# Law and ethics: a midwifery dilemma

Toni Martin

ORIGINAL

**Health care professionals are required by health care regulators to rationally and analytically resolve ethical dilemmas involving the people they encounter, putting the interests of those people first, respecting their decisions and upholding their rights. This can be a challenging task as many situations are complex and require professionals to provide care in an objective and compassionate manner regardless of their own views. Midwives and allied health professionals are directed by the Nursing and Midwifery Council's *The Code: professional standards of practice and behaviour for nurses and midwives* (NMC 2015) and as always, the best interests of the person they are caring for are paramount.**

## Scenario:

Laura who has schizophrenia, is 30 weeks' pregnant, and is refusing medication and treatment. Her partner is concerned and contacts the midwife to help him and Laura.

The scenario allows me to critically explore and evaluate the legal, ethical and professional implications arising from the issues. Within the paper I shall critically analyse the differing judgments within related case law, outlining different approaches, exploring the validity of alternative options, and appraising relevant literature to support my argument. Ethical theory linked to the scenario will be applied to explore the role of professionals and their accountability and responsibility for ensuring that Laura's needs are fully met within the constraints of the situation. I will conclude by stating my view of the most appropriate course of action as a professional, justifying it by the debates made throughout the essay (box opposite).

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## Exploring the scenario

The issues arising from the scenario include:

- Laura, a schizophrenic, is no longer taking medication that may be impacting on her responses, leading to physical aggression.
- She is 30 weeks' pregnant and her partner is concerned that she may be in premature labour. Laura may not be aware of, or influenced by this possible diagnosis. Either way treatment would be recommended to exclude delivery at home of a seriously premature baby.
- Laura is refusing care although she is accepting of the midwife's attendance. Her capacity and competence to make decisions may be compromised and requires exploration to ensure care is appropriate to the situation. It should not be assumed that Laura's capacity is diminished solely because of her mental health issues, as mental health patients do not always have diminished cognitive function.
- Laura's decision-making ability to allow consent is linked to capacity. Although Laura's ultimate decision may appear unwise, refusal to give consent is an autonomous act and if she has capacity, her wishes should be respected. Professionals should be mindful of possible coercion or persuasion by her partner, motivated by concern for her and their baby.
- The rights of the unborn fetus, which do not exist in law until the baby is born, will be examined in respect of the potential criminal liability of the mother to the child and whether the fetus has rights under Article 2 of the *Human Rights Act 1998*.
- The professional's role in providing care for Laura and her baby, reassuring her partner and providing ethical advice, mindful of legal principles, is firstly governed by the fact that the midwife cannot, in law, refuse to attend a woman in childbirth. The option to not respond, hoping that this will provoke attendance at hospital where there is considerably more support, including legal advice, is not an option and determines the midwife's ethical practice.

## Ethical practice

Though not always consciously aware, we make judgments daily about what is 'good' or 'bad'. The terms are subjective and their meaning derived from values that guide our lives, termed 'directional signals' by Thompson (2004:175) or a 'moral order' by Torres & De Vries (2009:14). Thompson discussed a 'values lens' that forms our view of situations and advises midwives working with women to understand how this can affect how they interact with, and provide care for women (Thompson 2004:175). Ogston-Tuck (2014) asserts that being ethical requires the professional to first be aware of the existence of a moral or ethical situation. Thompson described how medical ethics arose from the need to protect vulnerable patients from paternalistic codes of behaviour, focused more on the duties of doctors to each other than their obligation to patients (Thompson 2004). Principlism, a method of ethical problem solving outlined by Beauchamp and Childress (2009), guides professionals in practising ethically, ensuring that the rights of childbearing women are respected by professionals with the over-riding principle of care based on the obligation to see those rights maintained (Torres & De Vries 2009). Mason & Laurie (2013) maintain that ethics is not simply about discovering what is right, as that is simplistic and subjective. Instead they describe how professionals can justify a course of action utilising principles to assist in their decision making. The NMC Code requires professionals to always put the patient first, providing safe effective care whilst promoting trust and professionalism (NMC 2015).

## Consent and capacity

The right to choose a course of action is safeguarded by the principle of autonomy (Taylor 2013) and protected in policy and law *(Re C (Adult: refusal of treatment)* [1994], *Mental Capacity Act 2005* (MCA 2005), Department of Health (DH) 2009). For the health care professional to avoid a claim of battery, it is essential that adults, who are judged to be competent, be afforded the opportunity to provide valid consent before proceeding with medical interventions. Consent can render physical contact lawful whereby a patient's consent makes touching legally permitted (Mason & Laurie 2013). One's motive for the professional touching, ie if the act is designed to help the person, is irrelevant if the patient does not consent. Consent must therefore be voluntary, free from coercion or undue influence as upheld in *Re T (Adult: refusal of medical treatment)* [1992]. The judgment held that T's mother had pressurised and influenced her, so her decision had not been made independently. The Court of Appeal (CA) found that her mental capacity was impaired due to injuries and medication and that she had not been provided with sufficient information to make an informed decision. The CA upheld her right of self-determination but considered there was serious doubt about the legitimacy of her decision, due to the factors that influenced that decision. The Court emphasised professionals' duty of care to check the validity of decisions made and ensure that patients have mental capacity and are not unduly influenced.

This would be a consideration in Laura's case where her partner's anxiety and 'value lens' may create pressure for her to accept treatment that she does not want. The principle of self-determination was explored in *Airedale NHS Trust v Bland* [1993]:846, which decreed that '*the sanctity of human life must yield to the principles of self determination*', whereby it is against the law to force treatment even if the outcome was death. This however, is subject to exclusions in that the person making the decision must have the capacity to do so (Taylor 2013), though it is generally accepted in law that adult patients have decision-making capacity, unless evidence shows otherwise (MCA 2005). A decision made with full capacity must be respected even if it appears unwise or irrational. Where capacity is questioned, Section 2 of the MCA (2005) provides guidance for professionals. The legislation is quite unequivocal in stating that lack of capacity cannot be established by reference to:

'*(a) a person's age or appearance, or (b) a condition of his, or an aspect of his behaviour, which might lead others to make unjustified assumptions about his capacity*' (MCA 2005:s2).

Having certain medical disorders, including mental illness, should not lead to a presumption of incapacity (Simpson 2011). Furthermore, Lamont *et al* (2013) claim that the concepts that determine whether an individual is capable of making informed choices regarding health issues are 'capacity' and 'competence'. Though interchangeable the terms have different meanings. Capacity is a health outcome decided by health care professionals referring to a specific decision as opposed to the legal outcome of competence, determined by judges.

The test for capacity was set out in *Re C (Adult: refusal of treatment)* [1994] and formed the basis for the capacity test in the MCA (2005). In *Re C*, a case with similarities to Laura's, C, a schizophrenic, was refusing amputation of his leg. The judgment was that although he had serious mental illness, he had the required level of competence, therefore capacity, to make an informed decision. The subsequent test outlined in Section 3 of the MCA (2005:S3(1)) tests the individual's decision to understand, retain, weigh-up or balance the information and communicate the decision by whatever means he can. The MCA sets out the principles, which ensure protection of vulnerable patients, including preventing professionals proceeding with treatment of a patient without consent '*merely because he makes an unwise decision*' (MCA 2005:1).

Testing Laura's capacity can be undertaken by any registered health care professional though not all have expertise in this matter (Simpson 2011) and every effort should be made to communicate effectively in familiar surroundings. O'Brien (2010) suggests that clinicians should attempt to reach the same decision as a court would in the same situation. Awareness of intermittent states of capacity, known in law as a 'lucid interval', is important and the professional should ensure that consent, if given, is provided during a lucid interval for it to be valid. Awareness of the ability of a patient to have the capacity to make some decisions and not others in a given situation is also vital. Clear recording of the assessment is key to ensure an accurate representation of the conversation and ensuing treatment plan.

Babbitt *et al* (2014) outline the difficulty for clinicians when caring for women with major mental health problems, especially when presenting in labour, agitated or psychotic, where there is limited decision-making time. Laura's assessment should distinguish between disordered cognitive function and long-standing personal beliefs whilst taking into account the effect of labour pain on her. In *Re T (Adult: refusal of treatment)* [1992] 4 All ER 649 at 665, Lord Donaldson acknowledged that capacity might be absent as a result of the '*effects of fatigue, shock, pain or drugs*' being used in treatment. Assessment of Laura would have to determine if the effect of pain and agitation linked to labour or schizophrenia affected her ability to retain and understand the information relevant to a specific decision. Section 3(3) of the MCA (2005) clearly states '*the fact that a person is able to retain the information relevant to a decision for a short period of time only does not prevent him from being regarded as able to make the decision*' (MCA 2005:s3(3)).

Laura may be able to decide on some aspects of her care and not others and this is determined by examination of her capacity. Professionals' knowledge of mental illness is important to prevent the assumption of equating acceptance of treatment with capacity, whilst refusal means a lack of capacity (O'Brien 2010). Amer (2013) states that although patients with schizophrenia have a greater link with incapacity than those with serious depression, judgment of competence is specific to the particular decision about treatment and the schizophrenic patient with paranoid delusions may be capable of deciding treatment for a different medical condition. In contrast, Epright (2010) argues that patients with affective disorders such as schizophrenia are not capable of exercising informed refusal, specifically because of their lack of insight into the impact of their disorders. Epright (2010) claimed that psychotic diseases negatively impacted on the areas of the brain necessary for rational thought and that coercion of treatment in the short term would ultimately be in the best interests of the patient. Epright (2010) justified this paternalistic approach stating that the inherent lack of insight meant that the patient could not act autonomously to choose to withhold treatment. Furthermore, Epright (2010) argued for withholding all future decision making because even if not psychotic now, likely future psychotic episodes would render the patient incapable and put others at risk.

This view clearly places the patient outside the decision-making process by advocating removal of the option to refuse treatment. The lack of recognition of patient autonomy is in line with the original concept within the Hippocratic Oath, which asserts that medical practitioners should provide whatever treatment is required for the benefit of the patient using their professional judgment. This is termed a '*warrant for paternalism*' by Lamont *et al* (2013:702). Managing this dissonance is part of a professional's role and negotiating a clear, patient-centred focus is part of personal and professional accountability required of all health care practitioners.

## Best interests and decision making

The significant difference between refusal to accept treatment and an inability to make a decision is capacity. Should Laura be found to have capacity to balance information and make a decision, even if that is felt to be unwise by the professionals, then her choice should be accepted. This can be challenging for professionals when faced with a decision as in *St George's Healthcare NHS Trust v S; R v Collins, ex parte S* [1998]. In this case, S, a pregnant woman refusing to accept urgent delivery, was operated on under compulsion, and later held under the Court of Appeal that the judge had been given inadequate or misleading information. Although S had offered no resistance to the obstetric team, consent could not be presumed simply due to a lack of physical struggle. The judgment was that:

'*A pregnant woman's right not to be forced to an invasion of her body against her will, whether her own life or that of her unborn child depended on it, was not reduced or diminished merely because her exercise of that right might appear to be morally repugnant*' (*St George's Healthcare v S* [1998] 44 BMLR 160 at 162).

If she is unable to fulfill the test outlined in the MCA (2005), then a decision taking her best interests into account should be facilitated. In the case *Norfolk and Norwich Healthcare NHS Trust v W* [1997], where a patient arrived in labour, denying she was pregnant and refusing delivery, the judgment was that though she was not found to be suffering from a mental disorder, she was incapable of balancing the information and therefore lacked sufficient mental competence to make a decision. Termination of her pregnancy by delivery was considered to be in her best interests.

If the patient is unable or incapable of decision making, best interests should take into account what the patient's previous views were, as long as the professional focuses on the patient's interests not the doctor's wishes (Kelly 2011). The DH (2009) guidance suggests that it is good practice to involve those closest to the patient to establish previously held views and beliefs, unless the patient has clearly said she does not want those people involved (Simpson 2011). Using the *Bolam v Friern Hospital Management Committee* test [1957], the clinician is the primary decision maker for non-competent patients but Laura's partner would be a resource for outlining what her wishes were earlier in the pregnancy should she be found to be incapable of making a decision. It is important to recognise that he may also be conflicted by concern for the unborn baby and may have clouded judgment in this matter. The rights of the unborn child do not take precedent in law over the rights of the mother.

## Rights of the unborn child

Article 2 of the European Convention states that '*Everyone's right to life shall be protected by law*' (HRA 1998). The only proviso to this relates to execution of a sentence following conviction sanctioned in law. The right to life does not extend to the unborn child in the UK as the fetus is not regarded as a legal entity and any action could only be brought after birth (Dimond 2013). Dimond (2013) raises the question of whether the mother's actions in pregnancy, which might bring harm to the fetus, could constitute a criminal act. Nonetheless, Dimond (2013) concludes that it is unlikely unless her actions can be brought within the *Offences Against the Person Act 1861* or the *Infant Life (Preservation) Act 1929* whilst acknowledging that it would be difficult to determine the required criminal intent to proceed to a prosecution. *St George's Healthcare NHS Trust v S* [1998] 44 BMLR 160 at 181 made it very clear that:

'*While pregnancy increased the personal responsibilities of a woman, it did not extinguish her entitlement to decide whether or not to undergo medical treatment: an unborn child was not a separate person from its mother*'.

Delivery of the baby under compulsion was considered to be '*an infringement of S's autonomy, for which the perceived needs of the foetus could not provide the necessary justification*' (*St Georges Healthcare NHS Trust v S* [1998] 44 BMLR 160 at 181).

In their judgment their Lordships referred to *Re S (Adult: refusal of treatment)* [1992] where it was ruled that delivery of the baby could not be expedited to save the woman's and her unborn baby's life, even though this was contrary to her beliefs. Sir Stephen Brown held that the procedure was in the '*vital interests of the patient and her unborn child*' (*Re S (Adult: refusal of treatment)* [1992] 4 All ER 671 at 672). This judgment was later overturned and led to considerable professional debate and the production of guidance from the Royal College of Obstetricians and Gynaecologists Ethics Committee (RCOG 2006) supporting the stance that overruling the refusal of treatment by a competent woman is inappropriate even if it places her, and her unborn child's life at risk.

The rights, or lack, of the fetus, was further clarified in *Re MB (Adult: medical treatment)* [1997], which stipulated that:

'*a competent woman who has the capacity to decide may, for religious reasons, other reasons, or for no reasons at all, chose not to have medical intervention, even though, as we have stated, the consequence may be death or serious handicap of the child she bears or her own death*' (*Re MB (Adult: medical treatment)* [1997]:60).

The judgment held that the court does not have the power to protect the interests of the unborn baby even just prior to its birth. This is reflected in the *Congenital Disabilities (Civil Liability) Act 1976*, stating that action is given to the child only if born alive, for harm caused by negligence to the mother. The mother is not liable to the child, with the exception of driving a motor vehicle and in breach of duty of care. Laura's unborn child, therefore, has no legal weight but its potential life will be part of the discussions between Laura and the professionals. It is essential, despite the conflict the professional may feel in this situation, that unbiased, clear information is provided and that emotion does not allow paternalism to emerge if Laura is found to have capacity but refuses treatment.

## Refusal to consent

Under UK law, an adult with competence has an irrefutable right to refuse any medical intervention, reflecting the legal standing of respecting a person's right to determine what happens to her body (Bingham 2012). Conflict and ethical dilemmas arise when the refusal appears to place life or health in danger and is complicated further when an unborn baby is involved. The rights of the unborn baby do not overrule the right of the woman to refuse treatment if capacity is in place. In *Re MB (Adult: medical treatment)* [1997] MB contested the validity of the decision to overrule her refusal of treatment due to lack of capacity from severe needle phobia. The Court held that a pregnant woman has a similar entitlement for respect of her wishes as anyone else and a person with capacity cannot be forced to endure treatment against her will, without risk of prosecution. A further point made was when faced with refusal of consent that:

'*doctors should consider whether at that time he had the capacity which is commensurate with the*

*gravity of the decision which he purported to make. The more serious the decision, the greater the capacity required'* (*Re MB (Adult: medical treatment)* [1997]:18).

In *Ms B v An NHS Hospital Trust* [2002], B was declared mentally competent but the physicians refused to comply with her wishes to refuse treatment. The judgment was that:

*'Unless the gravity of the illness has affected the patient's capacity, a seriously disabled patient has the same rights as the fit person to respect personal autonomy. There is a serious danger, exemplified in this case, of a benevolent paternalism which does not embrace recognition of the personal autonomy of the severely disabled patient'* (*Ms B v An NHS Hospital* [2002]:94).

In *Re MB (Adult: medical treatment)* [1997] and in *St George's Healthcare NHS Trust v S* [1998] it was clear that the use of mental health legislation for detention in order to pursue non-mental health treatment was inappropriate and unlawful. This action would also be unethical when benchmarked against the requirement to act in the best interest of patients lacking capacity. Failing to accept a competent patient's wishes, as in Ms B, was also considered unlawful. Doctors had acted lawfully in overriding MB's refusal of treatment, in her belief that her irrational fear clouded her judgment, temporarily affecting capacity. Bingham (2012) considered this to be an example of justifiable paternalism but warned of the danger of unethical practice of professionals overriding a competent patient's decision, based on their own personal beliefs. This is reiterated in the NMC Code (2015).

## Accountability and advocacy

Griffith (2011) describes accountability as having its basis in law due to the formal relationship between midwives and the regulatory body or employer that holds them to account. Being accountable requires one to be answerable for all care provided or not and to understand when to seek help when practising outside one's sphere of competence or knowledge. The basis of decision making in medical practice is founded on the belief that individuals are autonomous and that health care professionals' practice should reflect the principles of respect for autonomy, beneficence, non-maleficence and justice (MacLellan 2014). This approach should dissuade giving information influenced by one's personal beliefs or values and reflects the standard expected of professionals within the NMC Code (2015).

The expectation is that professionals understand the nature of advocacy and accountability so they can recognise the risk of power imbalance between the patient and the caregiver and provide dignified respectful care. The case law described earlier provides additional assistance in complex, ethically challenging situations but not all professionals realise their practice breaches ethical principles leading to a disregard for patient autonomy and unethical, paternalistic practice. Midwives cannot refuse to attend a childbearing woman and to do so in this circumstance would be unethical, breaching ethical and regulatory standards.

Laura's case is complex and to ensure it is appropriately managed, placing her at the centre of her care, additional support is available for the midwife and should be requested. Her capacity to make decisions should be tested using the steps set out in the MCA (2005). A midwife is capable of doing this but should access support. Should capacity be absent, a decision taking her best interests, past beliefs and views into account should be made, accessing information from her partner. This may require recourse to mental health professionals to assess whether detention for assessment under s2 of the *Mental Health Act 1983* is necessary if admission is required and refused by Laura. Ultimately, though the fetus is a factor in this instance, it has no rights in law and Laura's care takes priority. Should Laura have capacity and be capable of making decisions, even if it involves the refusal of care, the midwife should respect that decision and provide what support she can, accessing support necessary to preserve safety. Clear and accurate record keeping is vital in this situation to demonstrate professional accountability (DH 2009, NMC 2015).

## Conclusion

Professionals faced with ethical dilemmas in care are rarely prepared for them and the understanding and knowledge of ethical frameworks as well as the relevant law will guide their actions and responses. Understanding the principles behind upholding the right to self-determination whilst protecting vulnerable patients is fundamental to compassionate, ethical practice. The relevant law and the MCA (2005) safeguards patients but it is the ethical enactment of those guiding principles by professionals that ensures that patient autonomy remains central to the care provided.

*Toni Martin, Lead Midwife for Education, Programme Leader-Midwifery, University of Worcester.*

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