Care and information provided to woman with a high risk pregnancy
16HDC00719, 17 December 2018

Obstetrician/gynaecologist ~ District health board ~ Referral ~ Cervical shortening Premature labour ~ Viability ~ Rights 6(1), 4(1)

A woman in her thirties was in her fourth pregnancy when an ultrasound scan identified a shortened cervical length and mild funnelling. The report recommended a specialist review. The woman's midwife made an electronic referral, and on the advice of the Senior Medical Officer, requested that the grading midwife direct the referral to the Obstetric and Gynaecological Ultrasound Service (OGUS). The referral was not reviewed until five days later, as referrals to OGUS are not triaged over the weekend or on public holidays.

The woman was asked to attend OGUS for an ultrasound scan. She assumed that it was a routine scan, as the midwife had not informed her about the cervical shortening and the fact that a referral had been made.

The report for the additional ultrasound stated that the cervix was 3.6cm long and dilated approximately 1.2cm throughout its length, and that the external os was the only closed portion. The woman was admitted to hospital for a rescue cerclage.

Approximately three weeks later, the woman was reviewed by an obstetric registrar. The registrar recorded an intention to review the woman at 35 weeks' gestation to discuss removal of the suture at 36 or 37 weeks' gestation, but there is no documentation of any discussion about what would occur if she gave birth before the baby was viable or at borderline viability.

At 23+0 weeks' gestation, the woman presented to the public hospital with contraction-like pain and yellow discharge. The woman was also tachycardic and had moderately elevated C-reactive protein levels, suggestive of infection. An obstetrician reviewed the woman and advised that she should be given medication to suppress labour, that the suture might need to be removed, and that steroids should be withheld. The obstetrician told HDC that he understood steroids to be contraindicated in the presence of significant infection, as in the woman's case.

The obstetrician said that he explained to the woman that her management would include antibiotics, pain relief, intravenous fluids, blood and urine tests to ascertain the site of infection, and listening to the fetal heart rate intermittently. He also told her that at 23 weeks' gestation babies do not survive, and that should she deliver her baby, the baby would not resuscitated by the neonatal team. He said that the woman and her husband did not ask any questions about resuscitation, and he thought that they understood and agreed with the management plan.

At 8.43am the suture was removed, and at 2.17pm a neonatal paediatrician discussed with the woman the outcome for the baby if he was delivered that day. The paediatrician told HDC that he informed the woman and her husband that active treatment was an option. However, the woman was in an advanced stage of labour, and he said that he could not engage them in conversation.

At 3.13pm, the woman had a normal vaginal delivery of a live male baby weighing 715g. The woman stated that her baby lived for approximately five hours but was not reviewed by a doctor until after his death.

Findings

It was found that the obstetrician failed to advise the woman of the option of active intervention and the associated risks, which was information that a reasonable consumer in the woman's circumstances would expect to receive. Accordingly, the obstetrician breached Right 6(1).

Adverse comment was made about the obstetrician's failure to involve neonatal services in his discussion with the woman and her partner.

It was found that the nine days that elapsed between the midwife's referral and the cerclage was not consistent with accepted standards of service delivery. By failing to assess and treat the woman in a timely manner, the district health board (DHB) breached Right 4(1).

Adverse comment was made about the absence of detailed documentation about the conversations that occurred after the rescue cerclage and at the specialist obstetric appointment, regarding the possibility of preterm labour. Comment was made about recent developments in the care of premature babies, including the detailed analysis undertaken by the Perinatal and Maternal Mortality Review Committee (PMMRC) in its 12th Annual Report.

Recommendations

It was recommended that the DHB provide additional training to relevant staff on its guideline on the management of pregnancies at borderline viability, and advise how it will act on the PMMRC's recommendation that lead maternity carers and DHBs employ strategies to reduce preterm birth by targeting identified high-risk groups. It was also recommended that the DHB make available to parents and whānau appropriate information and counselling about birth outcomes prior to 25 weeks' gestation. Further, the DHB was asked to apologise to the family.

It was recommended that the obstetrician provide a written apology to the woman for his breach of the Code, and support the DHB in reporting back to HDC on developments in the availability of appropriate information and counselling about birth outcomes prior to 25 weeks' gestation.