

Should Midwives be Held to a Different Standard of Care, Given New Zealand's Unique Autonomous Midwife-led Framework?

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Under New Zealand's maternity framework, a Lead Maternity Carer (LMC) is responsible for a woman's maternity care. The LMC is typically a midwife. This autonomous midwife-led model is shared only with the Netherlands — in other countries, maternity care tends to be medical-led. But recent events have cast doubts upon the quality and safety of midwife-led care. This article examines whether the standard of care expected of New Zealand midwives is appropriate, given our unique framework. New Zealand's maternity framework intended to enable women to choose between a midwife and a general practitioner with an obstetric certification (GPO) as their LMC. However, the funding structure has caused nearly all GPOs to leave maternity services. Thus, women are effectively forced to choose a midwife and are deprived of a GPO's higher standard of care. This contradicts the philosophy behind imposing different standards of care on different healthcare professionals, which assumes that women have a choice in provider. It is also unfair to women, who would expect the same standards of care from health practitioners that do the same job. This article examines various solutions to this choice contradiction. It concludes that either choice should be reintroduced into the maternity framework, or the standard of midwives should be raised.

I INTRODUCTION

Midwives care for the majority of pregnant women in New Zealand, from the beginning of pregnancy to a few weeks after birth. Where risk factors or complications arise, the midwife may refer the woman to a specialist, such as a general practitioner (GP) or an obstetrician. But for uncomplicated births, the midwife may be the only healthcare provider a pregnant woman encounters. This autonomous midwife-led maternity care model is shared

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only with the Netherlands — in most other countries, maternity care is medical-led.¹

New Zealand has not always followed this model. Just three decades ago, GPs typically led maternity care. The transition from a GP-led to a midwife-led framework was controversial, with friction between the two professions often hindering their cooperation.² Eventually, changes to the maternity framework caused GPs to exit maternity care.³ Midwives are now the primary maternity carers in New Zealand.⁴

However, controversy surrounding the quality of midwife-led care continues. A study published in 2016 found that midwife-led pregnancies had higher odds of adverse outcomes than medical-led pregnancies.⁵ Two recent cases of neonatal deaths (one involving maternal death) received widespread public attention.⁶ The LMC in each case was a recently-graduated midwife. On the other hand, the media has been criticised for gratuitous *midwife-bashing*.⁷ New Zealand's maternal and perinatal mortality rates are very low,⁸ and maternity outcomes are comparable with other developed countries with predominantly medical-led models.⁹ Midwives are also underpaid, earning “60 per cent less than male-dominated professions” that have similar levels of qualifications, responsibility and hours.¹⁰ In 2015, the New Zealand College of Midwives (NZCOM) filed a discrimination claim against the government.¹¹ Although the parties have recently settled, discussions are underway for a new funding model.¹²

This article examines what midwives' responsibilities *should* be — that is, whether their professional standard of care is appropriate. In New

- 1 Ellie Wernham and others “A Comparison of Midwife-Led and Medical-Led Models of Care and Their Relationship to Adverse Fetal and Neonatal Outcomes: A Retrospective Cohort Study in New Zealand” (27 September 2016) 13(9) PLOS Medicine 1 <www.journals.plos.org> at 3; and Tim Rowland, Deborah McLeod and Natalie Froese-Burns *Report: Comparative study of maternity systems* (Ministry of Health, 19 November 2012) at 63.
- 2 See, for example, Barbara Fountain “A maternity service recovers from crisis” *New Zealand Doctor* (online ed, Auckland, 24 September 2003).
- 3 Rowland, McLeod and Froese-Burns, above n 1, at 14.
- 4 At 14.
- 5 Wernham and others, above n 1, at 2.
- 6 See “Coroner: Better midwife training, supervision needed” *Newshub* (online ed, New Zealand, 30 January 2015); and Mike Mather “Waikato Hospital, midwife criticised over baby's death” *Waikato Times* (online ed, Hamilton, 5 February 2014).
- 7 See, for example, Emily Writes “‘Does everybody poo during labour?’: Emily Writes asks a midwife every embarrassing question you've ever wanted answered” *The Spinoff* (online ed, New Zealand, 16 February 2017).
- 8 9.7 perinatal deaths per thousand births in 2015; and 0.156 maternal deaths per thousand births between 2013 and 2015. See *Eleventh Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting Mortality 2015* (Health Quality and Safety Commission, June 2017) [PMMRC Mortality Report] at 2 and 12.
- 9 PMMRC Mortality Report, above n 8, at 45 and 122.
- 10 Deidre Mussen and Nicole Mathewson “Midwives drop bombshell with court action over pay discrimination” *Sunday Star Times* (online ed, New Zealand, 30 August 2015) as cited in Deborah Russell “Midwives and pay equity: actually, it *is* sexism” (31 August 2015) Left Side Story <www.deborahfrussell.net>.
- 11 New Zealand College of Midwives [NZCOM] “Historic Bill of Rights Case to be filed in the High Court Today” (press release, 31 August 2015); and NZCOM “The Claim” (press release, 31 August 2015).
- 12 NZCOM “Mediation Report to College Members” (25 May 2017) at 2.

Zealand, midwives carry out a similar role to GP LMCs, yet the standard of care expected from them for diagnosis and treatment is lower. In light of this, should that standard be raised? I discuss three solutions: change the policy; change the law; or change the education. I focus on midwives acting as autonomous LMCs rather than, for example, hospital midwives who work under obstetrician supervision. I consider the standard of care in relation to diagnoses and treatment, rather than in terms of the quality of information provided to patients.¹³

Part II examines New Zealand's maternity care framework and the evolution into its current form. I assess the objectives behind the reforms and whether they were met. Part III discusses the standard of care and its application to midwives. I conclude that the lack of choice offered by the framework is inconsistent with the philosophy underpinning professional standards of care, which assumes that women have a choice in healthcare provider. Finally, in Part IV I discuss options to fix or mitigate this inconsistency, by either reintroducing choice into the framework or adjusting the standard of care for midwives.

II NEW ZEALAND'S MATERNITY FRAMEWORK

New Zealand provides fully publicly-funded maternity care.¹⁴ Near the beginning of her pregnancy, a woman chooses an LMC to provide her maternity care.¹⁵ This includes monitoring her pregnancy; helping her to decide on her delivery method and location; and, more often than not, attending the birth.¹⁶ After birth, the LMC visits the mother to support in caring for the baby.¹⁷ The LMC is responsible for detecting risk factors, abnormalities and complications throughout and after pregnancy.¹⁸ The LMC is also responsible for referring the expectant mother to a specialist, if necessary.¹⁹ This specialist is usually an obstetrician.

The LMC can be a midwife, a GP with an obstetric certification (GPO) or an obstetrician.²⁰ For most women, only a midwife and GP are publicly funded.²¹ Women may only have an obstetrician LMC if they pay

13 The latter relates to informed consent, for which standards are more likely uniform between midwives and doctors. See *B v The Medical Council of New Zealand* HC Auckland HC11/96, 8 July 1996 at 16–17. Elias J distinguished diagnosis or treatment from information and communication adequacy. See also Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996 [Code of Patient Rights], right 6. This right requires the perspective of a "reasonable consumer" rather than a "reasonable practitioner".

14 Ministry of Health "Pregnancy services" (1 July 2015) <www.health.govt.nz>.

15 Ministry of Health "Maternity care" (6 September 2016) <www.health.govt.nz>.

16 Ministry of Health, above n 15; and "Primary Maternity Services Notice 2007" (13 April 2007) 41 *New Zealand Gazette* 1025 at 1067.

17 Ministry of Health, above n 15.

18 Ministry of Health, above n 15.

19 Ministry of Health, above n 15.

20 "Primary Maternity Services Notice 2007", above n 16, at 1059; and Ministry of Health "Choosing a midwife or specialist doctor" (24 July 2015) <www.health.govt.nz>.

21 Ministry of Health, above n 15.

privately or are referred by their midwife or GPO LMC.²² The objective underlying this framework is to allow women the choice between a GPO and a midwife as their LMC.²³ This objective of *choice* is best understood in the context of the framework's history.

Framework Origins

1 Predecessor

In the 1980s, a pregnant woman would typically have routine appointments with her GPO, who would refer her to publicly funded specialist obstetric care if required.²⁴ Upon labour, the expectant mother would contact her GPO and chosen hospital.²⁵ After initial assessment at the hospital, she would then receive routine care by shift-working hospital midwives.²⁶ Her GPO would visit during labour (depending on other commitments) and return if problems arose or birth was imminent.²⁷ If required, the GPO could carry out a forceps delivery.²⁸ Obstetricians were required for caesarean sections.²⁹ After birth, the mother and baby received fully-funded hospital care for two weeks and then appointments with the GPO for a further four weeks.³⁰

According to midwife Chris Hendry, midwives resented this division of labour between midwife and doctor:³¹

... midwives ... cared for women ... only calling the doctor again when birth was imminent or progress was delayed ... the doctors were onto a financial winner: the midwives generally did all the work, with the doctors coming in at the last minute so they could clock in and earn their (publicly funded) fee ... many women thought this was a "rip-off," ...

However, GPO Lynda Exton maintains:³²

... the work of doctors in maternity care is quite different from that provided by midwives. ... a doctor attends ... at key decision points, whereas a midwife offers care and support of a more continuous nature right through the labour.

22 Ministry of Health, above n 14.

23 *Nurses Amendment Act 1990: Information for health providers* (Department of Health, October 1990) at 1. This states that the reforms that first allowed autonomous midwifery practice would "increase the choices available to women and their families in childbirth services".

24 Lynda Exton *The Baby Business: What's happened to maternity care in New Zealand?* (Craig Potton Publishing, Nelson, 2008) at 47.

25 At 47.

26 At 47.

27 At 47.

28 At 47.

29 At 47.

30 At 47–48.

31 Chris Hendry "The New Zealand Maternity System: A Midwifery Renaissance" in Robbie Davis-Floyd and others (eds) *Birth Models That Work* (University of California Press, Berkeley, 2009) 41 at 43–44.

32 Exton, above n 24, at 63.

According to Dr Exton, GPOs are better placed to care for pregnant women. Apart from their higher levels of education and experience, GPOs are generally also the woman's family doctor. This means they are familiar with existing medical problems and do not "just focus on the bubble of time connected with pregnancy and birth".³³

Dr Exton argues that policymakers did not recognise the difference between doctors and midwives when assigning them the same role under the LMC framework, other than observing that midwives offered a "low-intervention, low-cost alternative for maternity care".³⁴ But this misunderstanding of roles was only a small factor behind the reforms. The two principal factors were: first, an erosion of women's trust in doctors coupled with the rise of feminism; and, secondly, a shift from a *medical* view to a *normalised* view of pregnancy.

2 Erosion of Trust in Doctors

The Cartwright Inquiry in the late 1980s into the "Unfortunate Experiment" at National Women's Hospital³⁵ eroded women's trust in doctors and was a catalyst for society's questioning of the "medical leadership model that had been the norm ... during the preceding few decades".³⁶ High maternal mortality rates and fear of infection in the 1920s had prompted a change from home births and autonomous midwifery to a culture of medical intervention and strict hospital routine.³⁷ Until the late 20th century, however, medical staff generally disregarded patients' views and focused little on obtaining informed consent.³⁸ Standard hospital routine included shaving expectant mothers' pubic areas, using enemas³⁹ and administering "twilight sleep" drugs that induced amnesia when birth was imminent — all administered with or without the woman's permission.⁴⁰ Babies were taken away upon birth and kept in controlled sterile environments.⁴¹ During their two-week hospital stay after giving birth, mothers only saw their babies at strict four-hour intervals to breastfeed.⁴² Labour, birth and post-birth was a

33 At 55.

34 At 59.

35 The "Unfortunate Experiment" was a study that "follow[ed] women with major cervical abnormalities without definitively treating them, and without their knowledge or consent. Twenty years on, many had developed cervical cancer and some had died". Women's Health Action "Cartwright Inquiry" (23 July 2014) <www.womens-health.org.nz>. See also Sandra Coney and Phillida Bunkle "An 'Unfortunate Experiment' At National Women's" *Metro* (Auckland, June 1987); and Silvia Rose Cartwright *The report of the Committee of Inquiry into Allegations Concerning the Treatment of Cervical Cancer at National Women's Hospital and into Other Related Matters* (Government Printing Office, Auckland, July 1988).

36 Exton, above n 24, at 58.

37 See, for example, Sue Kedgley *Mum's the Word: The Untold Story of Motherhood in New Zealand* (Random House New Zealand, Auckland, 1996) at 77. See also Jane Stojanovic "Midwifery in New Zealand, 1904–1971" (2008) 30 *Contemporary Nurse* 156.

38 Kedgley, above n 37, at 160, 195 and 240.

39 At 79.

40 At 87.

41 At 163.

42 At 163.

traumatic and lonely experience for women, who often felt they had lost control over their bodies.⁴³

Medicine was also a predominantly male profession at the time. The rise of feminism incited a trend of women striving to regain control over their bodies.⁴⁴ Pubic shaving, routine enemas and heavy sedation continued into the 1950s,⁴⁵ but interest in natural or home births had started to grow.⁴⁶ Midwives, who had been gradually “subsumed” into the nursing profession throughout most of the 20th century,⁴⁷ enjoyed a revival of interest in the 1970s — they listened to women’s wants and needs and worked with them to achieve their desired birth.⁴⁸

The Nurses Amendment Act 1990 re-separated the midwifery and nursing professions, and midwives could once again work autonomously.⁴⁹ With midwifery being a traditionally female profession, there was a theme of women working for and with women.⁵⁰ Midwives offered the option of natural home births with minimal intervention, or, at the very least, a more “woman centred” approach that involved “work[ing] in partnership” with the expectant mother.⁵¹

However, the erosion of trust factor may no longer be as relevant. Not only is the gender gap in New Zealand’s doctors closing,⁵² but the doctor-patient culture has changed. Today, all health practitioners must abide by the basic patient rights, including respect, providing sufficient information and obtaining informed consent.⁵³ Doctors who do not listen to and attempt to accommodate their patient’s wants and needs may be found in breach of the Code of Health and Disability Services Consumers’ Rights (Code of Patient Rights).⁵⁴ A doctor cannot force unwanted pain relief or medical intervention. Medical treatment is now patient-centred, and consequently “woman centred” for pregnancy and labour.⁵⁵ Midwives are, therefore, unlikely to provide more of a partnership culture or “woman centred” care than modern GPOs and obstetricians.⁵⁶

43 At 163–164.

44 At 232, 233 and 239.

45 At 160.

46 At 167–170.

47 Stojanovic, above n 37, at 1.

48 Kedgley, above n 37, at 242–243.

49 See Department of Health, above n 23.

50 Karen Guilliland as quoted in Kedgley, above n 37, at 283: “[P]regnancy and birth [are] a female domain ... and women are simply reclaiming that domain”.

51 These are pivotal values for NZCOM. See NZCOM “New Zealand Model of Partnership” (2017) <www.midwife.org.nz>.

52 Women comprised 41.7 per cent of the medical workforce in 2013 (up from 39.1 per cent in 2009) and “outnumbered men among new doctors”. Health Workforce New Zealand *Health of the Health Workforce 2015* (Ministry of Health, February 2016) at 5.

53 Code of Patient Rights, rights 1 and 7.

54 See, for example, *Obstetrician, Dr B: A District Health Board* (Health and Disability Commissioner, Opinion 12HDC00846, 17 April 2014) at [132]. A consultant obstetrician was found to have breached rights 1(1) (the right to be treated with respect) and 6(1)(a) (the right to be fully informed of his or her condition).

55 NZCOM, above n 51.

56 NZCOM, above n 51.

3 Two Views of Pregnancy

Midwife Chris Hendry reports that “[i]n the 1970s and 1980s, a group of consumers and activist midwives, dissatisfied with the increasing medicalization of maternity care, were the catalysts for change”.⁵⁷

Midwives have traditionally taken a non-interventionist approach that views pregnancy and childbirth as “normal life events” and accepts all of the risks involved.⁵⁸ An NZCOM consensus statement asserts that “[m]idwives ... have a responsibility to protect and support the woman to birth normally” and their “every action” must “support keeping birth normal”.⁵⁹ Dr Exton criticises this “normal” view of birth as insufficient to “provide holistic care for the many pregnant women with illnesses”.⁶⁰ She asserts that “normal” birth “may not perhaps be all that relevant for the 50 per cent of New Zealand women who currently require special assistance with the birth process”.⁶¹

The midwifery view can be contrasted with the doctors’ view of maternity, which sees “[t]he process of giving birth [as] unpredictable, sometimes with no notice at all”.⁶² They generally argue that childbirth is only normal in retrospect.⁶³ Doctors maintain they are “trained to expect the unexpected and to react accordingly should problems arise”.⁶⁴ This perspective has been criticised as medicalising the event with “a willingness to intervene too readily”.⁶⁵

These two opposing views have led to serious consequences. In 2001, three infants died within a few months of each other at the Waitakere Maternity Unit.⁶⁶ The “heart” of this crisis was described as:⁶⁷

... the differing professional beliefs held by independent midwives and obstetricians ... midwives [sought] to protect expectant mothers from unnecessary medical intervention, while hospital obstetricians found themselves meeting the soon-to-be mothers only when labour and delivery went wrong.

57 Hendry, above n 31, at 41.

58 Jane Sandall and others “Midwife-led continuity models versus other models of care for childbearing women (Review)” (2016) 4 Cochrane Database of Systematic Reviews 1 at 7; and Elizabeth Newnham “Midwifery directions: The Australian maternity services review” (2010) 19 Health Sociology Review 245 at 246.

59 NZCOM “Consensus Statement: Normal Birth” (July 2009) <www.midwife.org.nz> at 1–2.

60 Exton, above n 24, at 56.

61 At 56. This figure is subject to variability. See Exton, above n 24, at 64. Exton criticises Helen Clark’s claim that 85 per cent of mothers did not require intervention. Kedgley, above n 37, at 282. Kedgley paraphrases a claim by obstetrician Allan Sutherland that “20 per cent of all labours have problems requiring intervention”. Gaps in data records mean a concrete figure is unlikely to be obtained.

62 Exton, above n 24, at 54.

63 Newnham, above n 58, at 246.

64 Exton, above n 24, at 54.

65 Exton, above n 24, at 54. Of course, midwives may hold a medicalised view and doctors may favour a normalised view of birth. However, these midwives and doctors are likely minorities in their respective professions.

66 Exton, above n 24, at 146.

67 Fountain, above n 2.

Dr Exton argues that policymakers did not understand “the profound differences between the midwifery ... and the medical point of view, or how these differences might ... influence women’s care”.⁶⁸ Policies should not be seen as a solution to a problem, but rather as constituting various viewpoints of a political issue.⁶⁹ The two relevant viewpoints here are *normalising* birth and *medicalising* birth. A policy constituting both viewpoints would provide a woman with a choice between them so she could choose her LMC accordingly.⁷⁰

The current framework intended to achieve this by allowing women to choose between a midwife and a GPO for maternity care.⁷¹ However, the funding behind the framework produces a different result. Currently, midwives and GPOs are paid the same fixed rate of NZD 632 per pregnancy for antenatal services,⁷² despite the more rigorous training and qualifications required to become a GPO. A similar discrepancy applies to postnatal services. Furthermore, as GPOs will use midwifery services for the labour of each pregnancy, GPO LMCs only receive NZD 482 for the patient’s labour and birth, whereas a midwife LMC receives NZD 1,168.⁷³ This means that GPOs are paid less per pregnancy than midwives for LMC services.

This funding structure led to a severe decline in GPOs offering LMC services.⁷⁴ In 2014, only 0.4 per cent of pregnancies were GPO-led.⁷⁵ As a result, women who want a GPO LMC are not able to choose one because so few are available.

The policy means that expectant mothers can no longer subscribe to the medical view of pregnancy and birth unless they pay privately for an obstetrician LMC. They must rely on their midwife to decide whether — and, if so, when — medical intervention is necessary.⁷⁶ The policy assumes

68 Exton, above n 24, at 59.

69 Carol Lee Bacchi *Women, Policy and Politics: The Construction of Policy Problems* (SAGE Publications, London, 1999) at 2 as cited in Newnham, above n 58, at 246–247.

70 For examples of different perspectives and choices held by women, see Annemarie Quill “Delivery dilemma — the birthing centre debate” *Bay of Plenty Times* (online ed, Tauranga, 8 December 2014).

71 Department of Health, above n 23, at 1. Minister of Health Helen Clark states that the reforms that first allowed autonomous midwifery practice would “increase the choices available to women and their families in childbirth services”.

72 “Primary Maternity Services Amendment Notice 2017” (27 April 2017) 45 *New Zealand Gazette* 1 at 1. These figures have been adjusted since the original reforms, but the disparities between sums paid to GPs and midwives have always been present.

73 “Primary Maternity Services Amendment Notice 2017”, above n 72, at 1. These are fees for the patient’s first child. Fees are slightly reduced for subsequent births, except for vaginal births after caesarean. A cynic might argue this influences a Lead Maternity Carer [LMC] to encourage mothers to undertake a vaginal birth after caesarean, even though increased risks are involved.

74 See AIM: Action to Improve Maternity “Did you know? Facts about our maternity system” (2014) <www.aim.org.nz>.

75 *Report on Maternity: 2014* (Ministry of Health, December 2015) at 29.

76 Apart from the natural aversion that midwives have towards medical intervention, LMCs receive the largest payment under the funding framework if they care for the entire pregnancy (due to being paid per *module* of care). They also receive bonuses for home births, as well as births occurring in birthing clinics rather than hospitals. “Primary Maternity Services Amendment Notice 2017”, above n 72. While these bonuses exist to cover the extra labour and equipment needed, a cynic might again suggest that the bonuses provide at least an unconscious incentive for LMCs to delay or discourage seeking specialist medical help. See AIM, above n 74.

that a woman will want a less medicalised approach. However, this is unfair to women who want a *more* medicalised approach.

An Illusion of Choice?

As we have seen, there is a lack of choice for maternity care. And yet policymakers and midwifery advocates maintain that a choice still exists. The Ministry of Health asserts that “[m]ost women *choose* a midwife”.⁷⁷ It also published a report stating that “[m]idwives are the most common *choice* for LMC (90% of women now *select* a midwife ...)”.⁷⁸ According to Hendry:⁷⁹

[W]omen have increasingly *chosen* midwives over medical practitioners as the *preferred providers* of primary (uncomplicated) maternity care. Over time, almost all general medical practitioners ... have opted out of the direct provision of maternity care, and midwives have enthusiastically taken over the service.

These statements ignore the women who may have been forced to *choose* a midwife LMC simply because GPO LMCs were unavailable. This illusion of choice is unfair to women for two reasons. First, it is misleading to women through implying that more women choose midwives because they are somehow *better* than GPOs. Secondly, it gives the impression that the expectant mother has chosen a midwife LMC with her eyes open to the lower standard of care required of a midwife compared to a doctor.

III STANDARD OF CARE

Relevance of Standard of Care

Standard of care is a concept developed under the tort of negligence. While the negligence tort is largely redundant in New Zealand healthcare law due to the Accident Compensation Corporation (ACC) framework,⁸⁰ standard of care is still relevant when determining criminal liability, liability under the Health and Disability Commissioner Act 1994 (HDCA) and liability under the Health Practitioners Competence Assurance Act 2003 (HPCAA).

77 Ministry of Health, above n 20 (emphasis added).

78 Rowland, McLeod and Froese-Burns, above n 1, at 66 (emphasis added).

79 Hendry, above n 31, at 41 (emphasis added).

80 Provided that statutory criteria are met, the Accident Compensation Corporation framework compensates patients for any “treatment injury” regardless of whether the health practitioner was at fault. Accident Compensation Act 2001, ss 20, 32, and 33. In return, the patient is barred from claiming compensation in negligence against the practitioner under s 317. This covers the vast majority of adverse pregnancy outcomes injuring the mother or baby. Exemplary damages and damages for emotional harm are still possible, but unlikely.

1 Criminal Liability

A health practitioner may be liable for manslaughter if his or her “major departure from the standard of care expected of a reasonable person” caused the victim’s death.⁸¹ Liability under this provision requires a higher degree of negligence than ordinary — or common law — negligence.⁸²

In 2006 a midwife was prosecuted for manslaughter. She was accused of a lack of care and a failure to seek assistance, despite the occurrence of complications and high-risk factors.⁸³ The midwife argued that she did not seek medical assistance due to the mother’s alleged determination to have a natural birth. Although the midwife was acquitted, the case was highly controversial. It was criticised by the medical community and others who felt that the criminal court was the incorrect forum for discussions surrounding a health practitioner’s professional judgment.⁸⁴ As criminal prosecutions of health practitioners under this provision have “all but ceased” today,⁸⁵ this article will not discuss standard of care in a criminal context.

2 Liability under the HDCA

The HDCA provides a complaint mechanism for consumers of health and disability services, who would otherwise have limited recourse to courts and health providers under the ACC framework.⁸⁶ Partly a response to the Cartwright Inquiry,⁸⁷ the HDCA aims to “promote and protect the rights of health consumers” by “facilitat[ing] the fair, simple, speedy, and efficient resolution of complaints relating to infringements of those rights”.⁸⁸

Under the HDCA, anyone can complain to the Health and Disability Commissioner that a health provider has breached a Patient Right.⁸⁹ Right 4(1) of the Code of Patient Rights grants every consumer “the right to have services provided with reasonable care and skill”. Reasonable care and skill is determined by the standard of care against which a health provider is measured.

81 Crimes Act 1961, ss 155 and 150A(2). This was changed from ordinary negligence in 1997 after the controversial prosecution of an anaesthetist. See generally Kevin Dawkins “Medical Manslaughter” [1997] NZLJ 393.

82 See *JF v Police* [2013] NZHC 2729, (2013) 26 CRNZ 764 at [14].

83 “Midwife faces charge of manslaughter” *The New Zealand Herald* (online ed, Auckland, 7 March 2006). See also *Midwife, Ms B: Midwife, Ms C* (Health and Disability Commissioner, Opinion 04HDC05503, 28 November 2006).

84 See, for example, “Court ‘wrong place for midwife case’” *The New Zealand Herald* (online ed, Auckland, 22 March 2006).

85 Joanna Manning “The Required Standard of Care for Treatment” in Peter Skegg and Ron Paterson (eds) *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015) 95 at 100–101.

86 Rosemary Godbold and Antoinette McCallin “Setting the standard? New Zealand’s approach to ensuring health and disability services of an appropriate standard” (2005) 13 JLM 125 at 125.

87 Godbold and McCallin, above n 86, at 125.

88 Health and Disability Commissioner Act 1994 [HDCA], s 6.

89 Section 31.

The Commissioner can respond to a complaint by investigating whether any Patient Rights were breached.⁹⁰ The Commissioner can also investigate on his or her own volition.⁹¹ On finding a breach, the Commissioner may refer the matter to the Director of Proceedings,⁹² who may issue proceedings against the health provider. The Director can bring proceedings with the Human Rights Review Tribunal — which has a wide discretion of remedies, including civil remedies not covered by ACC.⁹³ The director can also bring proceedings with the Health Practitioners Disciplinary Tribunal.⁹⁴

The Commissioner also has wide discretion in making recommendations.⁹⁵ These typically include recommending that the practitioner attend further or supplementary training and provide the aggrieved consumer with a written apology.⁹⁶ Recommendations can also be directed at a disciplinary body or at the relevant District Health Board (DHB) or hospital.⁹⁷

As well as providing a complaints forum, the HDCA framework plays a role in setting professional standards. Commissioner opinions are “influential”, and it is “not unreasonable to assume that providers draw on [the opinions] to guide practice”.⁹⁸ The Commissioner’s recommendations also contribute to improving New Zealand’s health services.

3 HPCAA

The HPCAA aims to protect public health and safety “by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions”.⁹⁹ These mechanisms include a disciplinary framework.¹⁰⁰

The Tribunal carries out disciplinary proceedings.¹⁰¹ Proceedings can be brought by the Director of Proceedings or a professional conduct committee.¹⁰² Under s 100(1)(a), a health practitioner is guilty of professional misconduct for an act or omission amounting to malpractice or negligence. The practitioner can be found guilty if: first, there was a

90 Section 40.

91 Section 40(3).

92 Section 45(2)(f).

93 Sections 50 and 52.

94 Section 47(1)(d); and Health Practitioners Competence Assurance Act 2003 [HPCAA], s 91(1)(a).

95 HDCA, s 45(2).

96 See, for example, *Obstetrician, Dr D: A District Health Board* (Health and Disability Commissioner, Opinion 11HDC00515, 11 July 2013) at [118]; and *Midwife, Ms B* (Health and Disability Commissioner, Opinion 13HDC01460, 12 June 2015) at [116]–[117].

97 HDCA, s 45(2)(b)(i).

98 Godbold and McCallin, above n 86, at 130.

99 HPCAA, s 3(1).

100 Section 3(2).

101 Section 85.

102 Section 91(1). The professional conduct committee receives complaints from the relevant authority to whom the Commissioner refers complaints — for example, the Midwifery Council. See Joanna Manning “Professional Discipline of Health Practitioners” in Peter Skegg and Ron Paterson (eds) *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015) 927 at 953–954.

departure from “acceptable professional standards”; and, secondly, the departure was significant enough to “warrant sanction” for public protection purposes.¹⁰³ Standard of care is relevant in determining the “acceptable professional standards”.

If the Tribunal finds one or more disciplinary grounds to be satisfied, it can impose a fine of up to NZD 30,000; or cancel, suspend or place conditions on the practitioner’s registration.¹⁰⁴ Thus, the Tribunal has an important regulatory role in ensuring that all health practitioners are providing competent, safe and adequate care.

Establishing the Standard of Care

1 Basic Negligence Concepts

The law underlying the standard of care for health practitioners is relatively settled and follows basic negligence concepts. The starting point is the English case *Bolam v Friern Hospital Management Committee*, which held that a professional’s standard of care should be measured against “the ordinary skilled man exercising and professing to have that special skill”.¹⁰⁵ A doctor is measured against “the standards of reasonably competent medical men at the time”.¹⁰⁶ Similarly, a midwife is measured against the reasonably competent midwife, rather than a GPO or an obstetrician — even if they play the same role of LMC. A practitioner professing to be a specialist will be held to a higher standard than a regular doctor.¹⁰⁷ Inexperience is no defence, although inexperienced practitioners can partially protect themselves by recognising their limitations and seeking a senior’s help or advice.¹⁰⁸

In establishing the standard of care, the court will accept the opinion of any “responsible body ... skilled in that particular art”.¹⁰⁹ Subsequent interpretations of this test meant that if the defendant could produce a responsible witness of the same profession and qualifications testifying that he or she would have taken the same action in the same situation, the court could not “as a matter of law” hold the defendant liable.¹¹⁰

Bolitho v City and Hackney Health Authority eroded this defendant-friendly position, stating:¹¹¹

103 *F v Medical Practitioners Disciplinary Tribunal* [2005] 3 NZLR 774 (CA) at [54] and [80].

104 HPCAA, s 101(1).

105 *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582 (QB) at 586.

106 At 586.

107 *Poole v Morgan* [1987] 3 WWR 217 (ABQB) at [138] as cited in Manning, above n 85, at 117. See also Jackie Pearse “Health Professionals’ Standards” [2001] NZLJ 15.

108 See Manning, above n 85, at 114–118. See also *Midwife, Ms E; Midwife, Ms F* (Health and Disability Commissioner, Opinion 08HDC10923, 11 September 2009).

109 *Bolam*, above n 105, at 587.

110 Joanna Manning “The standard of care and expert evidence of accepted practice in medical negligence” (2007) 15 JLM 394 at 395 and 397.

111 *Bolitho v City and Hackney Health Authority* [1998] AC 232 (HL) at 243.

... if, in a rare case, ... the professional opinion is [demonstrated as] not capable of withstanding logical analysis, the judge is entitled to hold that the body of opinion is not reasonable or responsible.

Under *Bolitho*, the court now has ultimate responsibility to determine what constitutes a satisfactory standard. However, expert evidence can only be overridden in exceptional circumstances.¹¹² Judges cannot prefer one view over another if both have logical support.¹¹³

2 The New Zealand Context: HDCA and HPCAA

New Zealand largely follows the English position. Both the Commissioner and the Tribunal have held that “evidence of medical practice is relevant to, but not conclusive of, the standard of care”.¹¹⁴

The Commissioner will usually rely on a Commissioner-appointed expert’s opinion to determine whether a practitioner departed from reasonable competent standards and, if so, the severity of that departure.¹¹⁵ However, the Commissioner has stated that:¹¹⁶

... even in relation to diagnosis and treatment ... I am not bound to accept expert opinions uncritically. It is open to [the Commissioner] to hold that the standard acceptable to the profession was nonetheless not reasonable ... taking into account usual practice, as well as patient interest and community expectations.

The HPCAA approach is similar. The “required standard of competence” is defined as “the standard of competence reasonably ... expected of a health practitioner practising within that health practitioner’s scope of practice”.¹¹⁷ In the words of Elias J.¹¹⁸

[T]he reasonableness of the standards applied must ultimately be for the court to determine, taking into account all the circumstances including not only usual practice but also patient interests and community expectations, including the expectation that professional standards are not be permitted to lag.

112 At 243.

113 At 243.

114 Manning, above n 110, at 401. See *Registered Midwife, Ms A: Registered Midwife, Ms B: Registered Midwife, Ms C: River Ridge (East) Birth Centre Ltd* (Health and Disability Commissioner, Opinion 11HDC00123, 9 June 2014) at [149]; and *B v Medical Council*, above n 13, at 811. See also *Ambros v Accident Compensation Corporation* HC Auckland CIV 2004-404-3261, 21 March 2005 at [80]–[92]. *Ambros* is perhaps the “high-water mark”, with the court rejecting medical evidence from all four experts to conclude a breach of duty. Manning, above n 110, at 401–403.

115 See Godbold and McCallin, above n 86, at 127.

116 *Gynaecologist, Dr B: General Practitioner, Dr C: General Practitioner, Dr D: A Medical Health Centre: A District Health Board* (Health and Disability Commissioner, Opinion 08HDC07350, 15 March 2010) at 14 (footnotes omitted).

117 HPCAA, s 5(1).

118 *B v Medical Council*, above n 13, at 811.

Therefore, the Commissioner and the Tribunal (or appellate court) can, in rare cases, reject expert evidence or decide that the professionally acceptable standard is too low.¹¹⁹

3 *A Choice Contradiction*

There are two main reasons for imposing different standards of care on different types of health practitioners. First, there are fairness considerations from the practitioner's perspective. A midwife LMC puts herself forward as offering a midwife's expertise *only*, and, therefore, accepts that she will be held to the standard of a reasonably competent midwife.¹²⁰ It would be unfair to judge her conduct by comparing it to the conduct expected of an obstetrician, who has more training and experience, as well as — to a certain extent — a different philosophy on maternity care.

The second reason assumes a degree of knowledge and choice from the consumer, who is taken to have accepted a particular standard of care when consulting a certain type of professional.¹²¹ If a woman chooses a midwife, she is taken to accept that the midwife's medical knowledge will be less than that of a doctor or obstetrician. Similarly, if a woman chooses a GPO as LMC, she is assumed to expect the standard of a GPO, which is higher than that of a midwife, but lower than that of an obstetrician. Thus, imposing different standards of care on different types of health providers assumes there is a *choice* made by the consumer. However, as discussed in Part II, there is effectively no choice. New Zealand's maternity care framework means that only midwives are available for expectant mothers reliant on public funding.

This is unfair from the expectant mother's point of view. The maternity framework gives the illusion of choice between practitioners; and the law, accordingly, imposes different standards of care on different types of practitioners. From the law's point of view, a woman has *chosen* a midwife as her LMC, and is, therefore, entitled to only a midwife's standard of care. But from a woman's point of view, she has not truly *chosen* a type of practitioner, and, therefore has not *agreed* to any particular standard. It is unrealistic to assume that consumers know they are owed different standards of care from different types of practitioners, especially where the practitioners play the same role. Furthermore, even if a woman did know, she has taken the only option available to her. All she wants is a positive outcome for herself and her baby, which, for some expectant mothers, may

119 See, for example, *Lake v The Medical Council of New Zealand* HC Auckland HC123/96, 23 January 1998 at 38. This case criticised the defendant obstetrician's decision against performing a caesarean, despite the expectant mother's difficult obstetric history — this notwithstanding expert testimony that other obstetricians would have made the same decision. The Court found that, in light of the history, the probability of complications was much higher if vaginal birth was attempted (as high as 20 per cent) compared to a caesarean (less than one per cent). At 13.

120 I refer to midwives using female pronouns throughout this article because women constitute over 99.8 per cent of New Zealand's midwifery workforce as of 2016. Midwifery Council of New Zealand *2016 Midwifery Workforce Survey* (2016) at 2.

121 See *Shakoor v Situ* [2001] 1 WLR 410 (QB) at 416.

mean choosing an LMC that will be held to a higher standard. It is unfair for the law to assume that she had a choice and to then impose the standard of care according to the practitioner she *chose* — that standard being a midwife's standard of care.

IV RESOLVING THE CHOICE CONTRADICTION

Part III established a *choice contradiction*, with a lack of choice for expectant mothers, coupled with an assumption of choice underlying the imposed standard of care. Two ways to resolve this contradiction are to: adjust the framework by reintroducing choice; or adjust the standard of care.

Fixing the Framework

1 *The Return of GPOs*

While this article focuses on the standard of care, it would be incomplete without discussing the most obvious solution to the choice contradiction: reintroducing the originally-intended choice element into the framework. Reintroducing choice requires encouraging GPs to train and practise as GPO LMCs again. This involves examining factors behind the continued shortage of GPOs in maternity care and then exploring ways to mitigate those factors.¹²²

The most obvious factor is the remuneration received for each birth.¹²³ Under the current framework, a GPO LMC receives *less* per pregnancy than a midwife LMC.¹²⁴ While this article is not the place for a cost and efficiency analysis,¹²⁵ the funding framework plays a key role in the choice contradiction and should be reviewed.

2 *The Elephant in the Room*

Of course, funding is a significant factor in every policy decision. Paying midwives and GPOs the same amount per birth is cheaper than granting GPOs a premium or budget to cover midwifery costs. Midwives are also cheaper to train. International studies have found various midwife-led models are cheaper than their medically-led counterparts.¹²⁶

122 For possible factors, see Lucy Ratcliffe “Still catching babies: Last of the GPOs” *New Zealand Doctor* (online ed, Auckland, 14 August 2013) <www.nzdoctor.co.nz>; and Exton, above n 24, at 200–205.

123 Ratcliffe, above n 122. See also Exton, above n 24, at 66–125.

124 See discussion in Part II.

125 For example, some may argue that a general practitioner with an obstetric certification [GPO] spends less time with a woman during labour than a midwife does, and so should be entitled to less pay than a midwife.

126 Sandall and others, above n 58, at 21–22. However, Exton argues that they may be *more* expensive as obstetricians have to deal with pregnancy issues that a GPO could have dealt with. Exton, above n 24, at 162.

One could argue that the current funding framework is a policy decision to provide women with a midwife's standard of care *only*, so that women who desire a doctor's standard of care must pay privately. But if a midwife-led maternity framework is really a funding decision, policymakers should make this clear to consumers. It should not be hidden behind an illusion of choice. Only then can proper democratic processes occur to allow informed decisions on the amount of public funding allocated to the quality of New Zealand's maternity care.

This leads to the issue of whether the current quality of care, being the midwifery standard of care, *is* sufficient. This has been questioned in recent years by both the media and several studies — and the debate is ongoing. Below I outline both quantitative and qualitative evidence concerning the quality of midwife-led care in New Zealand and internationally.

(a) Quantitative Evidence

A study published in 2016 found an “unexplained excess of adverse events in midwife-led deliveries in New Zealand”.¹²⁷ Compared with midwife-led care, medical-led care was found to offer 55 per cent lower odds of oxygen deprivation to the infant during delivery, 39 per cent lower odds of neonatal encephalopathy¹²⁸ and 48 per cent lower odds of a low Apgar score.¹²⁹

The study received much media coverage and was not without criticism.¹³⁰ Some criticism against the study was defensive, focusing on limitations that the study had already acknowledged.¹³¹ One limitation was that, while the adverse outcomes related almost exclusively to intrapartum care, the study could not differentiate whether these outcomes were due to the midwife's actions or medical management during labour or birth.¹³² Furthermore, the study was not a randomised control study. This means that confounding variables such as age, ethnicity and social deprivation, could have affected the results. While the study attempted to adjust for such variables and found no residual confounding, these adjustments have been criticised as insufficient.¹³³ Some other criticisms were that the study: did not

127 Wernham and others, above n 1, at 2. However, this study did not find any significant difference in stillbirth and neonatal mortality rates between midwife-led and medical-led models. See 1–2.

128 Wernham and others, above n 1, at 2. Neonatal encephalopathy is described as “a condition that can result in brain injury”.

129 Wernham and others, above n 1, at 2–3. An Apgar score is described as “a measure of infant well-being immediately post-delivery, with a low score being indicative of an unwell baby”.

130 See, for example, Emily Murphy and Leah Flynn “Bad outcomes for new babies more likely with midwife, research shows” *Stuff* (online ed, Wellington, 28 September 2016); and Natalie Akoorie “Higher birth damage rates in midwifery-led care concerns ministry” *The New Zealand Herald* (online ed, Auckland, 28 September 2016).

131 For Wernham and her co-authors' responses to criticisms, see Ellie Wernham and Diana Sarfati “RE: Letter to the editor of PloS Medicine” (12 December 2016) PLOS Medicine <journals.plos.org/plosmedicine>.

132 Sally Tracy “Response to PLOS ONE” NZCOM <www.midwife.org.nz> at 1.

133 Tracy, above n 132, at 2; and Cynthia Farquhar, Lesley McCowan and Sue Fleming “Letter to the editor of PloS Medicine” (22 October 2016) PLOS Medicine <journals.plos.org/plosmedicine>.

take into account medical conditions arising after registration;¹³⁴ excluded women who booked DHB care rather than midwife or medical care;¹³⁵ and relied on odds ratios that were too small to be taken seriously.¹³⁶

A major criticism was the study's dismissal of a 2016 Cochrane Database review.¹³⁷ This review examined data from 15 randomised control studies around the world. It found that, under midwife-led continuity of care models, there was a lower likelihood of preterm births, foetal loss, neonatal deaths, and interventions such as instrumental vaginal births.¹³⁸ Under these midwife-led models, mothers were more likely to have spontaneous vaginal births¹³⁹ and were more satisfied with their care.¹⁴⁰ Importantly, however, the Cochrane review did not include any studies from New Zealand. New Zealand's definition of "midwife-led" is very different from that in the countries the studies were from.¹⁴¹ For example, the midwife-led interventions in the studies included involved "routine medical input",¹⁴² and midwives did not work autonomously.¹⁴³ The different definitions of "midwife-led care" mean that applying the Cochrane findings to the New Zealand context would be difficult and perhaps even illogical.¹⁴⁴

Studies from the Netherlands are of interest due to the similarities between New Zealand's and the Netherlands' maternity models. But they also have produced mixed results. A 2010 study found that low-risk mothers under midwife-led care had a *higher* risk of delivery-related death compared with high-risk mothers under medical-led care.¹⁴⁵ This raises concerns about the quality of midwife-led care. However, a 2015 study found no evidence of difference in relative risks of intrapartum and neonatal mortality between midwife and medical-led care.¹⁴⁶

Finally, all of the mentioned studies examined midwife-led care against obstetrician-led care rather GPO LMCs, who have a different standard of care to obstetricians. Ascertaining whether outcomes in New Zealand have improved or worsened since GPOs exited maternity care is difficult due to the lack of data.

134 Tracy, above n 132, at 2–3.

135 At 2.

136 Farquhar, McCowan and Fleming, above n 133. But see the rebuttal of this point in Wernham and Sarfati, above n 131.

137 Wernham and others, above n 1, at 4. Contrast Tracy, above n 132, at 1.

138 Sandall and others, above n 58, at 1–2.

139 At 2. But see Exton, above n 24, at 164. Exton reports that caesarean rates in New Zealand have reached an all-time high after transitioning to a midwife-led model.

140 Sandall and others, above n 58, at 2.

141 Ireland, Canada, Australia and the United Kingdom.

142 Wernham and others, above n 1, at 4.

143 Sandall and others, above n 58, at 8.

144 Wernham and others, above n 1, at 4.

145 Annemieke CC Evers and others "Perinatal mortality and severe morbidity in low and high risk term pregnancies in the Netherlands: prospective cohort study" (2010) 341 *BMJ* 1 at 1.

146 MMJ Wiegerinck and others "Intrapartum and neonatal mortality in primary midwife-led and secondary obstetrician-led care in the Amsterdam region of the Netherlands: A retrospective cohort study" (2015) 31 *Midwifery* 1168 at 1173.

New Zealand generally has comparable maternity outcomes to other countries, including England and Wales, Ireland, and Australia,¹⁴⁷ whose maternity models are predominantly medical-led.¹⁴⁸ While comparison is difficult, particularly because many other factors contribute to final outcomes,¹⁴⁹ the international similarity does not suggest that New Zealand's midwife-led framework is *less* safe than other countries.

In summary, the quantitative evidence is uncertain. There is limited and indirect evidence that midwife-led pregnancies result in worse maternity outcomes. The overall low rates of maternal and perinatal mortality¹⁵⁰ also make comparison between different models more difficult.

(b) Qualitative Evidence

A 2008 review of Commissioner opinions regarding midwives revealed several common themes. These included failures to refer the expectant mother to a specialist; to assess or monitor the expectant mother; and to recognise and respond to symptoms.¹⁵¹ A review of all midwife-related Commissioner opinions over the last decade reflects a continuation of these themes.¹⁵² The four disciplinary cases concerning a midwife's standard of care in the last decade reinforce this trend.¹⁵³ Common themes included a failure to monitor or interpret symptoms; a failure to assess or incorrect assessment;¹⁵⁴ and a failure to refer or recommend the mother to a specialist.¹⁵⁵

There are significantly fewer Commissioner opinions concerning obstetricians providing maternity care,¹⁵⁶ possibly because more maternity carers are midwives. And there are no decisions concerning GPOs, likely because their numbers were already declining when the HDCA came into

147 Wernham and others, above n 1, at 14–15. However, the latest *PMMRC Mortality Report* raised concerns about New Zealand's lack of neonatal death rate reduction, unlike the United Kingdom and Australia. New Zealand also has significantly higher maternity mortality than the United Kingdom, although the report found this was primarily due to New Zealand's higher maternal suicide rates. *PMMRC Mortality Report*, above n 8, at 23–25.

148 Rowland, McLeod and Froese-Burns, above n 1, at 103–111.

149 For example, funding, geography and socioeconomic conditions.

150 9.7 perinatal deaths per thousand births in 2015 and 0.156 maternal deaths per thousand births between 2013 and 2015. *PMMRC Mortality Report*, above n 8, at 2 and 12.

151 Elizabeth Finn *Midwifery Practice - Learning from Complaints* (Health and Disability Commissioner, 1 February 2008) at 3. These themes are not unique to New Zealand. See, for example, Marlies Eggermont "The Belgian, French and Dutch midwife on trial: A critical case study" (2015) 31 *Midwifery* 547.

152 See "Decisions & Case Notes" <www.hdc.org.nz>. See, for example, *Midwife, Ms B* (Health and Disability Commissioner, Opinion 13HDC01430, 7 April 2015); *Midwife, Ms C* (Health and Disability Commissioner, Opinion 11HDC00098, 22 March 2013); *Midwife, Ms B*, above n 96; and *Registered Midwife, Ms A*, above n 114.

153 See "Decisions & Case Notes", above n 152.

154 *Director of Proceedings v Robertson* HPDT Hamilton 130/Mid07/63D, 8 October 2007 at [75]–[88]; *Professional Conduct Committee v Casey* HPDT Christchurch 334/10/144P, 22 October 2010 at [99]–[111] and [126]–[132]; and *Director of Proceedings v Naidu* HPDT Auckland 165/Mid/08/82D, 21 July 2008 at [61]–[80] and [89]–[92].

155 *Director of Proceedings v Kapua* HPDT Auckland 227/Mid08/103D, 22 June 2009 at [315]–[318].

156 Around a two-thirds reduction, including Opinions concerning obstetric registrars. This is based on the author's review of all Commissioner Opinions concerning midwives and obstetricians over the past decade, available on the Commissioner's website as of 20 April 2017.

force. About half of the obstetrician-related opinions in the last decade concerned failure to assess the mother or to recognise and respond to symptoms.¹⁵⁷ The remainder concerned other shortcomings, such as junior registrars overstepping their responsibility,¹⁵⁸ insufficient supervision of junior staff¹⁵⁹ and clinical judgment errors.¹⁶⁰ The latter case resulted in the only disciplinary finding of misconduct for an obstetrician's standard of maternity care in the last decade.¹⁶¹

Unlike the clear repetition of themes in midwife-related opinions, every obstetrician-related opinion concerned a different situation. This could be due to either the small number of obstetrician-related opinions; or to the one-off nature of the events behind these opinions. While it is generally unwise to apply a few examples of qualitative evidence to an entire profession, the common themes in the midwife opinions may indicate a general need for improvement across the profession.

Two recent coroner reports fuelled the debate on midwifery standards. In 2015, the coroner reported on a case in which both the mother and baby died shortly after birth.¹⁶² The LMC was a graduate midwife in her first year of practice.¹⁶³ She failed to detect abnormalities during the pregnancy and labour, and, consequently, failed to refer the mother to a specialist or recommend a hospital birth over a birthing centre.¹⁶⁴ There would have been an 80 per cent chance of survival had the abnormalities been detected earlier.¹⁶⁵

Three years earlier, another neonatal death resulted in the mother suffering various injuries and requiring a hysterectomy among other surgical procedures.¹⁶⁶ The midwife LMC, also in her first year of practice, failed to assess or monitor the mother during labour.¹⁶⁷ She sent the mother home from the birthing centre when it was both clinically inappropriate and against the mother's wishes.¹⁶⁸ The coroner criticised the midwife's failure to recognise the abnormal labour progress and to refer the mother to a specialist or hospital at an earlier stage.¹⁶⁹

Midwives pushed back after both coroner reports. NZCOM argued that the coroner's recommendations in the latter case focused

157 See, for example, *Obstetrician, Dr B: Midwife, Ms C: Obstetric Group* (Health and Disability Commissioner, Opinion 15HDC00189, 29 June 2016) at [88]–[133].

158 *Obstetric Registrar, Dr B: Canterbury District Health Board* (Health and Disability Commissioner, Opinion 12HDC00932, 20 February 2014).

159 *Obstetrics Registrar, Dr B: Obstetrics Consultant, Dr C: Capital & Coast District Health Board* (Health and Disability Commissioner, Opinion 13HDC00093, 17 December 2014).

160 *Obstetrician, Dr B*, above n 157.

161 As of 20 April 2017. *Re Dr S HPDT Auckland 809/Med15/318D*, 16 May 2016.

162 *Nathan* [2015] NZCorC 3 (16 January 2015); and *Nathan* [2015] NZCorC 4 (16 January 2015).

163 *Nathan*, above n 162, at 1.

164 *Nathan*, above n 162, at 2.

165 Libby Wilson, Nancy El-Gamel, Aaron Leaman "Mum and baby deaths: Coroner slams midwife" *Waikato Times* (online ed, New Zealand, 31 January 2015).

166 *Barlow* [2012] NZCorC 87; and Mather, above n 6. A hysterectomy involves the surgical removal of all or part of the uterus, resulting in sterility.

167 *Barlow*, above n 166, at 1–2.

168 *Barlow*, above n 166, at 1–2.

169 *Barlow*, above n 166.

disproportionately on the midwife's shortcomings, when the hospital staff, obstetrician and DHB had also contributed to the outcome.¹⁷⁰ NZCOM maintained that midwives' "specific failures ... in one case can[not] be extrapolated to infer failings in the education and supervision of midwives across the board" and to do so "presents an inaccurate view of what is widely recognised as a world class maternity service".¹⁷¹ However, one could argue that the standard required from midwives in New Zealand should be *higher* than international standards, given the heavier responsibility placed on midwives in New Zealand.¹⁷² It is also interesting that there have been no coroner recommendations aimed exclusively at obstetricians within the last decade.¹⁷³ Given this, perhaps the fact that at least two coroner reports have focused on the shortcomings of midwives *should* call into question the general adequacy of midwife education and supervision.

3 Summary

Evidence of current quality sufficiency is mixed and the area would benefit from increased research. Even if New Zealand's standards are comparable internationally, one could argue that any preventable adverse outcome is one too many. Yet 14 per cent of perinatal deaths in 2015 and 39 per cent of maternal deaths between 2006 and 2015 were potentially avoidable.¹⁷⁴ Policymakers should strive to improve maternity outcomes and aspire to make New Zealand a world leader in quality maternity care.

Adjusting the Standard

Another way to mitigate the choice contradiction is to adjust the standard of care an LMC is held against, so that the justification behind the imposed standard of care does not rely on an illusion of choice.

1 The Case for a Unified Standard

As New Zealand's maternity framework removes choice, it is unfair that the law assumes a choice exists and imposes a standard of care according to the *chosen* practitioner. If the current framework is premised on giving women the choice between a midwife and GPO LMC, women who would choose a GPO should be entitled to a GPO's standard of care. As the framework effectively removes GPOs from the picture, one could argue that women

170 *Response from New Zealand College of Midwives to Recommendations made by Coroner Gordon Matenga Re. the Death of Baby Adam Barlow* (28 May 2012) [NZCOM Response] at [IV] as cited in *Barlow*, above n 166, at 6.

171 Libby Wilson "New midwives should not lead care — coroner" *The New Zealand Herald* (online ed, Auckland, 31 January 2015).

172 *World class* is an ambiguous term and, therefore, holds little meaning. I interpret *world class* as offering comparable standards to other developed countries.

173 Being all publicly accessible coroner reports.

174 *PMMRC Mortality Report*, above n 8, at 24 and 26. Maternal deaths are grouped over a range of years due to the small sample size.

who wanted a GPO, but were forced to have a midwife instead, should still be entitled to that higher standard of care.

One way to give effect to this choice is to create a unified standard of care, so that a woman will be entitled to the same standard of care whether her LMC is a GPO or a midwife. The question then arises: how should this standard be defined?

(a) The Search for the GPO Standard

One could argue that midwives should be held to the same standard of care as GPOs, as midwives play the role that GPOs did before the reforms: a *gatekeeper* role of detecting abnormalities or complications and referring the expectant mother to a specialist when required. Midwives are paid the same as (if not more than) GPOs per birth. Having undertaken the same role and pay as GPOs, they should be held to the same standard.¹⁷⁵

However, measuring a midwife against a GPO LMC when the latter is rare is somewhat artificial and produces practical difficulties in finding an expert witness. GPOs also have different practice scope and experience.¹⁷⁶

Furthermore, imposing the same standard would be hugely unfair on midwives due to their lower education and training standards. In New Zealand, a GPO LMC must achieve admission to medical school (which is notoriously competitive), undertake a six-year degree, spend at least two years working in a hospital, complete the three-year General Practice Education Programme to specialise in general practice,¹⁷⁷ then obtain the one year full time (or four-year part time) Postgraduate Diploma in Obstetrics and Medical Gynaecology.¹⁷⁸ This totals a minimum of 12 years to qualify. In contrast, a midwife undertakes a three-year degree before she can practice as an autonomous LMC upon graduation and registration.¹⁷⁹ A midwife must have attended just 40 (previously 20) births as a student and spent some of the final year of study working with an assigned LMC midwife.¹⁸⁰ The small number of births attended means that there is a high probability she will

175 This leans towards the *reasonable patient* view, which Godbold and McCallin suggest is more appropriate for determining standard of care than the traditional *reasonable practitioner* view discussed above. Godbold and McCallin, above n 86, at 134. A reasonable patient might expect the same standard of care from practitioners who do the same job. This approach might be appropriate for assessing sufficiency or quality of information. See, for example, *Rogers v Whitaker* [1992] HCA 58, (1992) 175 CLR 479; and *Montgomery v Lanarkshire Health Board* [2015] UKSC 11, [2015] AC 1430. However, it would be too practically difficult to implement for questions of diagnosis and treatment, and could lead to unrealistic expectations of health practitioners.

176 For example, a GPO can detect, diagnose and treat certain non-maternity related issues, whereas a midwife is only trained in maternity-related issues.

177 The Royal New Zealand College of General Practitioners “Become a GP: Entry requirements and fees” <www.rnzcgp.org.nz>.

178 “Primary Maternity Services Notice 2007”, above n 16, at 1108–1109. Study duration is based on the University of Auckland programme: The University of Auckland “Programmes: Postgraduate Diploma in Obstetrics and Medical Gynaecology (PGDipObstMedGyn)” <www.auckland.ac.nz>.

179 Though total education hours equate to four years education. NZCOM “Where to Start ... Becoming a Midwife” (2017) <www.midwife.org.nz>; NZCOM “Midwifery First Year of Practice” (2017) <www.midwife.org.nz>; and NZCOM “Regulation” (2017) <www.midwife.org.nz>.

180 NZCOM “Fact Sheet 1: Education of New Zealand Midwives” <www.midwife.org.nz> at 2.

encounter a common complication or abnormality in her autonomous practice that she did not encounter as a student midwife.¹⁸¹ Furthermore, midwifery training largely focuses on the *normal* birth. NZCOM believes focusing on the normal will allow a midwife to recognise the abnormal,¹⁸² despite many Commissioner opinions finding that midwives had wrongly assumed abnormal symptoms to be normal.¹⁸³

In light of coroner recommendations, NZCOM made its first-year midwifery programme compulsory.¹⁸⁴ In this programme the graduate midwife can access support from more experienced midwives and attend various training and education sessions.¹⁸⁵ However, this programme can be completed while the midwife is already providing autonomous LMC services. The more experienced midwives act merely as mentors, whom the graduate midwife sees for a total of 16 hours throughout the year.¹⁸⁶ Thus, the midwife does not work under direct supervision, but, effectively, decides on the extent of her own expertise.

Demanding a GPO standard of care from midwives is unworkable due to the lack of GPOs. It is also unfair due to the difference in training and qualification. An alternative is to demand a unified “reasonably competent” LMC standard.

(b) The Reasonably Competent LMC

One option for a unified standard of care is to define the acceptable standard as that of a “reasonably competent” LMC — whether the practitioner is a GPO or midwife.¹⁸⁷ This is an upfront way for the state to guarantee women a minimum acceptable standard of care despite the lack of choice between midwife and GPO.

181 For example, take the relatively common diagnosis Intrauterine Growth Restriction (IUGR), where foetal growth is restricted. Foetal growth restriction caused over eight per cent of foetal deaths in New Zealand from 2011–2015. *PMMRC Mortality Report*, above n 8, at 97. It occurs in about one in 20 pregnancies. Diagnosis depends on accurate measurements during early pregnancy. See David Peleg, Colleen M Kennedy and Stephen K Hunter “Intrauterine Growth Restriction: Identification and Management” (1998) 58 *Am Fam Physician* 453 at 454. Assuming the student encounters 40 early-stage pregnancies during study, which is likely an overestimation, there is a nearly 13 per cent chance that she will not encounter an IUGR diagnosis ($0.95^{40} = 0.1285$), equating to over one in eight student midwives. But there is a 99 per cent chance that an LMC midwife will encounter a client with IUGR in her first two years of practice (assuming 50 clients per year: $0.95^{100} = 0.006$).

182 NZCOM “Where to Start ... Becoming a Midwife”, above n 179.

183 See, for example, *Registered Midwife, Ms A*, above n 114.

184 See *Barlow*, above n 166, at Recommendation III(d); and “Ministry statement on Nathan inquest recommendations — comments attributable to Dr Don Mackie, Chief Medical Officer, Ministry of Health”.

185 NZCOM “Midwifery First Year of Practice”, above n 179.

186 *1/B53: Midwifery First Year of Practice Programme Interim Specification* (Ministry of Health, January 2009) at 18. This is a minimum number, consisting of eight two-hour sessions. Additional mentoring sessions are also required. These do not have to be in person, bringing total mentoring hours to 32.

187 Graham Rossiter “Cross-disciplinary Standards in Health Services” [2000] NZLJ 193 at 194 recommends something similar. Contrast *Pearse*, above n 107. *Pearse* responds to and argues against Rossiter’s views.

Establishing this unified standard would be difficult. If reasonably competent LMCs were called as expert witnesses, the standard would revert to a midwifery standard of care as most LMCs are midwives. One could argue that New Zealand effectively already has a unified LMC standard, with the current midwives' standard of care being the minimum standard of care guaranteed by the government. But this presumes that the current midwifery standard of care is acceptable — a debatable issue, as seen above. Moreover, such a standard of care would *lower* GPO standards to accord with the midwife's standard of care, rather than raising the midwife's standard of care — defeating the purpose of any reform.

An alternative way to establish an LMC standard of care is to increase dependence on guidelines. Under negligence law, guidelines do not bind the court, though they may be given considerable weight depending on their issuer and uptake in practice.¹⁸⁸ In New Zealand, however, guidelines may be legally binding, as right 4(2) of the Code of Patient Rights requires services compliant “with legal, professional, ethical, and other relevant standards”. Guidelines can be a good alternative to relying on expert witnesses.¹⁸⁹ Both the Tribunal and the Commissioner rely heavily on guidelines and will sometimes favour the standard set by the guidelines over expert testimony.¹⁹⁰

Yet guidelines have disadvantages. If they are not legally binding and are merely safe harbours, expert witnesses will still be required to determine breach. On the other hand, to render guidelines legally binding would be impractical and undesirable. Guidelines have been criticised as limiting professional autonomy.¹⁹¹ Currency is also an issue.¹⁹² Constant updating would result in uncertainty, but infrequent updates and outdated research could mean enforcing a suboptimal standard of care. Finally, there is little consensus on what an “evidence-based” guideline entails¹⁹³ and there are many grey areas that evidence-based medicine does not cover.¹⁹⁴

Increased dependence on guidelines also raises political questions of who determines their content and which guidelines have more weight.¹⁹⁵ Midwives' and doctors' differing views of pregnancy mean that their respective organisations will likely diverge on some issues. This divergence was illustrated in the coroner report *Barlow*, where the coroner favoured the expert obstetrician's advice over the expert midwife's advice as to how rigorously a midwife should follow the guidelines concerning referrals to specialists.¹⁹⁶ The obstetrician thought the guidelines should be followed

188 See Joanna Manning “Determining Breach of the Standard of Care” in Peter Skegg and Ron Paterson (eds) *Health Law in New Zealand* (Thomson Reuters, Wellington, 2015) 135 at 163–168.

189 Manning, above n 188, at 163–165.

190 See, for example, *Registered Midwife, Ms A*, above n 114, at [147]–[151] and [155].

191 Maxwell J Mehlman “Professional Power and the Standard of Care in Medicine” (2012) 44 *Ariz St LJ* 1165 at 1218.

192 James Tibballs “Clinical practice guidelines in the witness box: Can they replace the medical expert?” (2007) 14 *JLM* 479 at 486.

193 Mehlman, above n 191, at 1216.

194 Tibballs, above n 192, at 484.

195 At 489–490.

196 *Barlow*, above n 166, at Coroner's Comments, [II] and Recommendation [II]–[III].

rigorously, while the midwife felt they should not be complied with where there is “good reason ... to base ... clinical judgment”.¹⁹⁷ NZCOM criticised the coroner’s recommendations as lacking “universal understanding of the roles and responsibilities of the tertiary service” and argued that the guideline issues were more complex than the report presented.¹⁹⁸

Finally, the current framework aims to allow women the choice between subscribing to a *normalised* or *medicalised* view of birth. Prescribing guidelines that only follow one view would conflict with this objective.

Thus, establishing a unified LMC standard of care is impractical and undesirable. Are there, then, other ways to raise the midwife standard of care?

2 *Bolitho Saves the Day?*

One way to raise the midwife’s standard of care is for decision-makers to increase their currently sparing use of *Bolitho* and be more prepared to reject expert (midwife) testimony as illogical. After all, the *Bolam* test has been criticised as overly close to self-regulation, leading to a self-serving test.¹⁹⁹ As discussed above, both the Commissioner and the Tribunal have rejected expert evidence in the past.

But this is an unsatisfactory solution. First, the court is not medically trained. The *Bolam* principle’s survival is due to the court’s respect for other professions. *Bolitho* cautioned that “[t]he assessment of medical risks and benefits is a matter of clinical judgment” which the judge cannot normally make without expert evidence.²⁰⁰ Secondly, *Bolitho*’s usefulness on questions of clinical judgment may be limited to instances of particular decisions to act or omit to act. The case gave the example of decisions involving a risk-benefit analysis of treatment to the patient and coming to a “defensible conclusion”.²⁰¹ *Bolitho* is, therefore, less useful for questions of interpretation or diagnosis, where skill and experience come into play, and logic is not part of the decision. For example, cardiocography scans can be difficult to interpret, leading to many cases of failure to detect foetal distress.²⁰² In such situations, the court is not well-placed to criticise an

197 *Barlow*, above n 166, at Coroner’s Comments, [II].

198 *NZCOM Response*, above n 170, at [V]–[VI]. This is contrary to the Midwifery Council’s view, which, in 2015, stated that it “is strongly of the view that all midwives must practise within the Referral Guidelines and will hold midwives accountable if they do not”. Midwifery Council of New Zealand “Media Statement” (media statement, 29 January 2015).

199 Godbold and McCallin, above n 86, at 132–133.

200 *Bolitho*, above n 111, at 243.

201 At 242. For example, in *Lake* the logic behind the decision of whether to perform a caesarean in light of the woman’s condition was dissected by looking at the statistics of adverse outcome if a caesarean was performed versus if it was not performed. *Lake*, above n 119. Similarly in *Reynolds v North Tyneside Health Authority* the negligence calculus was employed to assess the logical basis behind the decision of whether or not to perform a vaginal examination. *Reynolds v North Tyneside Health Authority* [2002] Lloyd’s Rep Med 459 (QB) at [41]–[49].

202 See, for example, *Registered Midwife, Ms A*, above n 114, at [44]–[52]. See also *Midwife, Ms C*, above n 152; and *Midwife, Ms B: Midwife, Ms C: Midwife, Ms D: Obstetric Registrar, Dr E: A*

expert's testimony of whether the practitioner's failure was one that a reasonably competent practitioner would have done too.

3 Follow the Leader — But Who Leads?

The solutions proposed above involve the law playing a role in increasing the standard of care. In other words, the solutions involve the law *leading* the increase in the standard of care. But the above solutions were also shown to be impractical or unworkable.

There are other reasons why using the law to lead the standard of care is unsatisfactory. First, it is very much an ambulance at the bottom of the cliff approach. A certain number of adverse outcomes must occur before the case law can be developed. This is undesirable in a healthcare context where lives are at stake.

Secondly, it is a very ad hoc approach to raising the standard of care. The law depends on cases coming before decision makers, but many factors affect whether this happens or not. Complaints are the primary cause of cases coming before the Commissioner or the Tribunal — something correlated to treatment outcome and whether those involved in an incident are willing to make complaints. Furthermore, the HDCA provides for alternative dispute resolution procedures, which, if successful, may mean no investigation.²⁰³ Even where a case *does* come before the Commissioner or the Tribunal, the outcome can be highly fact dependent.

Thirdly, Commissioner or Tribunal decisions do not bind subsequent decisions. HDCA processes are designed to facilitate “speedy” resolution of complaints,²⁰⁴ meaning they are not necessarily the best arena for robust discussions on setting the standard of care. While Tribunal decisions can be appealed to higher courts, very few Tribunal cases concern the standard of care,²⁰⁵ and appeals tend to occur only where stakes are high.

Finally, it is questionable whether individual decisions will affect general industry practice. Commissioner opinions do not directly affect the legal rights and responsibilities of practitioners found in breach of patient rights.²⁰⁶ Negligence cases seldom reach the Tribunal.²⁰⁷ Common recommendations require the practitioner to attend further or supplementary training — improving only the individual's skill and knowledge, rather than the industry as a whole. The fact that common themes — such as failure to monitor or detect complications — still occur suggests that Commissioner and Tribunal decisions are not completely effective in upholding midwifery standards.²⁰⁸

District Health Board (Health and Disability Commissioner, Opinion 09HDC01592, 31 January 2012). Both cases involved an incorrect cardiotocography assessment.

203 See HDCA, ss 33–38 and 61.

204 HDCA, s 6.

205 Manning, above n 102, at 940–941.

206 See *Stubbs v The Health and Disability Commissioner* HC Wellington CIV-2009-485-2146, 8 February 2010 at [35].

207 Manning, above n 102, at 940–941.

208 Though one could argue that each case is fact dependent.

While the Commissioner and Tribunal are useful for maintaining professional standards, they should not be used to *increase* professional standards. Beating practitioners with a stick is not the way to teach them the standard of care at which they should be practising.

4 An Alternative Path: the Law Follows

Standards should not be raised by focusing on individuals and their failures. It is difficult to imagine situations where midwives are not trying their hardest to achieve the best outcomes for their clients. Adverse events leading to disability or death are tragedies not only for the family involved, but also for the health practitioners. Commissioner and Tribunal investigations greatly affect practitioners and threaten their confidence and willingness to continue their profession. And given New Zealand's maternity carer shortage,²⁰⁹ such situations are not ideal.

Instead, the entire system should be evaluated. The system should be changed to ensure a universal rise in standards — and the law should *follow* accordingly. If midwifery industry standards expect more from midwives, the “reasonably competent” midwife's standard will be higher and midwives, accordingly, will be held to a higher standard. This would be a fence at the top of the cliff approach with a preventative, rather than punitive, function.

Such an approach can be achieved by increasing midwifery education requirements. NZCOM maintains that New Zealand midwifery education delivers a “world class service” and is “a model of excellence internationally ... meet[ing] the standards outlined by the International Confederation of Midwives”.²¹⁰ But New Zealand does not necessarily have a “world class” system in the sense that its framework is comparable with other nations. New Zealand places more responsibility on midwives than most other countries, and, therefore, one would want New Zealand's midwives to receive education commensurate with that increased responsibility.

The main driver between the different standards of care expected from a midwife and GPO is the difference in education and experience. Of course, one reason for GPOs' lengthier training is to cover a wide variety of medical conditions before specialising in general practice and obstetrics. Midwives specialise immediately in maternity care. But this does not mean that additional training or experience would not be useful before practising autonomously. The first few years of any doctor's professional life involves working in a hospital under the supervision of more experienced practitioners. Requiring midwives to undergo something similar would ensure they attend more pregnancies and births before making autonomous decisions. The Commissioner once criticised a DHB for its culture of junior

209 “Midwife shortage ‘heading for crisis level’” (22 March 2017) *Radio New Zealand* <www.radionz.co.nz/national>.

210 NZCOM “Schools of Midwifery claim midwifery education world class” (press release, 5 October 2016).

doctors deciding on their own extent of expertise.²¹¹ Yet that is exactly what New Zealand’s maternity system expects from graduate LMC midwives, despite their lower education requirements (compared with junior doctors).

The coroner has previously recommended that midwives should not be allowed to practice autonomously in their first year of practice. Rather, a newly graduated midwife should practice in a supported environment, such as a “12-months’ hospital-based internship scheme ... or some alternative supervisory programme post-graduation”.²¹² NZCOM rejected these recommendations as “inappropriate, unsustainable and unnecessary”, arguing that they would lead to the “de-skilling” of graduate midwives.²¹³ With respect, it is difficult to see how such a scheme would lead to *de-skilling*. Surely it would lead to *up-skilling*, by allowing midwives more hands-on experience and the opportunity to learn on the job from more experienced midwives. In any case, one would expect a lower rate of adverse maternity outcomes because women would be cared for by more experienced LMC midwives.²¹⁴

While such a solution would not raise the midwife’s standard of care to equal a GPO, it would reduce the gap. Women would be confident that they were in the hands of a skilled and experienced practitioner, even if their LMC was a newly qualified midwife. The higher education requirements would also elevate the public perception of the midwifery profession. The current framework assumes LMC midwives to be quasi-doctors solely responsible for detecting concerns and taking the correct action. This responsibility is not currently reflected in their education requirements or — as NZCOM is currently arguing — their pay. Raising both will raise New Zealand’s perception of midwives as a more prestigious and important profession. This in turn will raise the standard of care expected from them, which will, hopefully, continue to improve New Zealand’s maternity outcomes.

V CONCLUSION

New Zealand’s maternity framework was developed to provide a choice between a midwife and GPO for maternity care. Each has their advantages: midwives supposedly offer lower intervention and higher satisfaction rates,

211 *Obstetric Registrar, Dr B*, above n 158, at [137]–[142].

212 Wilson, above n 171.

213 Wilson, above n 171.

214 Beverley Lawton and others “A retrospective cohort study of the association between midwifery experience and perinatal mortality” (2016) 132 *International Journal of Gynecology and Obstetrics* 94 at 96. The authors found that LMC midwives with under one year of experience had 33 per cent higher odds of perinatal mortality than those with five to nine years of experience. However, there was no evidence supporting a difference between perinatal mortality rates for midwives of different experience levels. As a result, no conclusions can be robustly drawn from this study. The study has been dismissed as problematic. See Karen Guilliland, Lesley Dixon and Claire MacDonald “The association between midwifery experience and perinatal mortality” (2016) 133 *International Journal of Gynecology and Obstetrics* 251.

and generally subscribe to a normalised view of birth. GPOs offer more extensive training, knowledge and medical experience, and generally subscribe to a medicalised view of birth. Different standards of care are, accordingly, imposed on the different types of providers. But with the exit of GPOs from maternity care, the reality is an absence of choice. The expectant mother must take the only readily available option: a midwife. With this lack of choice, the theory behind the different standards of care breaks down.

This article examined various ways to mitigate this choice contradiction. The framework can be altered to reintroduce choice by making GPOs a viable option for expectant mothers. Alternatively, the standard of care for midwives could be altered to be more comparable with that required of GPOs. A unified standard of care was considered and dismissed as too practically difficult to implement. Decreasing dependence on expert evidence is also problematic.

Finally, this article suggested raising midwifery education requirements. This would generally increase the skill and experience of LMC midwives, as well as public confidence in the midwifery profession. Midwives play a vital role in New Zealand's maternity system and take on more responsibility than their international counterparts. Their education system, pay and public perception should reflect this.

While funding is a dominant factor in every public policy decision, funding decisions should be made sufficiently transparent to allow public debate about the quality of New Zealand's maternity services and allocation of funds. A midwife-led model very possibly offers outcomes that are comparable with — or even better than — medical-led models. But the choice contradiction still exists. In resolving this contradiction, policymakers should aim to continually improve New Zealand's maternity outcomes.