Management of ventouse-assisted birth (06HDC12769, 6 August 2008)

Obstetrician ~ Gynaecologist ~ Vaginal delivery ~ Ventouse ~ Avulsion of umbilical cord ~ Registration ~ Recruitment ~ Malpractice claims ~ Reference checks ~ Medical council ~ Scope of practice ~ Induction ~ Labour ~ Misleading clinical records ~ Pain relief ~ Transfer of care ~ Informed Consent ~ Supervision ~ Bullying ~ Rights 1(1), 4(1), 4(2), 6(1), 7(1)

A woman complained about the care provided by an obstetrician and gynaecologist (the obstetrician) at Southland Hospital. The woman attempted a normal vaginal delivery, but it did not progress as expected and assistance was sought from the obstetric registrar. The registrar made two unsuccessful attempts to perform a ventouse-assisted delivery then called for the assistance of the on-call obstetric consultant.

Witnesses to the events reported that the obstetrician treated the woman in a disrespectful manner and did not fully explain the delivery options available to her. He initially advised the registrar to make preparations for a Caesarean section but then decided to attempt another ventouse-assisted delivery.

The obstetrician delivered the baby's head in one contraction, and passed responsibility for the rest of the delivery to the midwife. The umbilical cord was around the baby's neck and the midwife attempted to lift it over her head without success. According to the midwife, the obstetrician then intervened and attempted to manually lift it over the baby's head, causing avulsion (tearing) of the cord at the point where it joined the baby. In contrast, the obstetrician reported that the force of the woman's next push caused the avulsion of the cord.

After the baby was delivered, the bleeding from her torn umbilicus was controlled, and she was transferred to the neonatal unit. The obstetrician delegated the repair of the woman's vaginal lacerations (tears) to the midwife, but they were beyond her scope of practice to repair. The obstetrician subsequently repaired the lacerations under general anaesthetic.

The baby received paediatric care in the neonatal unit but her condition deteriorated. Clinicians suspected a subgaleal haemorrhage and she was transferred to a larger hospital by helicopter. Despite intensive care the baby died shortly afterwards.

It was held that the obstetrician failed to provide obstetric care of an appropriate standard; failed to provide adequate information about the available delivery options; failed to obtain the woman's informed consent to the third attempt at ventouse-assisted delivery; pressured other providers to make false entries in the clinical notes; made his own misleading entries in the clinical notes; and failed to discuss the adverse event with the woman. These failings amounted to breaches of Rights 1(1), 4(1), 4(2), 6(1), and 7(1).

It was also held that Southland DHB took appropriate care in the recruitment and supervision of the obstetrician, and therefore was not liable for his actions, and did not breach the Code.

The obstetrician was referred to the Director of Proceedings.The Director decided to lay a charge before the Health Practitioners Disciplinary Tribunal. The Tribunal concluded that none of the particulars were established, and the charge was dismissed.

Link to HPDT decision: http://www.hpdt.org.nz/portals/0/med08107ddecdp070web.pdf