Care provided to a high risk patient during labour (12HDC00846, 17 April 2014)

Obstetrician ~ District health board ~ Respect ~ Communication ~ Clinical decision making ~ Labour and delivery ~ Rights 1(1), 4(1), 4(5), 6(1)(a)

In 2011 a woman, aged 46 years, was pregnant with her fourth child. She had an uncomplicated pregnancy. When the woman was 37+5 weeks' gestation she experienced a spontaneous rupture of membranes and went into hospital. A decision was made to await spontaneous onset of labour. Syntocinon was commenced two days later because of the woman's failure to progress into spontaneous labour.

The hospital midwife caring for the woman noted a series of decelerations on the cardiotocograph (CTG). The clinical charge midwife was called after each deceleration which were initially managed by change of position. A deceleration that was slow to recover was then noted and a fetal scalp electrode attached. Following a further deceleration the on-call obstetrician was called.

Following an assessment, the obstetrician decided to obtain a fetal blood sample to establish the fetal condition, but opted to await the arrival of the obstetric registrar to collect the sample. The woman said that the obstetrician did not explain the assessment or his proposed management plan, and the assessment was distressing due to the obstetrician's manner.

When the registrar arrived she reviewed the CTG trace and noted that the woman was experiencing pain between contractions. The registrar asked the obstetrician if she could call for an emergency Caesarean section. However, the obstetrician requested that fetal blood sampling be done first. The fetal blood sample showed severe acidosis and the obstetrician decided to proceed with a Caesarean section. The baby was born pale and unresponsive. Resuscitation attempts were unsuccessful. A concealed placental abruption was diagnosed.

It was held that the obstetrician failed to provide services with reasonable care and skill by failing to respond appropriately to the abnormalities on the CTG, and by delaying the emergency Caesarean section. Accordingly, the obstetrician breached Right 4(1). In addition, the obstetrician's manner was unprofessional and he failed to treat the woman with respect, breaching Right 1(1).

For failing to heed the concerns raised by his colleague, the obstetrician breached Right 4(5), and for failing to inform the woman fully about her condition and his management plan, he was found to have breached Right 6(1)(a).

The obstetrician was referred to the Director of Proceedings in accordance with section 45(2)(f) of the Health and Disability Commissioner Act 1994 for the purpose of deciding whether any proceedings should be taken.

The obstetrician's failure to proceed with an urgent Caesarean section when severe fetal compromise became apparent was an individual clinical error and could not be attributed to any systemic deficiencies at the district health board.

Adverse comment was made about the adequacy of the care provided by the clinical charge midwife and her responses to the changes on the CTG.

Consideration was given as to whether the midwives and the registrar should have taken any further steps to raise their concerns about the obstetrician's decision to obtain a fetal blood

sample and delay the Caesarean section. It was concluded that their actions taken to voice their concerns were reasonable in the circumstances.

The Director brought disciplinary proceedings against the obstetrician in the Health Practitioners Disciplinary Tribunal which resulted in a finding of professional misconduct. The obstetrician appealed the Tribunal's finding of professional misconduct in the High Court. The High Court dismissed the obstetrician’s appeal and upheld the Tribunal's decision. The Director did not take HRRT proceedings against the obstetrician.