right 4(2) of the Code.²⁰⁵

2 Referrals

Comprehensive documentation plays a significant role in guiding future healthcare.²⁰⁶ For example, thorough record-keeping is essential where mothers and babies need to be referred to other health practitioners and midwives must share vital information about their progress thus far. Right 4(5) of the Code states that "every consumer has the right to co-operation among providers" and an effective transfer of the woman's maternity notes is key to a

¹⁹⁹ Clause B5.

²⁰⁰ Health and Disability Commissioner *Case 05HDC18619*, above n 187, at 23.

²⁰¹ Health and Disability Commissioner *Case 11HDC00957* (10 June 2013) at 16.

²⁰² At 16.

²⁰³ Ministry of Health *Your Pregnancy*, above n 56, at 22.

²⁰⁴ Health and Disability Commissioner *Case 11HDC00957*, above n 201, at 18.

²⁰⁵ At 1.

²⁰⁶ Health and Disability Commissioner *Case 06HDC18721* (14 May 2008) at 32.

successful handover. Co-operation among providers also ensures that continuity of care can be maintained, a central principle within the midwifery-led model.

A lack of continuity of care was a major factor in an incident investigated by the HDC in 2008.²⁰⁷ A baby developed hypoglycaemia and sustained significant neurological damage after four different midwives provided him with care and failed to share crucial information about his well-being.²⁰⁸ The Commissioner held that “the documentation in this case was not sufficient to ensure all the necessary information was available to the midwifery staff...and this may well have contributed to his deteriorating condition.”²⁰⁹ Despite recognition of a poor documentation culture within the maternity facility, all four midwives were held to be professionally responsible for breaching right 4(2) of the Code.²¹⁰ Even where there are hospital-wide issues with record-keeping, midwives must remember that they are autonomous practitioners and have to meet all the required standards for midwifery care and practice.

3 Retrospectivity

Retrospective documentation is one area of particular concern to the HDC. Although the realities of a midwife’s role can force them to document some events after the fact, blanket retrospectivity is not appropriate. A midwife is unlikely to recall specific clinical observations if they are not documented contemporaneously, leaving gaps in the notes or inaccurate estimates.²¹¹

The HPDT has considered the issue of retrospective documentation and believes that “no health professional should mislead the Commissioner or any other person about their records.”²¹² Although a midwife may not intentionally seek to mislead, amending or changing records retrospectively can give the impression that they provided a better quality of care than they actually did.²¹³

²⁰⁷ Health and Disability Commissioner *07HDC04325* (13 October 2008).

²⁰⁸ Health and Disability Commissioner *07HDC04325*, above n 207.

²⁰⁹ At 13.

²¹⁰ At 15.

²¹¹ Health and Disability Commissioner *Case 05HDC18619*, above n 187, at 40.

²¹² New Zealand Health Practitioners Disciplinary Tribunal (58/Med05/15D, 2006) at [156].

²¹³ Health and Disability Commissioner *Case 05HDC18619*, above n 187, at 40.

In 2007, the HDC investigated a mother's midwifery care after her baby was stillborn.²¹⁴ The results of the inquiry were described as "very concerning" with numerous examples of documentation being amended or added to retrospectively.²¹⁵ Despite over 20 years' experience in obstetrics and more than 8 years working as a midwife, the practitioner in this case failed to follow a number of important requirements including Standard Four which requires that midwives maintain purposeful, ongoing and updated records.²¹⁶ The midwife was subsequently held to have breached right 4(2) of the Code²¹⁷ and the Director of Proceedings issued a disciplinary charge against her.²¹⁸

B Lack of Informed Choice and Consent

A fundamental aspect of midwifery care is the expectant mother's right to informed choice and consent. The importance of this right is reflected by its inclusion in the Notice;²¹⁹ the Code;²²⁰ the Competencies for Entry to the Register;²²¹ the Code of Conduct;²²² the Standards of Midwifery Practice;²²³ the Code of Ethics;²²⁴ and the Referral Guidelines.²²⁵

In order to exercise informed choice and consent, a woman needs to understand the options open to her and should be provided with clear information about the associated risks and potential outcomes for each alternative. Right 6(1) of the Code states that "every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive".

²¹⁴ Health and Disability Commissioner *Case 05HDC18619*, above n 187.

²¹⁵ At 36.

²¹⁶ New Zealand College of Midwives, above n 71, at 18.

²¹⁷ Health and Disability Commissioner *Case 05HDC18619*, above n 187, at 36.

²¹⁸ At 44.

²¹⁹ Primary Maternity Services Notice 2007, cl CB6.

²²⁰ Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, rights 6 and 7.

²²¹ Competency One - New Zealand College of Midwives, above n 71, at 5.

²²² Midwifery Council of New Zealand *Code of Conduct*, above n 80, at 4.

²²³ Standard Two - New Zealand College of Midwives, above n 71, at 16.

²²⁴ At 12.

²²⁵ Ministry of Health *Guidelines for Consultation*, above n 63, at 18.

Right 6(1) reflects the prevalent approach to information provision by combining objectivity (“a reasonable consumer”) and subjectivity (“in that consumer’s circumstances”).²²⁶ According to Skegg, a health practitioner:²²⁷

...should disclose not merely what some hypothetical reasonable person would wish to know...but also any other information which he has reason to believe that the particular person would wish to know.

A similar sentiment is reflected in leading case law on informed consent. In *Rogers v Whitaker*, the High Court of Australia held that a health practitioner has a duty to warn a patient about any material risks attached to the proposed treatment which a reasonable person in the patient’s position would be likely to assign significance.²²⁸ This principle was subsequently applied in the High Court of New Zealand²²⁹ and remains influential in New Zealand case law today.²³⁰

The HDC has received a number of complaints involving issues with informed choice and consent during midwifery care. Although a mother chooses an LMC to care for her during her pregnancy and birth, she should remain in control of her own experience. In 2004, a baby died after a midwife providing antenatal care to the baby’s mother failed to respond appropriately to the woman’s concerns about reduced fetal movements.²³¹ The HDC found that the midwife breached right 6(1) of the Code by failing to provide the mother with sufficient information about her condition and the options available to assess her baby’s well-being.²³²

Similarly, in 2010, a woman suffered an extensive 2nd degree perineal tear requiring surgical repair after a midwife failed to provide her with sufficient information about birth management.²³³ The woman, who had suffered a serious tear during the birth of her first child, was worried about the same injury occurring again and had advised the midwife of her concern to no effect.²³⁴ The HDC concluded that the midwife breached rights 6(1) and 7(1) of

²²⁶ Ron Paterson and PDG Skegg “The Code of Patients’ Rights” in PDG Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Thomson Brookers, Wellington, 2006) 23 at 40.

²²⁷ PDG Skegg *Law, Ethics, and Medicine: Studies in Medical Law* (Clarendon Press, Oxford, 1984) at 92-93.

²²⁸ *Rogers v Whitaker* (1992) 175 CLR 479 at [16].

²²⁹ *B v Medical Council of New Zealand* [2005] 3 NZLR 810 (HC).

²³⁰ PDG Skegg “The Duty to Inform and Legally Effective Consent” in PDG Skegg and Ron Paterson (eds) *Medical Law in New Zealand* (Thomson Brookers, Wellington, 2006) 205 at 209.

²³¹ Health and Disability Commissioner *Case 05HDC01760* (22 November 2006).

²³² At 32.

²³³ Health and Disability Commissioner *Case 10HDC00267* (21 May 2012) at 3.

²³⁴ At 2.

the Code by failing to provide the information required; and failing to place the mother in a position where she could choose how best to minimise the risk of further tearing.²³⁵

Right 7 of the Code is complementary to right 6 and relates specifically to informed choice and consent. Right 7(1) states that bar a statutory or common law provision to the contrary, health and disability services can be only provided to a consumer where that person has exercised informed choice and consent.

The nature of midwifery care requires informed consent to be an ongoing process rather than a one-off event.²³⁶ For example, an expectant mother's care plan should not be viewed as a fixed record of her consent to certain procedures. The plan merely indicates the woman's wishes at a particular moment in time²³⁷ and she can change her mind or withdraw consent at any point.²³⁸

Although informed consent is recognised as a central feature of midwifery care, Godbold states that the "proportion of midwifery complaints investigated by the Commissioner - which relate directly to informed consent - suggest that this area of practice may be one of the most problematic."²³⁹ In 2006, the HDC investigated a complaint where a mother received an episiotomy without her consent.²⁴⁰ An episiotomy is a very intimate procedure involving "an incision through the perineal tissue, made to enlarge the vulval outlet during delivery."²⁴¹ The documentation shows little evidence that the midwife engaged with the mother.²⁴² She appears to have presumed that the episiotomy was in the woman's best interests considering her fast labour.

As set out in Part V, midwifery practice is based on the ethical principles of beneficence and non-maleficence. Although the concepts behind these two principles are clear, there are many different views on what qualifies as a benefit or harm.²⁴³ Making a decision on what will

²³⁵ At 21.

²³⁶ Judith Fyfe, Andrew Connolly and Barnett Bond "Informed Consent" in Ian St George (ed) *Cole's Medical Practice in New Zealand* (12th ed, Medical Council of New Zealand, Wellington, 2013) 96 at 97.

²³⁷ Bridgit Dimond *Legal Aspects of Midwifery* (3rd ed, Books for Midwives, Edinburgh, 2006) at 133.

²³⁸ New Zealand Bill of Rights Act 1990, s 11; Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996, right 7(7).

²³⁹ Rosemary Godbold "Informed Consent and Midwifery Practice in New Zealand: Lessons from the Health and Disability Commissioner" (2010) 42 *New Zealand College of Midwives Journal* 12 at 12.

²⁴⁰ Health and Disability Commissioner *Case 04HDC20394*, above n 191.

²⁴¹ At 21.

²⁴² At 25.

²⁴³ Lynley Anderson and Bronwen Pelvin "Ethical Frameworks for Practice" in Sally Pairman and others (eds) *Midwifery: Preparation for Practice* (2nd ed, Churchill Livingstone, Chatswood, 2010) 283 at 288.

benefit others “is a particularly difficult and dangerous task, and is best left to the individual to decide for themselves.”²⁴⁴

The ethical principle of autonomy recognises this “inherent worth of others as self-managing, self-interested actors with goals and life plans.”²⁴⁵ Like beneficence and non-maleficence, autonomy plays a substantial role in midwifery care with expectant mothers free to decide which treatments and procedures they will accept and refuse.²⁴⁶ Women are also free to make choices that other people would not make in the same circumstances, including those they may regret at a later date.²⁴⁷

As pointed out by Jones:²⁴⁸

If autonomy means being in control of your life, self-governing and self-ruled, then it is essential that the individual is at least a partner in any decision-making process that involves them directly. To be excluded from the process would mean that true consent has not been established.

On occasion, the ethical principles of beneficence and autonomy clash. For example, an expectant mother may refuse to consent to a procedure that a midwife deems necessary for the well-being of her unborn baby. The resolution of issues such as this sits outside the scope of this paper but it is important to note that these ethical dilemmas exist, particularly when analysing the actions of the midwifery profession. Fortunately for midwives and mothers these dilemmas are rare, and a woman’s wishes generally coincide with the best interests of her baby.²⁴⁹ The HDC has stated that:²⁵⁰

It would be an unusual woman who would risk the life and well-being of her baby in order to adhere to her choices for her labour and delivery, if the midwife is clear about the risks her choices pose.

Although a woman’s autonomy must be respected, the midwife has a duty to use her training and experience to reduce any potential risks to the mother and baby.²⁵¹ In this sort of

²⁴⁴ At 288.

²⁴⁵ Glenys Godlovitch “Ethics” in Rebecca Keenan (ed) *Health Care and the Law* (4th ed, Brookers, Wellington, 2010) 487 at 499.

²⁴⁶ At 499.

²⁴⁷ Health and Disability Commissioner *Case 04HDC05503*, above n 127, at 9.

²⁴⁸ Jones, above n 152, at 103.

²⁴⁹ Anderson and Pelvin, above n 243, at 288.

²⁵⁰ Health and Disability Commissioner *Case 04HDC05503*, above n 127, at 10.

²⁵¹ At 10.

situation, knowledge is power and an expectant mother must be suitably prepared to make decisions in her own best interests and those of her unborn child.

C Homebirthing

Birthing at home is one of the more controversial choices an expectant mother can make with many individuals questioning the safety of birth outside the hospital environment. In May 2000, a baby died after a midwife failed to recognise an abnormal and obstructed labour during a homebirth.²⁵² Although the mother was eventually transferred to hospital for a caesarean section, the baby was unable to be resuscitated at birth.²⁵³ There was also no evidence that the midwife had developed a comprehensive management plan to deal with complications like this should they arise.²⁵⁴

When the woman's second stage became prolonged, the midwife should have recommended that responsibility for her care be transferred to a specialist in accordance with the Referral Guidelines.²⁵⁵ The mother had a right:²⁵⁶

...to be told, without asking, about the progress of her labour, the abnormalities that had been detected, the expected risks, and the options available...in a manner that enabled her to make her own decisions relating to the well-being of herself and her baby.

An independent advisor to the HDC stated that the baby's death was "directly linked to the prolonged obstruction" and likely to be a result of the midwife not acting early enough on the assessments she made.²⁵⁷ The Commissioner concluded that the midwife "took the lack of progress...to its widest limits" and breached rights 4(1), 4(2), 4(5) and 6(1) of the Code.²⁵⁸ At times during the homebirth experience, the midwife failed to provide services with reasonable skill and care; failed to comply with professional standards; failed to promptly transfer the client to hospital care; and failed to provide the mother and her family with adequate information.²⁵⁹

²⁵² Health and Disability Commissioner *Case 00HDC08628* (30 July 2002) at 7.

²⁵³ At 10.

²⁵⁴ At 35.

²⁵⁵ At 35.

²⁵⁶ At 37.

²⁵⁷ At 20.

²⁵⁸ At 34-38.

²⁵⁹ At 34-38.

Similar rights were breached by a midwife in 2003 when she failed to prepare a homebirth care plan in conjunction with the expectant mother.²⁶⁰ As discussed above, it is critical to have a comprehensive care plan for all expectant mothers but advance preparation is particularly important where a birth is arranged away from the hospital environment and prompt obstetric support. The mother and her family should also be provided with accurate information about the woman's ongoing suitability for homebirth and the options available if complications arise.

D Inadequate Antenatal Care

The term 'antenatal care' is used to describe midwifery services offered to expectant mothers prior to labour and birth. At antenatal visits the midwife monitors the well-being of the mother and unborn baby; prepares a care plan in conjunction with the woman; and offers crucial guidance and advice.²⁶¹ In the early stages of pregnancy, it is essential for a midwife to meet with an expectant mother and discuss the different options available to her during her pregnancy, birth and postpartum period. This pre-emptive delivery of information provides the woman with ample opportunity to consider the various alternatives and form a personalised care plan to reflect her wishes.²⁶²

Unfortunately for a small number of New Zealand women, they are provided with substandard antenatal care and are left ill-prepared for the rest of their pregnancy and birth. In 2006, the HDC received a complaint about inadequate antenatal care experienced by a woman who went on to give birth to a stillborn baby.²⁶³ Although the mother wanted a natural approach to pregnancy and birth, she did not intend to forsake conventional forms of assessment or refuse medical intervention if the need arose.²⁶⁴ She claimed that the midwife:²⁶⁵

...actively discouraged them from taking up testing options, failed to keep antenatal appointments, did not conduct adequate antenatal examinations and did not accurately record the details of her antenatal visits.

²⁶⁰ Health and Disability Commissioner *Case 04HDC00460* (10 January 2005) at 10.

²⁶¹ Primary Maternity Services Notice 2007, cl DA19.

²⁶² Health and Disability Commissioner *Case 05HDC18619*, above n 187, at 28-29.

²⁶³ Health and Disability Commissioner *Case 06HDC18721*, above n 206.

²⁶⁴ At 28.

²⁶⁵ At 28.

The investigation ultimately revealed that the midwife had breached rights 4(1), 4(2) and 6(1) of the Code.²⁶⁶ The HDC found that she had provided minimal antenatal care; neglected to offer the usual routine testing; and failed to effectively document her consultations with the mother.²⁶⁷ An independent advisor to the Commissioner emphasised that the legal and professional standards set for midwifery care offer clear guidance on the services required during the antenatal period and the ways in which those services should be provided.²⁶⁸ This statement is particularly true of the Notice, which sets out service specifications for all three trimesters.²⁶⁹

E Poor CTG Monitoring

It is important to monitor the well-being of an unborn baby where the mother's pregnancy is thought to be high risk and complications could potentially arise during labour. For this purpose, a CTG is used to record "changes in the fetal heart rate and their temporal relationship to uterine contractions."²⁷⁰ Despite the widespread use of this technology, the HDC continues to receive complaints about undiagnosed fetal distress and there are significant indications that a number of New Zealand's midwives struggle to use CTG equipment effectively.²⁷¹

In 2009, a baby died after a midwife struggled to operate a CTG machine and was too embarrassed to ask for assistance.²⁷² The HDC held that the midwife had an obligation to act on her concerns and should have acquired help from hospital staff if she was not capable of performing the task on her own.²⁷³ The fear of professional embarrassment should never compromise the safety of a mother or unborn baby.

²⁶⁶ At 2.

²⁶⁷ At 2.

²⁶⁸ At 28.

²⁶⁹ Primary Maternity Services Notice 2007, cls DA19 and DA21.

²⁷⁰ Sally K Tracy "Interventions in Pregnancy, Labour and Birth" in Sally Pairman and others (eds) *Midwifery: Preparation for Practice* (2nd ed, Churchill Livingstone, Chatswood, 2010) 863 at 869-870.

²⁷¹ Health and Disability Commissioner *Case 01HDC05155* (12 February 2003); Health and Disability Commissioner *Case 04HDC04652* (17 January 2006); Health and Disability Commissioner *Case 05HDC17106* (30 April 2007); Health and Disability Commissioner *Case 07HDC15908* (5 December 2008); Health and Disability Commissioner *Case 09HDC01592* (31 January 2012); Health and Disability Commissioner *Case 10HDC00996* (11 January 2013); Health and Disability Commissioner *Case 11HDC00098* (22 March 2013).

²⁷² Health and Disability Commissioner *Case 10HDC00996* (11 January 2013) at 25.

²⁷³ At 25.

The extent to which this particular midwife struggled to monitor the fetal heart rate is very concerning. As discussed in Part IV, the practical component of a midwife's education is extensive with students graduating with at least 2400 hours of hands-on experience.²⁷⁴ Under the midwifery practice requirements set down by the MCNZ, a student's practical work must include the "assessment, monitoring and interpretation of fetal heart patterns using a pinard, ultrasound and cardiotocograph equipment."²⁷⁵

Midwives practise as autonomous health professionals and must be capable of performing all the tasks required of a primary maternity services provider. The HDC has stated that experienced midwives should be able to recognise when CTG results indicate fetal compromise.²⁷⁶ If a midwife fails to recognise vital warning signs like non-reassuring CTG results, they will breach right 4(1) of the Code which requires them to work with reasonable skill and care.²⁷⁷

In 2007, a newborn baby died after a midwife failed to exercise reasonable skill and care when monitoring the fetal heartbeat via a CTG.²⁷⁸ Standard Six requires a midwife to identify "deviations from the normal" and consult and refer as appropriate.²⁷⁹ Unfortunately, this midwife did neither. By overlooking critical signs that the baby was suffering distress, the midwife was unable to deliver crucial information to the obstetric team about the baby's well-being.²⁸⁰

Evidence provided by the mother's maternity records showed that the baby's cord was wrapped around his neck several times.²⁸¹ Although this was essentially an unpredictable event, it may have been resolved without loss of life if the midwife had recognised the heart rate irregularities.²⁸²

In another case involving poor monitoring, a midwife relied on an obstetrician's reassurance that CTG results were within normal range despite the fact that they were "grossly abnormal".²⁸³ The baby passed away at four and a half months from cerebral palsy and ACC

²⁷⁴ Midwifery Council of New Zealand *Standards for Approval of Pre-Registration Midwifery Education Programmes*, above n 69, at 12.

²⁷⁵ At 17.

²⁷⁶ Health and Disability Commissioner *Case 05HDC17106* (30 April 2007) at 23.

²⁷⁷ Health and Disability Commissioner *Case 11HDC00098* (22 March 2013) at 1.

²⁷⁸ Health and Disability Commissioner *Case 07HDC15908*, above n 181, at 15.

²⁷⁹ New Zealand College of Midwives, above n 71, at 20.

²⁸⁰ Health and Disability Commissioner *Case 07HDC15908*, above n 181, at 15.

²⁸¹ At 28.

²⁸² At 28.

²⁸³ Health and Disability Commissioner *Case 01HDC05155* (12 February 2003) at 22.

investigations found that the outcome was “largely due to the inadequate assessment of the foetal status throughout the labour.”²⁸⁴ Where opinions differ on the interpretation of CTG results, a midwife must be able to rely on their own experience and training to identify whether the birth should be expedited.

F Poor Infant Resuscitation

Like the necessary skills for CTG monitoring, basic infant resuscitation techniques such as ventilation and chest compressions²⁸⁵ are included in the midwife’s pre-registration education.²⁸⁶ The effective performance of these techniques can mean the difference between life and death for newborn babies and the MCNZ requires midwives to participate in a two hour refresher course each year.²⁸⁷

Despite this ongoing training, and the inclusion of resuscitation techniques in Competency Two,²⁸⁸ the HDC still receives complaints about poor infant resuscitation. In 2008, the Commissioner investigated the quality of a baby’s care after she sustained a major brain injury thought to be the result of a delay in establishing effective resuscitation.²⁸⁹ An independent expert to the HDC stated that there may have been a different outcome for the child if adequate ventilation had been established before chest compressions began.²⁹⁰ The HDC concluded that the midwife breached right 4(1) of the Code when she failed to exercise reasonable care and skill in her resuscitation attempts on the baby.²⁹¹

Sadly, it may be impossible to save a baby’s life if the child is already ‘flat’ at birth. In these circumstances, the HDC notes the resuscitation attempts on the baby but does not find the midwife in breach of the Code for that portion of care.²⁹²

²⁸⁴ At 28.

²⁸⁵ Health and Disability Commissioner *Case 07HDC08615*, above n 189, at 21-22.

²⁸⁶ Midwifery Council of New Zealand *Standards for Approval of Pre-Registration Midwifery Education Programmes*, above n 69, at 17.

²⁸⁷ Midwifery Council of New Zealand *Recertification Programme: A Summary for Midwives*, above n 92, at 3.

²⁸⁸ New Zealand College of Midwives, above n 71, at 8.

²⁸⁹ Health and Disability Commissioner *Case 07HDC08615*, above n 189, at 4.

²⁹⁰ At 28.

²⁹¹ At 23.

²⁹² Health and Disability Commissioner *Case 05HDC01760*, above n 231, at 45.

G Inexperienced Midwives

Errors made by newly graduated midwives are one of the most heavily publicised aspects of substandard midwifery care. In the past five years, numerous articles have been written on the dangers of inexperienced and unsupervised midwives with campaigners calling for Parliamentary change to education requirements.²⁹³ Attention-grabbing headlines assert that services provided by new midwives are “dangerous”²⁹⁴ with inexperience linked to poor quality care²⁹⁵ and even infant death.²⁹⁶

Although the MCNZ firmly denies such claims,²⁹⁷ there is evidence that some new graduates require additional support during their transition into autonomous practitioners and struggle if this support is not provided. For example, two HDC reports released in June and July this year concluded that the midwives involved, both of whom were new graduates, breached the Code with their poor standard of care.²⁹⁸

In the first report in June, a graduate midwife was found to have breached right 4(1) of the Code after she failed to communicate effectively with the parents; failed to carry out adequate reviews of the mother; failed to maintain comprehensive documentation; and failed to take appropriate action when she suspected something was awry with the fetal heart rate.²⁹⁹ Unfortunately, the baby in this case was born with no audible heartbeat and was unable to be resuscitated.³⁰⁰

The second HDC report released in July involved an equally concerning outcome with a young mother suffering a severely infected perineal laceration which required hospital admission and surgical reconstruction.³⁰¹ The Commissioner concluded that the midwife breached rights 4(1) and 4(2) of the Code on numerous occasions by failing to provide adequate antenatal advice; failing to communicate effectively with the mother and her

²⁹³ Amanda Cameron “Petition Seeks Longer Training For Midwives” *New Zealand Doctor* (online ed, Auckland, 5 August 2010); Natalie Akoorie “Campaigners Seek Maternity Shake-Up” *The New Zealand Herald* (online ed, Auckland, 25 May 2012).

²⁹⁴ Emily Watt “Delivery By New Midwives Dangerous” (17 December 2009) Stuff.co.nz <www.stuff.co.nz>.

²⁹⁵ “Midwife Fails Teen Mother” (3 September 2013) Stuff.co.nz <www.stuff.co.nz>.

²⁹⁶ Martin Johnston and Natalie Akoorie “Babies’ Deaths Reignite Maternity Row” *The New Zealand Herald* (online ed, Auckland, 23 June 2012).

²⁹⁷ Midwifery Council of New Zealand *Annual Report 2012*, above n 113, at 6.

²⁹⁸ Health and Disability Commissioner *Case 11HDC00521* (10 June 2013); Health and Disability Commissioner *Case 12HDC00301* (9 July 2013).

²⁹⁹ Health and Disability Commissioner *Case 11HDC00521* (10 June 2013) at 2.

³⁰⁰ At 2.

³⁰¹ Health and Disability Commissioner *Case 12HDC00301*, above n 190, at 1-2.

supporters; failing to attend the labour; failing to provide adequate breastfeeding support; and failing to adequately assess the perineal tear and provide appropriate treatment.³⁰²

The HDC report indicated considerable concern about the sheer number of departures from expected standards in this case and described the midwife's care as "seriously sub-optimal".³⁰³ The case has been referred to the Director of Proceedings in accordance with section 45(2)(f) of the HDCA.³⁰⁴

H Conflict Between Doctors and Midwives

The troubled relationship which exists between doctors and midwives is one of the weakest aspects of New Zealand's maternity system. Where mothers have high risk or complicated pregnancies, it is essential for primary and secondary service providers to work together but collaboration is extremely difficult where tension levels are high. Similarly, confusion over roles and responsibilities can lead to gaps in the provision of maternity care with each faction believing that the other one has the task in hand.

An obstetric advisor to the HDC has stated that specialist teams at maternity facilities rely on midwives to provide accurate information about a mother and baby's well-being.³⁰⁵ The Referral Guidelines (set out in Part IV) aid this process by indicating when a specialist should be consulted and when care responsibilities need to be transferred. The notion of transferring care however:³⁰⁶

...should not be used to pass responsibility for assessments and clinical action on to another health professional. When care becomes complex and medical decision-making is required, the midwife must still be responsible for her own ongoing clinical assessments and actions.

The referral process appears straightforward but evidence presented to the HDC suggests this is not the case in practice. In 2006, the Commissioner investigated an incident in which a baby suffered septicaemia after his mother's care was affected by tension between doctors and

³⁰² At 2.

³⁰³ At 2.

³⁰⁴ At 2.

³⁰⁵ Health and Disability Commissioner *Case 07HDC15908*, above n 181, at 13.

³⁰⁶ Health and Disability Commissioner *Case 04HDC04652* (17 January 2006) at 28.

midwives.³⁰⁷ Despite the existence of the referral guidelines, the health professionals involved held differing views on the best response to the mother's pre-term labour and disagreed about their respective care responsibilities.³⁰⁸

Both doctors and midwives have the same ultimate goal – to provide the very best care to expectant mothers and their babies.³⁰⁹ Unfortunately:³¹⁰

It seems that obstetricians (who take a risk-averse, interventionist approach) and midwives (who take a less interventionist approach, to allow the normal physiological process of labour to proceed) do not agree on what is reasonable care.

If midwives and doctors cannot work together, continuity of care collapses and mothers and babies are left at risk. In 2008, a baby died shortly after birth when a midwife and doctor clashed over her mother's care.³¹¹ The midwife told the HDC that she lacked the energy to have a series of necessary conversations with the consultant and accepted the doctor's approach despite concerns it was incorrect.³¹² The HDC held that the midwife had a significant duty to advocate her concerns to the doctor and should have contacted the on-call consultant for a second opinion when those concerns were not addressed.³¹³

Unfortunately the midwife was in an unenviable position where existing systems and norms would expect her to heed the advice of the registrar despite the fact she believed it was incorrect.³¹⁴ Avoiding conflict in the workplace is important but not at the expense of safety. Midwives are accountable for their own practice and tiredness or fear of reprimand does not justify inaction when action is required.³¹⁵

In a virtually parallel complaint made in 2007, a bereaved couple expressed how they “blindly assumed that the LMC and hospital staff would work together to ensure the safety of both mother and baby.”³¹⁶ The couple felt that the quality of care deteriorated once they entered the hospital environment because of a lack of adequate policies to facilitate effective communication between the self-employed midwives and District Health Board (DHB)

³⁰⁷ Health and Disability Commissioner *Case 04HDC03530* (14 February 2006) at 25.

³⁰⁸ At 25.

³⁰⁹ Crawford and others, above n 50, at 69.

³¹⁰ Health and Disability Commissioner *Case 07HDC16053* (10 June 2008) at 12.

³¹¹ Health and Disability Commissioner *Case 09HDC01592* (31 January 2012).

³¹² At 12.

³¹³ At 26.

³¹⁴ At 40.

³¹⁵ At 26.

³¹⁶ Health and Disability Commissioner *Case 07HDC15908*, above n 181, at 10.

staff.³¹⁷ An independent midwifery advisor to the HDC echoed the parents' concerns and stated that the lack of communication between the professionals involved contributed to the baby's tragic outcome.³¹⁸ Many women believe that a safety net is in place if they choose to birth in hospital but fraught relationships between doctors and midwives make that belief largely illusory.³¹⁹

Right 4(5) of the Code states that every consumer has the right to co-operation between the health professionals involved in their care. Where doctors and midwives are unable to work together effectively, the quality of care received by the mother and baby is reduced and right 4(5) is breached. Midwives involved in this sort of situation are also likely to be in breach of the Notice;³²⁰ the Midwifery Scope of Practice;³²¹ the Code of Conduct;³²² the Code of Ethics;³²³ Competencies Two and Four;³²⁴ and Standards Six and Seven.³²⁵

I General Conclusions From HDC Reports

“To err is human”³²⁶ and midwives, like other health professionals, are bound to make mistakes from time to time. However, where mistakes accumulate and result in poor quality maternity care, the outcome can be devastating for all involved. The central themes in HDC reports suggest that the midwifery profession is under extreme pressure and some practitioners are cutting corners to cope with the workload. It is also likely that graduates are entering midwifery practice without the required competence to operate autonomously. Where doctors and midwives conflict, practitioners are left even more vulnerable without the support that comes from interprofessional collaboration.

In Part VII, this paper will explore a number of regulatory solutions to the problems identified above. These solutions will need to work in unison to ease the pressure placed on midwives; enhance interprofessional relationships; improve practitioner competence; and increase overall compliance with the Code.

³¹⁷ At 10.

³¹⁸ At 24.

³¹⁹ Health and Disability Commissioner *Case 04HDC05503*, above n 127, at 13.

³²⁰ Primary Maternity Services Notice 2007, cl CB9.

³²¹ New Zealand College of Midwives, above n 71, at 4.

³²² Midwifery Council of New Zealand *Code of Conduct*, above n 80, at 5.

³²³ New Zealand College of Midwives, above n 71, at 12.

³²⁴ At 9 and 11.

³²⁵ At 20-21.

³²⁶ An anonymous Latin saying.

VII Looking Forward - Can Regulation Improve Code Compliance?

As outlined in Part IV, the current system of midwifery regulation in New Zealand appears to be reasonably comprehensive. Nevertheless, in light of the number of concerning HDC reports on substandard midwifery care, the following sections will consider a series of regulatory changes designed to improve compliance with the Code. These amendments fit under the headings: standardised documentation; two person birth teams; strengthened referral guidelines; minimum requirements for antenatal care; compulsory and comprehensive mentorships; improved CTG and resuscitation training; interprofessional education; and relationship enhancement.

A Standardised Documentation

Although there are a number of specific obligations relating to the upkeep of documentation, there is no standardisation of the records themselves and self-employed midwives are known to employ a variety of different antenatal record books³²⁷ including those which only allow for tick boxes and extremely abbreviated notes.³²⁸ Such compact record books are generally unsuitable for midwifery practice because they cannot accommodate the comprehensive documentation required by New Zealand law. For example, it is very difficult to determine whether a woman has made an informed decision about her maternity care when a record of the decision-making process is absent.³²⁹

The Ministry of Health is currently developing a system of electronically transferable maternity notes due to be implemented nationwide by 2014.³³⁰ The concept of online record-keeping was initially introduced as part of the draft *Maternity Action Plan* in 2008³³¹ but the idea was fast-tracked after the Government elected to focus on immediate timeframes and improving what it felt mattered most.³³²

³²⁷ Health and Disability Commissioner *Case 05HDC18619*, above n 187, at 42.

³²⁸ Health and Disability Commissioner *Case 03HDC07983* (19 October 2004) at 14.

³²⁹ At 23.

³³⁰ *Government Response to Report of the Health Committee on Petition 2008/23 of Jennifer Maree Hooper* (January 2011).

³³¹ Ministry of Health *Maternity Action Plan 2008–2012: Draft for Consultation* (2008) at 11.

³³² Tony Ryall “Quality and Safety Push in Maternity Services” (press release, 5 February 2010).

The National Health IT Board Director Graeme Osborne has stated that:³³³

The new system is the first part of implementing a comprehensive maternity and neonatal information programme...It will exchange data with existing community-based maternity systems and general practice management systems.

In line with this change, the Notice should be amended to require uniform completion of online records. For example, wherever there is a reference to documentation, the relevant clause could be updated to include ‘via the online documentation system’. Similar amendments may also need to be made to a number of DHB maternity care policies; the Competencies for Entry to the Register;³³⁴ the Standards of Midwifery Practice,³³⁵ and the Referral Guidelines.³³⁶

The introduction of electronically stored notes is likely to ease the transfer of crucial care information; provide consistency across different maternity providers; and permit access from multiple locations including the woman’s own home. An online system of documentation could also store the date, time and user information for every entry; and facilitate the use of reminders to ensure all aspects of care are covered. While checklists may seem “lowly and simplistic” they help to fill the gaps in our brains.³³⁷ According to Gawande, checklists play a critical role in the quality and productivity of virtually every field of work combining high risk and complexity.³³⁸

In order to protect the midwifery profession, the system of online documentation could include a function to record the circumstances behind any delayed entries or variances from the referral guidelines. There may be a number of valid reasons why midwives deviate from the expected norm and they should be given an opportunity to note down these reasons for later reference.

Similarly, the electronic maternity notes could incorporate a record of informed consent, acting as a readily accessible register of each mother’s wishes; and a reminder to midwives that confirmation of that consent is required before services proceed. As expectant mothers

³³³ “New Information System Will Support Better Quality Maternity Services” (23 April 2013) IT Health Board <www.ithealthboard.health.nz>.

³³⁴ Competencies One and Two - New Zealand College of Midwives, above n 71, at 6-9.

³³⁵ Standards Three, Five and Seven - New Zealand College of Midwives, above n 71, at 16-21.

³³⁶ Ministry of Health *Guidelines for Consultation*, above n 63, at 2-18.

³³⁷ Atul Gawande “Cowboys and Pit Crews” *The New Yorker* (online ed, New York, 26 May 2011).

³³⁸ Gawande, above n 337.

have the right to forego aspects of their maternity care, it is also important to record any treatment refusals including the mother's level of understanding, and her acceptance of risk.³³⁹

Despite all the positive aspects of online documentation, the establishment of electronic record-keeping could introduce a number of complications. For example, a 2013 report from the United Kingdom identified substantial concerns about the security of online medical records.³⁴⁰ The report found that both doctors and patients are apprehensive about electronic documentation with “over half of doctors aware of records being lost in their practice and one in eight members of the public claiming their records have been lost in the past.”³⁴¹ Similar security concerns are likely to be held in New Zealand in light of recent online breaches experienced by ACC, Work and Income, and the Earthquake Commission.³⁴²

Users of electronic documentation may also require substantial guidance and support to effectively operate the system.³⁴³ Midwives could receive group instruction during their pre-registration education but each individual mother would need to be shown how to access and interpret her online records in a safe and appropriate way.³⁴⁴

B Two Person Birth Teams

The Notice currently requires an LMC to ensure that another midwife, GP, or obstetrician is available to attend any birth planned outside a hospital facility.³⁴⁵ The Ministry of Health has stated that to be ‘available’, the second practitioner must be aware of their role as back-up and be available to attend the birth³⁴⁶ but they do not need to be present at the birth location.

³³⁹ National Health and Medical Research Council *National Guidance on Collaborative Maternity Care* (2010) at 3-4.

³⁴⁰ Medical Protection Society *Online Medical Records and the Doctor–Patient Partnership* (April 2013) at 14.

³⁴¹ At 14.

³⁴² Tom Pullar-Strecker “Most Kiwis Concerned About Info Security” (22 May 2013) Stuff.co.nz <www.stuff.co.nz>.

³⁴³ Medical Protection Society, above n 340, at 3.

³⁴⁴ At 3.

³⁴⁵ Primary Maternity Services Notice 2007, cl DA23(2)(a).

³⁴⁶ Health and Disability Commissioner *Case 05HDC01760*, above n 231, at 36.

In the past, “two pairs of hands at every birth” was the golden rule.³⁴⁷ A similar argument can be made for the presence of two service providers at births in the 21st century. Although this change would be an extension of the current regulations, it is unlikely to cause any serious issues because a second professional is already needed on standby. It would also be in line with tikanga Māori by ensuring that mothers are surrounded by support during birth.

At a minimum, homebirth care should be strengthened by amending clause DA23(2)(a) of the Notice to require the actual presence of another midwife, GP, or obstetrician at the birth, rather than just their availability to attend. This change would affect the safety of over 2,000 births a year with approximately 3.2% of New Zealand women choosing to birth at home.³⁴⁸

Research has shown that safety levels similar to those experienced in maternity facilities can be achieved if homebirth care is “planned with a well-screened population of women, within a supportive health care system, and attended by professionally trained midwives carrying emergency equipment.”³⁴⁹ Two health professionals (including one midwife experienced in homebirth care) are currently required to be present at every Western Australian homebirth with policy-makers lauding the benefits of immediate support, consultation, and assistance in emergency situations.³⁵⁰ This approach also echoes the calls of Coroner Ian Smith in his 2010 report on a fatal homebirth. Smith believes that it is not good midwifery practice “to go it alone” and backup midwives should be present at all homebirths.³⁵¹

On the other hand, requiring the presence of a second service provider at every birth would ensure that all mothers and babies receive one-on-one attention regardless of birth location. Attendance by two health professionals could also improve the interpretation of CTG results and the completion of contemporaneous documentation. Not only would there be two pairs of hands at each birth, but also two pairs of eyes.

Upon birth, a mother and baby become distinct individuals with potentially divergent needs. Having two midwives present at each birth would avoid the need to prioritise treatment with both mother and baby receiving the care and support they require during the immediate

³⁴⁷ “Maternity in a Mess” *Otago Daily Times* (Dunedin, 28 June 2002) at 12 as cited in Lynda Exton *The Baby Business: What’s Happened to Maternity Care in New Zealand?* (Craig Potton Publishing, Nelson, 2008) at 108.

³⁴⁸ Ministry of Health *Report on Maternity 2010*, above n 17, at 2 and 12.

³⁴⁹ College of Midwives of Ontario *The Facts About Home Birth in Ontario* (2010).

³⁵⁰ Western Australian Department of Health *Women’s and Newborns’ Health Network: Policy for Publicly Funded Homebirths Including Guidance for Consumers, Health Professionals and Health Services* (February 2012) at 15.

³⁵¹ Helen Murdoch “Coroner Urges Backup Midwives” (3 November 2010) [Stuff.co.nz <www.stuff.co.nz>](http://www.stuff.co.nz).

postnatal period. For example, in 2008, the HDC investigated an incident where a mother and baby required resuscitation at the same time, something impossible for one midwife to achieve. Fortunately for all involved, this particular incident occurred in the hospital environment where other midwives were on hand to assist. If only one midwife had been present, they would have been forced into making an intolerable decision between saving the life of the mother or that of her child.

Even where there is little to no concern about ongoing welfare, it is important to actively monitor the mother and baby for at least one hour following birth.³⁵² After the intensive period of care required during labour and birth, it could be useful for each midwife to have an opportunity to take a break and freshen up whilst their colleague offers any necessary support.

C Strengthened Referral Guidelines

The Referral Guidelines were initially appended to the Section 88 Maternity Services Notice 2002 but have since been separated off as a distinct protocol to be used in conjunction with the current Notice introduced in 2007.³⁵³ Action to Improve Maternity (AIM), a not-for-profit organisation set up to campaign for improved maternity care in New Zealand, has expressed concern that the Referral Guidelines are now merely recommendations and no longer have the required legal effect to attract compliance.³⁵⁴ AIM has compared the current Guidelines to those relating to Animal Welfare and argues that they too should encompass minimum standards elevated to the status of a code.³⁵⁵

Advocates of non-prescriptive guidelines, on the other hand, praise the ability to provide care on an individualised basis. As discussed in Part VI, there are many different views on what qualifies as a benefit or harm, and applying a set list of rules to a diverse range of circumstances is likely to result in inappropriate care for some mothers. According to Banks, “guidelines are for the consideration of the wise and the adherence of fools”³⁵⁶ with the depth

³⁵² Ministry of Health *Observation of Mother and Baby in the Immediate Postnatal Period: Consensus Statements Guiding Practice* (July 2012) at 1.

³⁵³ Ministry of Health *Guidelines for Consultation*, above n 63, at i.

³⁵⁴ Action to Improve Maternity *Submission to the Ministry of Health on the Discussion Document: Proposed Amendments to the Maternity Referral Guidelines and Processes for the Transfer of Care* (25 March 2011).

³⁵⁵ Action to Improve Maternity *Submission to the Ministry of Health on the Discussion Document*, above n 354.

³⁵⁶ Maggie Banks “But Whose Art Frames the Questions?” (2001) 4 *The Practising Midwife* 34 at 35.

and breadth of childbirth experience making the definition of normality not only problematic, but near impossible.³⁵⁷

In order to balance these two approaches, the Referral Guidelines could be preserved in their current form but reattached to the Notice to indicate a heightened legal status. The Notice could also be amended to indicate disciplinary procedures followed when midwives unjustifiably deviate from the recommendations made. A similar effect could be achieved by incorporating the Guidelines into the HPCAA. For example, section 118 setting out the functions of authorities like the MCNZ could require referral guideline creation in line with current healthcare practice.

D Minimum Requirements for Antenatal Care

At present, the Notice sets out minimum standards for postnatal care but does not specify the same for antenatal services. As discussed in Part VI, substandard antenatal care can leave expectant mothers ill-informed at a time when critical decisions must be made about the rest of their pregnancy and birth. To ensure that every woman receives sufficient guidance and support, the Notice should be amended to require a minimum number of antenatal visits. The contents of clause DA29(1)(b)(iii) could be replicated under DA19 and DA21 to indicate the minimum number of antenatal visits required during the first, second and third trimesters. An independent midwifery advisor to the HDC has stated that the accepted standard for antenatal care is 11 visits between 14 weeks gestation and birth – “monthly till 28-30 weeks, 2 weekly till 36 weeks and weekly till the birth.”³⁵⁸

E Compulsory and Comprehensive Mentorships

Newly graduated midwives are currently expected (but not required) to participate in the MFYPP “where they receive further education to consolidate their knowledge...and have an identified mentor midwife who supports them into practice.”³⁵⁹ Despite its potential to improve graduate performance, the MFYPP has been criticised for its limited scope. Under

³⁵⁷ At 35.

³⁵⁸ Health and Disability Commissioner *Case 04HDC00460*, above n 260, at 9.

³⁵⁹ Ministry of Health *Submission to the Health Select Committee from the Ministry of Health on the Submission from Jennifer Maree Hooper*, above n 134, at 6.

the current arrangement, “the mentor is not expected to attend births...nor physically supervise the practice of the graduate midwife”³⁶⁰ and MP Barbara Stewart claims that participants receive only 32 hours of contact time over an entire calendar year.³⁶¹

The inadequacy of such minimal supervision has been identified as a national issue by the Ministry of Health with a report on maternity services in the Wellington area stating that new midwives are:³⁶²

...authorised to assist birthing women without any oversight. While for normal births this may be safe, it may not be safe for the birthing woman, her baby or the new graduate midwife if the latter, through inexperience, does not recognise and appropriately manage or refer a complication of pregnancy or delivery.

Gaskin questions whether we would treat new pilots in the same way, throwing them into an extremely stressful situation where lives are at risk and expect them to perform effectively.³⁶³ Like their counterparts in the airline industry, a graduate midwife deserves to be supported in a hands-on way, not made to fly solo from the moment of qualification.

An effective mentorship programme should address two central questions:³⁶⁴

Firstly, are new graduates competent in their clinical knowledge and skills at the point of registration and secondly, are they confident enough in their knowledge and skills to practice autonomously in new models of care?

Managing a full caseload of expectant mothers can be extremely challenging for a skilled midwife and graduates transitioning into this line of work are likely to find the experience even more stressful and all-consuming. A 2006 study found that New Zealand midwives moving into self-employed practice wanted help to establish confidence despite being competent to practise.³⁶⁵ The graduates felt their vulnerability was accentuated by the “demanding and unpredictable nature of midwifery practice” and occasionally “unsupportive” hospital environments in which they worked.³⁶⁶

³⁶⁰ Health and Disability Commissioner *Case 08HDC10923* (11 September 2009) at 13.

³⁶¹ (28 August 2012) 683 NZPD 4772.

³⁶² Crawford and others, above 50, at 48.

³⁶³ Gaskin, above n 16, at 110-111.

³⁶⁴ Deborah Davis and others “The Self Reported Confidence of Newly Graduated Midwives Before and After Their First Year of Practice in Sydney, Australia” (2012) 25 *Women and Birth* e1 at e3.

³⁶⁵ Mary Kensington “The Faces of Mentoring in New Zealand: Realities for the New Graduate Midwife” (2006) 35 *New Zealand College of Midwives Journal* 22 at 22.

³⁶⁶ At 26.

The MCNZ has stated that it will endorse any state-funded initiatives to strengthen the support given to newly graduated midwives including making the MFYPP obligatory.³⁶⁷ If the programme was turned into a compulsory mentorship, all graduates could be guided into autonomous practice and supported during the more challenging aspects of their role like comprehensive documentation; infant resuscitation; and CTG interpretation.

The ability of midwives to transition smoothly into autonomous practice could also have a positive effect on the midwifery profession; and New Zealand's maternity system as a whole.³⁶⁸ At present, there is a critical shortage of midwives both domestically³⁶⁹ and internationally,³⁷⁰ and it is essential that practitioners are retained within the industry. A recent Australian study of newly graduated nurses and midwives found that effective transition programmes have significant effects on the retention of staff.³⁷¹ The retention of midwifery practitioners will become even more important in New Zealand if this paper's proposal of two midwives at every birth is accepted.

The implementation of a compulsory mentorship could be largely based on the existing MFYPP with increased supervision and comprehensive support throughout the entire year. The Recertification Programme, established in accordance with the HPCAA, already requires a new graduate to attend a technical skills workshop and MSR at the end of their first year of practice. These requirements could be broadened to include participation in the MFYPP with the graduate's recertification reliant on the programme's completion.

F Improved CTG and Resuscitation Training

Despite their inclusion in pre-registration education and the Recertification Programme, CTG monitoring and infant resuscitation remain areas of midwifery practice in need of further attention.³⁷² Although the use of CTG monitoring is contraindicated for women with uncomplicated pregnancies,³⁷³ the technology is vitally important for assessing the well-being of unborn babies where pregnancies are high-risk.

³⁶⁷ Midwifery Council of New Zealand *Annual Report 2012*, above n 113, at 6.

³⁶⁸ Davis and others, above n 364, at e2.

³⁶⁹ Crawford and others, above n 50, at 42.

³⁷⁰ Davis and others, above n 364, at e2.

³⁷¹ At e2.

³⁷² Health and Disability Commissioner *Case 11HDC00098*, above n 277, at 25.

³⁷³ At 26.

Similarly, advanced resuscitation techniques will be vitally important where basic training proves to be inadequate but practitioners will only possess these potentially life-saving skills where they attend additional training at their own volition.³⁷⁴ An independent advisor to the HDC has stated that the scope of midwifery practice in New Zealand is based around ‘normal’ births and maintaining advanced resuscitation skills can be a challenge for many practitioners.³⁷⁵ Failed attempts at intubation are also likely to lead to further problems for the asphyxiated baby.³⁷⁶

However, where midwives attend births at private homes or rural maternity facilities, the ability to perform advanced resuscitation could be critical to the well-being of a mother and baby. For example, 149 New Zealand babies experienced serious brain injuries at birth during the 2010-2011 period and inadequate resuscitation was listed as the cause for 15% of these cases.³⁷⁷

Even in larger hospitals, where support staff are likely to be available to take over resuscitation, experience in intubation could mean the difference between life and death. Any delay in establishing an airway can result in serious injury to the patient with brain damage occurring after only five minutes of oxygen deprivation.³⁷⁸ The PMMRC supports this approach and has recommended that the midwifery profession continually enhances the standard of resuscitation provided by its practitioners.³⁷⁹

In order to ensure that both CTG monitoring and resuscitation techniques are improved, the MCNZ could increase the amount of time spent learning and refining these skills by amending the pre-registration and recertification requirements issued in accordance with sections 12 and 41 of the HPCAA. An extension to these programmes would require additional state-funding but it is likely to be money well spent. ACC has recently stated that life-long care for a brain-injured child will cost the New Zealand Government approximately \$34 million³⁸⁰ while the effect on families who suffer maternal or perinatal loss is incalculable.

³⁷⁴ Health and Disability Commissioner *Case 07HDC08615*, above n 189, at 22.

³⁷⁵ At 35.

³⁷⁶ At 35.

³⁷⁷ Action to Improve Maternity “Births No Safer for Kiwi Mothers and Babies” (press release, 13 June 2013).

³⁷⁸ “What is Cerebral Hypoxia?” National Institute of Neurological Disorders and Stroke <www.ninds.nih.gov>.

³⁷⁹ Perinatal and Maternal Mortality Review Committee, above n 178, at 6.

³⁸⁰ Action to Improve Maternity “Births No Safer for Kiwi Mothers and Babies”, above n 377.

G Interprofessional Education

The maternity system in the Netherlands is very similar to the one found in New Zealand with women receiving primary care from a midwife or GP unless complications arise during their pregnancy or birth.³⁸¹ The education received by future obstetricians and gynaecologists, however, is substantially different with trainee practitioners exposed to midwifery-led “normal births” before moving on to study pathology.³⁸² This interaction fosters collaboration between the two professions and allows trainees to see just how well the natural process works when left undisturbed.³⁸³

The Dutch approach is likely to be supported in New Zealand in light of the Ministry of Health’s recommendations that obstetric-registrars spend a portion of their training with self-employed midwives.³⁸⁴ If doctors are able to develop an understanding of the context in which midwives work, they are likely to provide greater support when things go awry.³⁸⁵

As Hall points out, communication skills taught to students are usually focused on interactions with patients and families rather than between professions.³⁸⁶ In order:³⁸⁷

To develop collaborative skills that can bring down the walls of the professional silos, health professional students need opportunities to spend time together, to learn and to work together in meaningful ways.

Content-related issues are likely to include how best to ensure individuals develop an understanding of other roles within the maternity system without learning to do each other’s jobs.³⁸⁸ Despite the comprehensive interprofessional education required of Dutch doctors and midwives, the factions continue to recognise their unique roles in the childbirth process and maintain a strong sense of professional identity.³⁸⁹

In order to implement such a change in New Zealand, the NZCOM and Royal Australian and New Zealand College of Obstetricians and Gynaecologists would need to work closely

³⁸¹ Raymond De Vries *A Pleasing Birth: Midwives and Maternity Care in the Netherlands* (Temple University Press, Philadelphia, 2004) at 53.

³⁸² Gaskin, above n 16, at 72.

³⁸³ At 72.

³⁸⁴ Crawford and others, above n 50, at 50.

³⁸⁵ At 50.

³⁸⁶ Pippa Hall “Interprofessional Teamwork: Professional Cultures as Barriers” (2005) 19 *Journal of Interprofessional Care* 188 at 193.

³⁸⁷ At 193.

³⁸⁸ Jennifer Weller and others “Are Doctors Team Players, And Do They Need To Be?” (2010) 123 *NZMJ* 109 at 114.

³⁸⁹ De Vries, above n 381, at 50-51.

together to develop a top-down approach to collaboration that can filter through to their respective members. In the past, these professional organisations have “focused on the provision of excellent maternity care in isolation from each other”³⁹⁰ with collaboration and teamwork pushed aside by “entrenched attitudes about scopes of practice, professional turf and historical power structures.”³⁹¹ Turf wars are not unknown in other areas of healthcare but the depth of feelings involved in maternity care undoubtedly reflects the emotional and social significance of the birth experience itself.³⁹²

The main virtue of collaboration is a focus shift from professional interests to those of the consumer.³⁹³ It is important to remember that maternity care is not actually about health professionals although they may be a critical component.³⁹⁴ The central figures in this equation are expectant mothers and babies because they are ones who suffer if doctors and midwives fail to collaborate over care.³⁹⁵ The future of maternity services in New Zealand relies on health professionals “retooling” how they practise to make sure that the provision of care reaches the highest standard possible.³⁹⁶

Although all sectors within the maternity system must be ready for change, the midwifery profession can lead the way by strengthening the collaboration aspects within the Midwifery Scope of Practice; the Code of Conduct; the Code of Ethics; the Competencies for Entry to the Register; and the Standards of Midwifery Practice. For example, the Scope of Practice already requires collaboration between health professionals where referral occurs and this obligation could be extended to incorporate interprofessional education. The section on educational responsibilities is currently limited to women, their families and the community but could be amended to include other factions within New Zealand’s maternity system.

³⁹⁰ Crawford and others, above n 50, at 9.

³⁹¹ Eileen McKinlay, Ben Gray and Sue Pullon “Interdisciplinary Collaboration: Working in Teams for Patient Care” in Ian St George (ed) *Cole’s Medical Practice in New Zealand* (12th ed, Medical Council of New Zealand, Wellington, 2013) 142 at 146.

³⁹² Kerreen Reiger “Domination or Mutual Recognition? Professional Subjectivity in Midwifery and Obstetrics” (2008) 6 *Social Theory and Health* 132 at 133.

³⁹³ Karen Lane “The Plasticity of Professional Boundaries: A Case Study of Collaborative Care in Maternity Services” (2006) 15 *Health Sociology Review* 341 at 348.

³⁹⁴ Riri Ellis *He Rato Tapuhi: Maternity Services for Maori Women* (Waikato Print, Hamilton, 1998) at 76.

³⁹⁵ At 77.

³⁹⁶ CA Orchard, V Curran and S Kabene “Creating a Culture for Interdisciplinary Collaborative Professional Practice” (2005) 10 *Medical Education Online* 1 at 1.

H Relationship Enhancement

The introduction of interprofessional education is likely to reduce some of the conflict between doctors and midwives but relationship quality could be further advanced by the establishment of enhancement programmes at each DHB. Through an approach implemented at Waitakere Hospital since 2001, interprofessional relationships within the maternity department have significantly improved and an atmosphere of friendly collaboration has replaced the hostility.³⁹⁷ At one workshop, “participants role played labour room crises, slowing down time to allow exploration of interactions, behaviours, beliefs, and difficulties in communication.”³⁹⁸

Mothers and babies benefited from these changes too. Waitakere’s neonatal apgar scores became some of the best in Australasia and patient complaints reduced by more than 75%.³⁹⁹ The changes at Waitakere initially came out of crisis but resulted in an unexpected level of success and all for the modest sum of \$2000.⁴⁰⁰

Programmes such as that implemented at Waitakere demonstrate that “collaborative teams do not happen by chance.”⁴⁰¹ They require skilful leadership; a readiness and commitment to change; interdisciplinary respect; and an opportunity to develop trust between individuals within the team.⁴⁰² Creating an effective team is also an active process.⁴⁰³ The Ministry of Health has indicated that it would like DHBs to organise multi-disciplinary forums to facilitate ongoing information sharing between maternity providers within the hospital environment.⁴⁰⁴

Similar benefits could also be achieved by the introduction of a midwifery liaison officer in all DHBs. The liaison officer could work to facilitate the development of collaborative relationships between doctors and midwives and has “the potential to significantly increase the safety, quality and continuity of maternity care.”⁴⁰⁵

³⁹⁷ R Youngson, T Wimbrow and T Stacey “A Crisis in Maternity Services: The Courage to Be Wrong” (2003) 12 *Quality Safe Health Care* 398 at 399.

³⁹⁸ At 398-399.

³⁹⁹ At 399-400.

⁴⁰⁰ Leah Haines “Another Unfortunate Experiment?” *New Zealand Listener* (online ed, Auckland, 31 January 2009).

⁴⁰¹ McKinlay, Gray and Pullon, above n 391, at 145.

⁴⁰² At 145.

⁴⁰³ Weller and others, above n 388, at 112-113.

⁴⁰⁴ Ministry of Health *Maternity Action Plan 2008–2012*, above n 331, at 25.

⁴⁰⁵ Crawford and others, above n 50, at 69.

Although changes to individual DHB policies are beyond the scope of this paper, the midwifery profession could again lead the way by amending their own practice. For example, the Recertification Programme could require annual participation in a relationship enhancement programme with other health professionals from the midwife's local DHB.

Similarly, the New Zealand Government could amend the Notice to require compulsory participation in these enhancement programmes by inserting a clause akin to CB11 which currently requires midwife participation in professional reviews. The involvement of a liaison officer could also be incorporated by amending CB9 to promote communication between LMCs and those employed to facilitate collaborative relationships. At present, clause CB9 requires maternity providers "to co-operate with others in order to promote safe and effective primary maternity services" and the inclusion of the liaison role would be fairly straightforward.

VIII Conclusion

Birth is an important stage in the life process yet competing factions within the health profession struggle to agree on the best way to deliver maternity services. Despite this long-standing tension, the midwifery-led model has dominated New Zealand's maternity system for more than two decades with the majority of women enjoying a safe and positive birth experience and expressing satisfaction with the care provided.

The midwifery-led model is particularly appropriate for New Zealand women as it provides a number of significant benefits; enjoys consumer support; and echoes the tikanga Māori approach to childbirth. The New Zealand Government has specific obligations to Māori mothers and babies under the Treaty of Waitangi and must consider how best to meet their needs within the healthcare system.

Although New Zealand's current regulatory framework for midwifery practice appears fundamentally sound, the life-long effect on those who undergo substandard care warrants considerable attention. In recent times, the midwifery profession has found itself under fire in the media and HDC reports on poor quality healthcare suggest that some public concern is justified.

This paper proposes that midwifery practice in New Zealand could be greatly enhanced by the introduction of standardised online documentation; compulsory mentorships; two person birth teams; strengthened referral guidelines; minimum antenatal requirements; comprehensive CTG and resuscitation training; and extensive interprofessional education and relationship enhancement programmes.

Such amendments could work in unison to address substandard documentation; training deficiencies; long-standing conflict between doctors and midwives; inadequate information provision and consent; and poor antenatal and homebirth care. By implementing these changes, the New Zealand Government could safeguard valuable midwifery-based principles whilst still ensuring that high quality maternity care is provided to all of the country's mothers and babies.

Word Count: the text of this paper (excluding title page, abstract, table of contents, appendices, bibliography and footnotes) comprises **14,990** words.

IX Appendix 1 – Abbreviations

ACC – Accident Compensation Corporation

AIM – Action to Improve Maternity

CPR - Cardiopulmonary Resuscitation

CTG – Cardiotocograph

DHB – District Health Board

GP – General Practitioner

HDC – Health and Disability Commissioner

HDCA - Health and Disability Commissioner Act 1994

HPCAA - Health Practitioners Competence Assurance Act 2003

HPDT - Health Practitioners Disciplinary Tribunal

LMC – Lead Maternity Carer

MCNZ – Midwifery Council of New Zealand

MFYPP - Midwifery First Year of Practice Programme

MSR - Midwifery Standards Review

NZBORA - New Zealand Bill of Rights Act 1990

NZCOM – New Zealand College of Midwives

PMMRC - Perinatal and Maternity Morality Review Committee

UDHR – Universal Declaration of Human Rights

WHO – World Health Organisation

*X Appendix 2 – Midwifery Scope of Practice*⁴⁰⁶

The midwife works in partnership with women, on her own professional responsibility, to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn.

The midwife understands, promotes and facilitates the physiological processes of pregnancy and childbirth, identifies complications that may arise in mother and baby, accesses appropriate medical assistance, and implements emergency measures as necessary. When women require referral midwives provide midwifery care in collaboration with other health professionals.

Midwives have an important role in health and wellness promotion and education for the woman, her family and the community. Midwifery practice involves informing and preparing the woman and her family for pregnancy, birth, breastfeeding and parenthood and includes certain aspects of women's health, family planning and infant well-being.

The midwife may practise in any setting, including the home, the community, hospitals, or in any other maternity service. In all settings, the midwife remains responsible and accountable for the care she provides.

⁴⁰⁶ New Zealand College of Midwives, above n 71, at 4.

*XI Appendix 3 – Code of Conduct*⁴⁰⁷

1 Professional relationships

Through their conduct, Midwives ensure that:

- 1.1 Personal information is obtained and used in a professional way that ensures privacy and confidentiality for clients
- 1.2 Professional relationships are maintained at all times
- 1.3 Their personal beliefs should not affect the advice or options that are provided to women
- 1.4 They practise in a way that respects difference and is non-discriminatory
- 1.5 They end their professional relationship with women at the appropriate time as communicated with each woman and in a professional manner
- 1.6 They provide impartial, honest and accurate information in relation to midwifery care and health care products

2 Inter-professional relationships

Through their conduct, Midwives ensure that:

- 2.1 Due process is followed when a woman or baby's care is being referred or transferred
- 2.2 They interact with their colleagues in a fair and respectful manner
- 2.3 When there is an emergency, they provide appropriate care to women. When a midwife calls for help, all midwives have a duty and obligation to attend and assist as able

⁴⁰⁷ Midwifery Council of New Zealand *Code of Conduct*, above n 80, at 3-6.

3 Professional behaviour

Through their conduct, Midwives ensure that:

3.1 They act in a way that does not bring the midwifery profession into disrepute

3.2 They are fit and able to carry out the practice of midwifery

3.3 Social networking sites are to be used with caution to avoid inappropriate professional and clinical-related discussion

3.4 They recognise their professional position and do not give or accept gifts or benefits that could be viewed as a means of securing their interest

3.5 They claim benefits or remuneration only as and when appropriate for midwifery services that are provided

3.6 They do not use drugs and alcohol in such a way that it impairs their clinical judgment

3.7 If they are using medication to manage a health condition, they have a responsibility to ensure this has no adverse effect on the care they provide. They adhere to the specified regime and through their actions, do not place women and their babies at risk

3.8 They act without delay if they believe a health professional may be putting a woman or baby at risk

3.9 They ensure that their workloads or client numbers are not so large as to compromise the quality of care

*XII Appendix 4 – Turanga Kaupapa*⁴⁰⁸

Whakapapa - The wāhine and her whānau is acknowledged

Karakia - The wāhine and her whānau may use karakia

Whanaungatanga - The wāhine and her whānau may involve others in her birthing programme

Te Reo Māori - The wāhine and her whānau may speak te reo Māori

Mana - The dignity of the wāhine, her whānau, the midwife and others involved is maintained

Hau Ora - The physical, spiritual, emotional and mental well-being of the wāhine and her whānau is promoted and maintained

Tikanga Whenua - Maintains the continuous relationship to land life and nourishment; and the knowledge and support of kaumātua and whānau is available

Te Whare Tangata - The wāhine is acknowledged, protected, nurtured and respected as Te Whare Tangata

Mokopuna - The mokopuna is unique, cared for and inherits the future, a healthy environment, wai ū and whānau

Manaakitanga - The midwife is a key person with a clear role and shares with the wāhine and her whānau the goal of a safe, healthy, birthing outcome

⁴⁰⁸ Midwifery Council of New Zealand *Statement on Cultural Competence for Midwives*, above n 89.

*XIII Appendix 5 – Code of Ethics*⁴⁰⁹

Responsibilities to the woman

- Midwives work in partnership with the woman
- Midwives accept the right of each woman to control her pregnancy and birthing experience
- Midwives accept that the woman is responsible for decisions that affect herself, her baby and her family/whānau
- Midwives uphold each woman's right to free, informed choice and consent throughout her childbirth experience
- Midwives respond to the social, psychological, physical, emotional, spiritual and cultural needs of women seeking midwifery care, whatever their circumstances, and facilitate opportunities for their expression
- Midwives respect the importance of others in the woman's life
- Midwives hold information in confidence in order to protect the woman's right to privacy. Confidential information should be shared with others only with the informed consent of the woman, unless otherwise permitted or required by law
- Midwives are accountable to women for their midwifery practice
- Midwives have a responsibility not to interfere with the normal process of pregnancy and childbirth
- Midwives have a responsibility to ensure that no action or omission on their part places the woman at risk
- Midwives have a professional responsibility to refer to others when they have reached the limit of their expertise
- Midwives have a responsibility to be true to their own value system and professional judgements. However, midwives' personal beliefs should not deprive any woman of essential health care

⁴⁰⁹ New Zealand College of Midwives, above n 71, at 12-13.

Responsibilities to the wider community

- Midwives recognise Māori as tangata whenua of Aotearoa and honour the principles of partnership, protection and participation as an affirmation of the Treaty of Waitangi
- Midwives encourage public participation in the shaping of social policies and institutions
- Midwives advocate policies and legislation that promote social justice, improved social conditions and a fairer sharing of the community's resources
- Midwives acknowledge the role and expertise of community groups in providing care and support for childbearing women
- Midwives act as effective role models in health promotion for women, families and other health professionals

Responsibilities to colleagues and the profession

- Midwives support and sustain each other in their professional roles and actively nurture their own and others' sense of self-worth
- Midwives actively seek personal, intellectual and professional growth throughout their career, integrating this into their practice
- Midwives are responsible for sharing their midwifery knowledge with others
- Midwives are autonomous practitioners regardless of the setting and are accountable to the woman and the midwifery profession for their midwifery practice
- Midwives have a responsibility to uphold their professional standards and avoid compromise just for reasons of personal or institutional expedience
- Midwives acknowledge the role and expertise of other health professionals providing care and support for childbearing women
- Midwives take appropriate action if an act by colleagues infringes accepted standards of care
- Midwives ensure that the advancement of midwifery knowledge is based on activities that protect the rights of women
- Midwives develop and share midwifery knowledge through a variety of processes such as midwifery standards review and research
- Midwives participate in education of midwifery students and other midwives

- Midwives adhere to professional rather than commercial standards in making known the availability of their services

*XIV Appendix 6 – Code of Health and Disability Services Consumers’ Rights*⁴¹⁰

Right 1 - Right to be treated with respect

- (1) Every consumer has the right to be treated with respect.
- (2) Every consumer has the right to have his or her privacy respected.
- (3) Every consumer has the right to be provided with services that take into account the needs, values, and beliefs of different cultural, religious, social, and ethnic groups, including the needs, values, and beliefs of Māori.

Right 2 - Right to freedom from discrimination, coercion, harassment, and exploitation

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial, or other exploitation.

Right 3 - Right to dignity and independence

Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.

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.
- (3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

⁴¹⁰ Health and Disability Commissioner (Code of Health and Disability Services Consumers’ Rights) Regulations 1996, sch, cl 2.

(4) Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.

(5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

Right 5 - Right to effective communication

(1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.

(2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

Right 6 - Right to be fully informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive...

(2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

(3) Every consumer has the right to honest and accurate answers to questions relating to services.

...

Right 7 - Right to make an informed choice and give informed consent

(1) 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.

(2) Every consumer must be presumed competent to make an informed choice and give informed consent, unless there are reasonable grounds for believing that the consumer is not competent.

...

(7) Every consumer has the right to refuse services and to withdraw consent to services.

...

Right 8 - Right to support

Every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer's rights may be unreasonably infringed.

Right 9 - Rights in respect of teaching or research

The rights in this Code extend to those occasions when a consumer is participating in, or it is proposed that a consumer participate in, teaching or research.

Right 10 - Right to complain

(1) Every consumer has the right to complain about a provider in any form appropriate to the consumer.

...

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