General Practitioner, Dr B

Opinion – Case 99HDC12423

Complaint

The Commissioner received the following complaint from the consumer, Miss A:

- *On 5 March 1997 the general practitioner, Dr B, attended the consumer, Miss A, at the public hospital when she gave birth to her first child. Miss A became exhausted and distressed and requested a caesarean section, but Dr B said that it would not be necessary.*
- *Dr B refused to hand care over to the hospital's Professorial Unit when the midwife asked him to.*
- *Dr B antagonised Mr E, the baby's father, which caused him to leave the delivery suite, so Miss A lost her support person.*
- *Dr B did not give Miss A adequate pain relief before commencing a high forceps delivery.*
- *Dr B pulled on the baby with the forceps while Miss A was not having contractions, and he did not stop when asked to. Miss A was injured during this delivery. Her tailbone was fractured, stomach muscles torn, and there was a large tear between her anus and vagina. She subsequently suffered several infections.*

Investigation Process

The complaint was received on 17 November 1999 and an investigation commenced on 13 January 2000.

Information was received from:

Miss A	Consumer
Dr B	Provider / General Practitioner
Ms C	Midwife
Ms D	Midwife
The public hospital	

Advice was obtained from an independent general practitioner. Relevant medical and ACC records were also reviewed.

General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Information Gathered During Investigation

Background
In 1996, 17 year old Miss A became pregnant. Dr B, general practitioner, and Ms C, midwife, provided shared care to her during her pregnancy.

Dr B advised me that he obtained a Diploma in Obstetrics in 1971, which followed three months' experience as a house surgeon and six months as a senior house officer. At that time Dr B was the only house surgeon at the public hospital for nine months and therefore gained considerable experience, including many forceps deliveries, occasionally alone if the consultant was busy. He has been in general practice continuously since 1973 and has performed up to 100 deliveries each year. He ceased practising obstetrics at the end of 1998.

Dr B stated that Miss A saw him when she was four weeks pregnant, with her partner, Mr E, who wanted the pregnancy to be terminated. Miss A refused. She had had a previous termination. Dr B reported that Miss A had a normal pregnancy except for an admission to the public hospital at 26 weeks, with tightenings.

Labour
Miss A went to the public hospital on 4 March 1997 with irregular contractions but was sent home to wait for established labour. Early on the morning of 5 March 1997 Miss A went into labour.

Miss A was admitted to the delivery suite at the public hospital, at 2:45am on 5 March 1997. As well as Mr E and Miss A's mother, midwife, Ms C, was present along with student midwife, Ms D.

At 4:00am Miss A requested more pain relief than the nitrous oxide gas she had been receiving since 3:00am. Ms C performed a vaginal examination and found Miss A to be 3cms dilated and the presenting part of the baby to be at station 0. (This means that the head was level with the ischial spines in the maternal pelvis.) Ms C gave Miss A 100mgs of Pethidine at 4:15am which had a good effect and she stated that Miss A laboured well. At 4:30am it was recorded in the Labour Summary that Miss A was feeling relaxed and sleepy and was trying to rest through the contractions.

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Information Gathered During Investigation *continued*

By 5:00am contractions were stronger and longer, and at 5:45am it was recorded in the Labour Summary that Miss A was feeling pain and pressure and was becoming distressed again. At 6:20am she got into the spa pool.

Miss A explained to me that the first stage of her labour progressed well until she got into the spa pool and found that she could not sit properly. Miss A stated that this was because her baby's head was facing upwards. Miss A stated that this was known before she went into labour but it was hoped that the baby would turn itself. She explained that Ms C had told her and her mother this during her pregnancy. Ms C advised me, however, that the first that they knew of the baby's position being occipito posterior rather than occipito anterior was when the child was delivered.

A baby would be expected usually to present in the occipito anterior position (OA) for delivery (the occiput is the back of the head). This means that the baby is head-down, facing the mother's spine. If, however, the baby is in an occipito posterior position (OP) it faces the mother's abdomen and its spine is towards the mother's spine. With an OP presentation a larger part of the baby's head, the back, presents to be born first. With an OP presentation the labour may take longer, and there is an increased likelihood of maternal injury and that the delivery may require assistance.

It is recorded that at 6:45am Miss A was feeling a lot of pressure and another vaginal examination by Ms C found her to be 8cms dilated, station 0. At this point Ms C artificially ruptured Miss A's membranes and found "*thick meconium liquor*", although the CTG (cardiotocograph) showed the baby's heartbeat to be satisfactory. Ms C then notified Miss A's general practitioner, Dr B, who arrived at the hospital at 7:25am. The Labour Summary records:

> "*0645 Feeling pushy. VE* [vaginal examination] *as over. Copious meconium liquor.* [Dr B] *notified.*
> *0655 Paed*[iatrician] *notified of need for his presence at delivery. FH* [foetal heartrate] *145 ↓ 110 with contractions.*"

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Information Gathered During Investigation *continued*

Although Miss A felt more comfortable after her membranes had been ruptured, she began to feel pressure again by 7:50am. At 8:05am Ms C performed another vaginal examination, which showed Miss A to be almost fully dilated (9.5cm) but with a small rim of cervix anteriorly.

Miss A said that after pushing for a while from 7:45am, she was exhausted and distressed, and requested a caesarean section which Dr B refused. Miss A stated that Dr B told her a caesarean section was unnecessary, but he did not explain further.

Dr B stated that at 9:00am he examined Miss A again and found she was fully dilated, the baby was station 0 and position OA. Dr B confirmed that Miss A demanded a caesarean section, and that he explained to her that a caesarean was impracticable as she was by that time fully dilated. Dr B explained to me that he then tried to comply with her demands to expedite the delivery.

Delivery

Dr B decided to deliver Miss A's baby using forceps. Miss A stated that Dr B explained to her that her baby was blocked, its head was like a plug and that a natural birth was no longer possible. He was therefore going to try a forceps delivery during which he would pull on the baby while Miss A had a contraction and pushed.

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Information Gathered During Investigation *continued*

Miss A said that instead of waiting for a contraction Dr B just pulled on her baby. Miss A said that he cut her and ripped her; she was screaming but he did not respond to her requests for him to stop. She said that Dr B did not explain to her why he would not stop pulling or why he pulled when she was not having a contraction:

> "[Dr B] *wanted to talk to me to discuss the forceps delivery. He clearly stated that when I had a contraction I would be pushing when he pulled. From what I can gather he did not give me the right pain relief, or the right amount of pain relief to numb the area for the forceps delivery (*[Ms C] *told me this). My whole bottom half started shaking when they had me in the stirrups and I was begging for someone to help me.* [Dr B] *took no notice of me, or my mother, or the midwives crying and straight away started pulling the baby out. I screamed at him stating I wasn't having a contraction and he just kept pulling. The midwife also screamed at him that I wasn't having a contraction and asked him to stop but he kept pulling her – or ripping her as I would put it – out of me.*"

Dr B stated that he did not pull on the forceps when there was no contraction as that is not his practice. He commented that it is sometimes difficult to detect contractions when there is other discomfort. At 9:24am a healthy baby girl was delivered, and the Labour Summary recorded that at 9:28am the placenta and membranes were delivered complete. The baby's Apgar score was 9/10 at one minute and 10/10 at five minutes. It was noted that there was a forceps graze on the baby's cheek.

The Delivery Summary incorrectly recorded that Miss A was fully dilated at 7:45am. The first stage of Miss A's labour was therefore recorded as having lasted for three hours and 45 minutes, and the second stage for two hours and nine minutes.

With regard to the forceps delivery Ms C stated that she had not worked with Dr B before and assumed he would consult with the Professorial Unit before attempting the delivery. She suggested this and Dr B refused, advising her that this delivery was within his expertise.

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Information Gathered During Investigation *continued*

In a letter dated 21 March 1997 to the Obstetrics and Gynaecology Department at the public hospital Ms C noted the following. (She did not identify either Miss A or Dr B in this letter.)

> "[Miss A] *had been more comfortable after the ARM* [artificial rupture of membranes] *but by 0750hrs was again feeling pressure. An examination by me found her to be almost fully dilated – a small rim of cervix only anteriorly. She used some gas to get through the next contractions but then was unable to resist the strong urge to push.* [Dr B] *was happy to let her do so but after 45 minutes of strong pushing there was no visible sign of the baby, no anal pouting and no vaginal gaping.*
>
> [Miss A] *was by now very distressed and tired, requesting a caesarean to end it all.*
>
> [Dr B] *wished to re-examine her (which further distressed her) to check that she was indeed fully dilated. He confirmed full dilation and found the presentation to be OA* [occipito anterior] *and still station 0. He suggested a pudendal block and forceps delivery. The CTG continued to be satisfactory.*
>
> *Having not worked with this particular GP before I assumed he would consult with the Prof Unit and relayed this to the patient and her mother but he insisted that he did not need to consult and was quite able to do this delivery himself. I was still unsure about the appropriateness of this given the great distress of the young lady and her reservations about the doctor so I asked a member of the core staff to relay the information to the senior midwife ... who sent back word that she believed this GP to be very experienced. At this stage I also asked for assistance from the core staff ....*

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General Practitioner, Dr B

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Information Gathered During Investigation *continued*

I must concede that [Dr B] *did indeed manage to apply the forceps easily and with moderate difficulty deliver the baby (girl) via episiotomy and laceration face to pubes! I do however have some concern over the large amount of local anaesthetic used (at least 85mls) which still did not give very effective analgesia for the procedure, the fact that* [Dr B] *applied traction to the forceps when* [Miss A] *did not have a contraction and also that the baby was surprisingly delivered face to pubes. Baby was in good health apart from a small forceps scratch on the face.*"

Ms C has subsequently advised me that she cannot be 100% certain that Dr B pulled on the forceps when Miss A was not having a contraction. She had the impression that this is what occurred but said that Miss A was being very vocal at this time and the whole situation was very emotional. She did however state that Dr B did not respond to Miss A's repeated requests to stop the forceps delivery. Ms C also confirmed that it was not known that the baby was an occipito posterior presentation rather than occipito anterior, until it was delivered face to pubes. Dr B did a vaginal examination just before commencing the forceps delivery, and concluded that the baby was around the right way (OA).

Dr B wrote to ACC on 12 November 1999:

"*My notes 'no progress in second stage, very uptight demanding a caesarean section, PV station 0, fully dilated OA. Pudendal block Kobak needle Lignocaine 1% 32mls, 10mls to perineum. Easy application of forceps, moderate pull. Face to pubes, placenta complete, episiotomy repaired 2/0 vicryl'. ...*

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General Practitioner, Dr B

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Information Gathered During Investigation *continued*

I did not refuse her a caesarean section as a caesarean section was inappropriate with her being fully dilated and having had a short labour. I tried to explain this to her but she would not listen so at one stage I may have told her to shut up and listen. The midwife was one I had not worked with before and she thought that I needed the [Professorial] *Unit when I stated* [Miss A] *needed a forceps delivery, she did not realise I was capable of doing it myself. Her inappropriate concerns did not help the patient's confidence. It was a Neville Barnes forceps delivery with easy application to the head mid cavity. I did ask for Haig Ferguson forceps which are still in current use, but the midwife didn't know what they were, hence the remark about the old fashioned forceps.*

[Miss A's] *claim that no analgesia was given is untrue (see above), also* [Miss A's] *claim that it was a high forceps which means the head is not engaged. I always only pull on the forceps when there is a contraction, her claim that I ripped her baby out is untrue.* [Miss A's] *statement about tearing her abdominal muscle is also untrue. I presume she has some divarication of her rectus abdominis.*

It is obviously unfortunate that she had an unpleasant experience. I feel that given better analgesia eg by epidural, the forceps would have been more comfortable. Also her perineal repair could have been in retrospect better. It would have been difficult to organise an epidural as we would have had to wait, as 8:00am is when anaesthetists come on duty and there is always a wait."

Miss A subsequently clarified that she had meant that the analgesia had not been effective, not that it had not been given.

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Information Gathered During Investigation *continued*

Dr B subsequently advised me that:

> "*Whilst there was a less than optimal result to the delivery I let myself be encouraged to expedite the delivery at* [Miss A's] *request. Her request needs to be seen in the light of her personality, her lack of attendance at antenatal classes and lack of preparation for birth. It is noted in my records she did not attend antenatal classes.*"

The public hospital advised me that anaesthetic support generally took between five and 15 minutes to be provided, and that neither Dr B nor Ms C requested an epidural for Miss A on this occasion. At the time Miss A's labour was progressing a registrar would have been on the maternity unit and therefore immediately available to assist. An on-call registrar had been available at five minutes' notice during the night (11:00pm to 7:00am).

Dr B explained that:

> "*In spite of what you have been told by hospital management epidurals are difficult to get at* [the public hospital] *at that time of day. As one shift of anaesthetists finish at 8:00am it is often difficult to get their services promptly as they have other commitments at that time. One is encouraged to wait for the next shift ....*
>
> *For management to suggest that an anaesthetist could be available in as little as 5 minutes is to point to a protocol as if it were proof of what actually exists. In reality the actual response time at that time of day is a far cry from the protocol. This should be taken into account when looking at my decision to do a pudendal block rather than wait for an anaesthetist to do an epidural*."

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General Practitioner, Dr B

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Information Gathered During Investigation *continued*

I was given conflicting information about the amount of pain relief administered to Miss A. Dr B stated Lignocaine 1%, 32mls as a pudendal block and 10mls to the perineum (a total of 42mls); Ms C stated that at least 85mls of local anaesthetic were given; and the Abnormal Delivery Summary recorded 100mls of Lignocaine as a pudendal block.

Loss of support person
Student midwife, Ms D, who was also present that morning, described the events as follows:

> "*I was called out at 1:30am on the 5 March 1997 and arrived in* [the public hospital] *in time to greet* [Miss A] *and her whanau.* [Miss A] *was in first stage labour when she arrived in an ambulance.* [Miss A] *laboured well. In second stage labour and after pushing for a length of time* [Miss A] *became tired.* [Dr B] *arrived when* [Miss A] *was pushing.* [Miss A] *continued pushing.*
>
> [Dr B] *prepared to conduct an episiotomy followed by a forcep intervention to deliver* [Miss A's] *baby.* [Miss A] *became extremely anxious as* [Dr B] *was gathering equipment and pleaded that he leave her alone. I felt that* [Dr B] *was insensitive to* [Miss A's] *plea.* [Miss A] *was full of fear and literally crawled backwards up the bed as* [Dr B] *approached her.* [Miss A] *begged me to help her and asked me to stop* [Dr B] *from doing anything to her. I felt utterly helpless and shall never forget this experience.* [Miss A's] *mother and boyfriend* [Mr E] *were noticeably shaken by the impending procedure and* [Miss A's] *boyfriend threatened to assault* [Dr B]. [Ms C] *and I were shocked by the attitude, behaviour and conduct of* [Dr B] *towards* [Miss A]."

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General Practitioner, Dr B

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Information Gathered During Investigation *continued*

Ms D later explained to me that Mr E was very upset with Dr B because he saw Dr B was hurting his girlfriend and it was obvious that Miss A was scared of Dr B. Ms D stated that in a way typical of a teenage boy Mr E threatened Dr B, telling him to back off and leave Miss A alone. Dr B pushed Mr E out of the way with a hand on his chest and a comment like "*step aside son*". At this point Mr E attempted to punch Dr B so Ms D took Mr E outside the room where he punched the wall and cried as he was upset at having no control over this situation.

Miss A advised me:

> "*The father of the baby was right beside me but* [Dr B] *asked him to move. I said no because I wanted him there, and this ended in the father of the baby leaving the delivery room as* [Dr B] *nudged him out of the way and this almost caused a punch up ending in the baby's father storming out and refusing to come back in, and so I lost my support.*"

With regard to Mr E leaving the room, Dr B advised me:

> "*I asked* [Mr E] *to move out of the way as he was leaning over* [Miss A] *and I was unable to adequately examine her abdomen. He reacted strongly to this, I think he may have tried to punch me and he left the theatre. ... I feel that her mother who was present was a more appropriate support person.*
>
> [Miss A] *had 32mls of Lignocaine 1% as a pudendal block and 10mls in the perineum. Obviously an epidural would have been preferable but this takes time to organise and work. As* [Miss A] *was in some distress I felt it was best to do a forceps under pudendal block. ... I did not pull on the forceps without a contraction as I do not do this. It is sometimes difficult to detect contractions when there is other discomfort. ...*

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General Practitioner, Dr B

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Information Gathered During Investigation *continued*

One of her concerns seems to be I damaged her abdominal wall with the forceps. The forceps was a mid cavity (head station 0) moderate pull, the midwife recorded this as difficult this was not so, an easy application delivered face to pubes. There is no way this would have damaged her abdominal wall."

Post natal care and problems
Medical records note visits from Dr B to Miss A in hospital on 6, 8 and 10 March, and telephone consultations with hospital staff on 6 and 7 March.

Dr B stated that puerperal care was difficult as Miss A refused to let him examine her to ascertain damage and carry out any further repair.

Miss A was referred to an obstetrician and gynaecologist, Dr F, in September 1997. Dr F summarised his examination findings as follows:

"*On examination the perineum was intact although there was some distortion presumably related to her forceps delivery, episiotomy and vaginal tear in March 1997.*

There is some laxity of the posterior vaginal wall but no evidence of a fistula. The anal sphincter tone appeared to be normal. There is no incontinence of urine, flatus or faeces. There was fairly marked tenderness along the line of the episiotomy scar."

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Information Gathered During Investigation *continued*

Miss A described her postnatal problems as follows:

"*Not only did I suffer a traumatic birth, I still had a lot of pain and suffering ahead of me. My problems had only just begun. While I was in hospital it became apparent that I had fractured my tailbone, during the birth. I was unable to go to the toilet so required a catheter. I then began to get many infections from here on in. I was unable to sit for many weeks suffering a lot of pain and many sleepless nights. The pain was ... to the point where my mother had to look after myself and my baby. I was not coping with the delivery and later found out that* [Dr B] *not only was inappropriate but requested forceps which were outdated, one of my midwives also heard him tell me to shut up when I was in agony, begging for help.*

A year later I was referred to do physio due to lack of muscle tone and having many problems with the water works. It was then that I was informed that my stomach muscle had split in half and there was nothing that I could do to fix the look of my stomach. I then received a second opinion from my new doctor (I never went back to [Dr B] *after the birth)* […] [who] *referred me to a Consultant Surgeon .... However at this point I had become pregnant .... Due to the pregnancy, the unsightly stretch marks and the gap between the abdominal appeared not to be that bad and in* [the consultant surgeon's] *opinion it did not require surgery. Due to this I left his office one very upset person. ...*

After the birth of my second child I began to see [Professor G] *where I then required surgery because I had a deficient posterior perineum with significant dyspareunia. On the 14/09/99 I was admitted into hospital for the surgery of the reconstruction of the external anal sphincter. Since then I am now recovering but have suffered more than expected, it has come to* [Professor G's] *attention that I may still need a vaginal repair which can not be done until next year when everything is healed from the surgery which I have just had done.*

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Information Gathered During Investigation *continued*

I feel that I should not have had to go through any of these problems which I have had to face since the birth of my first child. ... I feel that [Dr B] *should have listened to my midwives and let the prof unit take over, that way I would have received the adequate pain relief or even caesarean section. Which if any of these had ... been done, I would not have suffered this severely and not be confronted with requiring surgery. I feel that* [Dr B] *is the cause of why my stomach muscle has split in half, and therefore need surgery. However this is the surgery which needs to be done, but I consider it to be a repair rather than cosmetic surgery. I am not in the financial position to pay for this type of surgery that needs to be done. I am now begging for help, for I have suffered enough. But worse of all, I have to live with the mental side of things, having to live with the birth for the rest of my life, which to this day still haunts me and still spend many nights crying myself to sleep. ...*"

Ms C described Miss A's postnatal problems as follows:

"*Following this delivery* [Miss A] *was extremely uncomfortable for five days, requiring intramuscular Pethidine as well as Voltaren and Panadol. She appears to have a fractured coccyx and was unable to pass urine until five days postpartum, requiring a catheter. Her lochia* [vaginal discharge for several days following childbirth] *became offensive and the Postnatal staff had to ask* [Dr B] *to come and see his patient in order for him to prescribe antibiotics.*

After discharge from [the public hospital] *on day six this young woman was very distressed to find herself incontinent of urine whenever she had a bath and feeling as though she was not able to empty her bladder properly.*

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General Practitioner, Dr B

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Information Gathered During Investigation *continued*

Nine days after delivery her lochia remained offensive and she was still very uncomfortable. [Miss A] *refused to let me contact* [Dr B] *so I arranged a consult with a female obstetrician who prescribed a further course of antibiotics for infected sutures and reassured* [Miss A] *that her body would probably eventually recover but it would take time.*

Two weeks postpartum [Miss A] *was readmitted to the Postnatal Ward following a* [postpartum haemorrhage] *at home. Ultrasound showed two small pockets of ? retained products. At this time she was cared for by the Prof Unit. She has been continued on antibiotics and discharged after the bleeding settled.*

This young woman is petrified at the thought of ever being pregnant again and very distressed at her recent experience. It is not helping her to be positive about motherhood in what is already a stressful situation."

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Information Gathered During Investigation *continued*

ACC

ACC accepted Miss A's claim for medical misadventure as a medical mishap, an adverse consequence of treatment properly given. The cover acceptance letter to Miss A dated 31 July 2000 states the following:

"*Mishap*

Although perineal trauma often occurs in childbirth, and often where delivery by forceps has been undertaken, the adverse consequences in some cases are less likely than in others. In your particular case the injury occurred in 1997. Since that time you have experienced a range of problems, including urinary incontinence, persistent vaginal discharge, pain during intercourse, passing of air from the vagina and bowel problems. Physically, you are described, by [Professor G]*, as having been left with a very narrow perineal body between the anus and vagina – so narrow that there were only millimetres separating both openings. In addition, a fistula was noted to have formed between the anal and vaginal canals. The anal sphincter was also damaged and required surgical repair.*

These findings would appear to explain a great many of your ongoing problems, as listed earlier. Such complex damage would occur in less than 1% of cases where delivery by forceps had been performed, following managed OP labour and would therefore be considered as rare.

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General Practitioner, Dr B

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Information Gathered During Investigation *continued*

From the report by [Professor G] *dated 24/02/00, it is evident that many problems still persist, despite some repair surgery having already been undertaken. He mentions that you still have difficulty evacuating your bowel, you still have urinary incontinence and that he expects you will require vaginal repair sometime in the near future. ... For the reasons given, your claim can be accepted as medical mishap. However, it should be noted that this decision does not cover your divarication of the rectus sheath, or separation of your stomach muscles, as this is a recognised effect of pregnancy and is not caused by the use of forceps or the failure to carry out a caesarean section rather than vaginal delivery.*

Error

... [I]t is clear you felt you should have been given a caesarean section at the time of the second stage of labour. However, ACC cannot find any evidence of negligence in the management of your labour.

Occipito-posterior presentations (face to pubes) are not always easily identifiable in labour, unless there are associated complications such as a latent first stage, delayed progress in labour, incoordinate contractions (where you contract too often and do not dilate) and poor descent of the baby's head. It is clear that you made very good progress in your labour, especially for a first time mother.

...

It is not possible to establish, from information available, that there was an element of the error in your labour management. There were no warning signs during the first stage that the baby was not in a good position, as progress was actually extremely good. The failure to proceed to caesarean section during the second stage was not negligent, as you were fully dilated and the head had descended sufficiently to allow for a forceps delivery.

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Information Gathered During Investigation *continued*

There is likely to have been a delay of some time if a caesarean section was to be arranged at this point and the chances are you would have progressed on to a vaginal delivery in that time anyway, or the baby could have become distressed.

In addition, there are many serious complications associated with caesarean section, as it remains that it is major abdominal surgery, therefore to undertake such a procedure where it was not necessary would be inappropriate.

For these reasons, ACC have been unable to make a finding of medical error in this case."

General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Independent Advice

The following advice was obtained from an independent general practitioner practising in obstetrics:

"*In my view a number of errors in judgement and management have compounded to create this very traumatic birth experience. These are summarised as follows:*

1 *Despite the baby being in an occipito-posterior (OP) position* [Miss A's] *labour progressed rapidly in the first stage. By full dilatation she was extremely distressed by the pain of the labour. She responded to this by imploring* [Dr B] *to get the baby out. This was early in the second stage (or pushing out phase) of labour, but before significant descent of the baby's head had occurred. This is often described as phase one of the second stage in which, although full dilatation has occurred, the powerful urges to push have not yet arisen as the baby's head is still too high. This is often an extremely uncomfortable part of the labour, particularly so when the baby is in a posterior position. The correct assessment of this situation is that in the absence of foetal distress (or an abnormally prolonged second stage) the best management is appropriate pain relief. This 'buys' time that allows either a normal vaginal delivery to occur, or at least further descent of the head, facilitating any other intervention. If delivery is not imminent or if instrumental delivery is a probability, then an epidural is a good option if this is acceptable to the patient. As there was no foetal distress or failure to progress, a caesarean section would have been inappropriate management at this stage in* [Miss A's] *labour. The error in management at this point therefore was not alleviating* [Miss A's] *distress by providing effective pain relief.*

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Independent Advice *continued*

2 An error seems to have occurred in assessing the duration of the second stage. While [Dr B] *contends that the second stage was of two hours' duration, the hospital notes show the progress of labour recorded by the midwife as follows:*

> *'8 centimetres dilated at 06:45am, 9 ½ centimetres dilated at 08:05am and fully dilated at 09:00 hours. Delivery occurred at 09:24am. The decision was made to effect delivery at 09:00 hours.'*

Full dilatation may have occurred some time before 09:00 so she probably had a second stage of, at most, just under one hour's duration. The average or normal duration of the second stage in a woman having her first baby without an epidural is about 1½ hours. Thus 1 hour is an abnormally short second stage in a primagravida, especially in the presence of a posterior position. If [Dr B] *was under the impression that 2 hours had elapsed in the second stage then this may have contributed to his decision that forceps delivery was the best course of action. Indeed if 2 hours had elapsed and there had been no progress, then depending upon the station and the position of the head a forceps delivery may have been a reasonable option.*

3 Obviously an error was made in assessing the position of the baby's head. This is a mistake even the most experienced practitioner can make. Depending upon the configuration of the foetal skull bones, the degree of flexion of the head and the effects of labour in moulding the foetal skull bones, accurate diagnosis of the position of the baby's head can be extremely difficult. The application of forceps however, necessitates extreme care in evaluating the position of the baby's head, and if there is any doubt in the absence of foetal distress, alternative management would be the preferred option. For example this might be to provide epidural analgesia and use syntocinon augmentation of the labour to encourage further descent of the head, and hopefully either a spontaneous delivery or at least a low forceps delivery.

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Independent Advice *continued*

4 *The station (or descent into the pelvis) was assessed by* [Dr B] *at 'station 0'. This means that the top of the baby's head had reached the level of the ischial spines in the maternal pelvis. A high forceps occurs when forceps are applied when the head is above this level. A mid cavity forceps occurs when forceps are applied when the head is between station 0 and 'plus 2', or 2 centimetres below the ischial spines. At this level the widest diameter of the foetal head (the bi-parietal diameter) has reached the mid-pelvis and difficulties with the delivery are less likely to occur. Thus the application of forceps in this case was at the upper range of what is acceptable for safe obstetric practice assuming the baby had been in an anterior or OA position. In my view it is only in rare circumstances of certain obstetric emergencies that it is appropriate for General Practitioner Obstetricians to perform forceps delivery when the head is at station 0. If specialist advice was available (as it was in this case) then an opinion should have been sought if it was felt that immediate delivery was in the best interests of either the mother or the baby.*

Unfortunately the baby was in a posterior position and this presents a wider antero-posterior diameter to the maternal pelvis making delivery considerably more difficult. Usually the head must rotate to an anterior position before vaginal delivery is possible. If the malposition had been recognised at the time it would normally require either:

(i) conservative management if there was no compelling reason for immediate delivery, eg foetal distress or a danger to the mother. This may include awaiting normal progress, or if there was some delay using Oxytocin to improve uterine contractions and encourage rotation.

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Independent Advice *continued*

(ii) specialist consultation if immediate delivery was necessary. A decision would be made between caesarean section and instrumental delivery depending upon the clinical assessment.

It was most unfortunate that [Dr B] *was unable to correctly diagnose the position of the baby's head because I believe this would have changed greatly the outcome of this case. If the baby had been OA, the delivery would have been less traumatic to* [Miss A] *and may have been uncomplicated postnatally. If* [Dr B] *had correctly identified the baby's position as OP I am sure he would have either ordered an epidural or sought specialist help.*

5 A mid-cavity forceps delivery usually requires an epidural to provide good analgesia. A pudendal nerve block is effective at numbing the skin of the perineum and is useful for a low forceps delivery. It would not usually be considered adequate for a mid-cavity forceps delivery unless an epidural was not available or the need for urgent delivery outweighed the advantages of waiting for adequate analgesia. Inadequate maternal pain relief would have added enormously to the patient's perception that the force used was excessive and obviously added immensely to the trauma of the birth experience. In the context of all this pain and distress it was probably difficult to identify exactly what did and did not occur with regard to pulling on the forceps with or between the contractions, and obviously there are conflicting accounts of this. I believe that inadequate provision of pain relief for a mid cavity forceps delivery was an error in management and I am unable to make a judgement on the issue of pulling on the forceps between contractions.

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Independent Advice ***continued***

6 After the decision to deliver by forceps had been made the OP position would have added considerably to the difficulty of the delivery, and therefore also to the potential trauma to maternal tissues. It is very difficult to say to what extent excessive force resulted in the subsequent trauma to the maternal tissues. It may well have been a contributing factor, however the delivery of a baby in good condition with no damage to the foetal head is reassuring that no excessive forces were applied, at least to the baby. Disruption of the anal sphincter is not in itself a result of mismanagement as it may occur (often undetected) in up to 24% of instrumental vaginal deliveries. Similarly urinary incontinence is more related to the size of the foetal head, OP position and the duration of the second stage than it is to forceps delivery. To my knowledge the separation of the abdominal wall (rectus) muscles is not a known complication of forceps delivery, and is just as likely to have occurred had the baby been born by caesarean section. Injury to the tailbone (coccyx) causing prolonged discomfort (coccydnia) may occur after a normal delivery but is more likely to occur after delivery of a baby in an OP position because of the wider antero-posterior diameter of the baby's head as it comes through the maternal pelvis.

7 Subsequent poor management of the perineal repair, and even worse neglect in the puerperium as it became complicated, added very significantly to the pain and distress this patient suffered, and continues to suffer. A rectal examination after the perineal repair to search for any small (buttonhole) extension into the rectum would have enabled early diagnosis of a situation that needed immediate and skilled repair. The severe pain [Miss A] *suffered postnatally necessitating not just anti-inflammatory medication but pethidine on several occasions was an early indication that all was not well with her perineum, and that infection and/or more extensive trauma was likely.*

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Independent Advice *continued*

8 It is unfortunate that throughout her lengthy and problematic puerperium [Miss A] *had no continuity of care from a caregiver who could have diagnosed and treated her perineal problems at an early stage. Despite early specialist referral by her new GP it was not until she was seen by* [Professor G] *2 years after her delivery that the extent of the defect in her perineal body was recognised, along with the realisation that she had indeed suffered a fourth degree tear and had a small recto-vaginal fistula associated with this. Serious inattention to her needs in the days, weeks and months after her birth have greatly amplified her trauma and thus the significance of the original errors of management.*

I support the patient's complaint of inadequate management but have the view that the problem was not a simple one of an ill advised forceps delivery, but rather a web of unfortunate and compounding problems, some excusable and some not.

In summary the errors in management are as follows:

1 Inadequate pain relief. The decision to effect delivery was based on maternal distress and instead of responding to this with management of the pain, [Dr B's] *decision to perform a forceps delivery with inadequate analgesia in fact created more maternal distress.*

2 Intervention occurred too early in what may otherwise have been a normal second stage of labour. Inaccurate information concerning the duration of the second stage of labour may have contributed this decision, but this showed poor attention to an important detail.

Continued on next page

General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Independent Advice ***continued***

3 Failure to diagnose correctly the position of the baby's head. This is a mistake that everybody involved in providing maternity care may make from time to time, but it is certainly not one that you wish to find out about after the application of forceps.

4 The forceps were applied at a stage when the descent of the baby's head was at the upper range of what is acceptable obstetric practice. Given that there was no foetal distress or maternal danger I believe that this was unacceptable practice for a General Practitioner Obstetrician.

5 Failure to diagnose the fourth degree tear.

6 Lack of continuity of skilled post-natal care when it was desperately needed. Infection and breakdown of the perineal wound occurred followed by ongoing problems of perineal pain, urinary symptoms and symptoms relating to the unrecognised buttonhole tear from the vagina into the rectum.

In this case a precipitous decision to relieve maternal distress by delivering the baby inadvertently created much more pain and distress for the patient. Failure to correctly diagnose the position of the baby's head contributed very significantly to the trauma that ensued. Finally there were complications of the delivery that were not treated post-natally and this greatly increased this woman's suffering. I suspect that with the choice of an epidural to provide effective pain relief for the forceps delivery, and skilled intervention at an early stage when [Miss A's] *perineal problems first became evident, the birth experience would have been quite different even if the same forceps delivery had taken place. The decision to perform a forceps delivery however carries with it the responsibility to manage these other aspects of care effectively.*

Continued on next page

General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Independent Advice *continued*

Although there may be mitigating factors for several of the points that I have itemised in my criticism of [Dr B's] *management, there is one point that is beyond dispute and about which I feel most strongly. In the absence of the need for immediate vaginal delivery on account of either maternal danger or foetal distress, continuing with the forceps delivery when* [Miss A] *was screaming with agony and begging for help showed unacceptable insensitivity and lack of concern for the patient's wellbeing. Using* [Miss A's] *words, the fact the birth experience 'still haunts me' and that she still 'cries herself to sleep' suggests that this birth experience was indeed sufficient to have induced some post-traumatic stress disorder. I am not a bit surprised that* [Miss A] *did not wish to continue under* [Dr B's] *care. It was however a very unfortunate consequence of this that she suffered serious inattention to her needs in the days, weeks and months following the birth.*

I conclude from my observations of this case that although [Dr B] *was obviously motivated to relieve* [Miss A's] *distress by delivering the baby, he did not exercise reasonable care and skill in managing her delivery.*"

General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights are applicable to this complaint:

RIGHT 4
Right to Services of an Appropriate Standard

1) Every consumer has the right to have services provided with reasonable care and skill.

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –
a) An explanation of his or her condition; and
b) An explanation of the options available ….

RIGHT 7
Right to Make an Informed Choice and Give Informed Consent

1) Services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent, except where any enactment, or the common law, or any other provision of this Code provides otherwise.

…

7) Every consumer has the right to refuse services and to withdraw consent to services.

RIGHT 8
Right to Support

Every consumer has the right to have one or more support persons of his or her choice present, except where safety may be compromised or another consumer's rights may be unreasonably infringed.

General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Other Relevant Standards

The public hospital advised me that the guidelines for the handover of care from an LMC to secondary or tertiary obstetrics which are referred to in Dr B' access agreement with the public hospital at the relevant time, were the Regional Health Authority Criteria for Referral to Obstetric and Specialist Related Medical Services (1993). Copies of this document are no longer available.

I have therefore consulted the following guidelines as indicative of the standard of care expected at that time.

The replacement guidelines are:

The Transitional Health Authority Maternity Project's Guidelines for Referral to Obstetric and Specialist Related Medical Services (July 1997)

…

Circumstances Where Guidelines May be Varied
The THA does not intend the guidelines to be restrictive to good clinical practice and therefore recognises that there are at least five ways in which there may be some flexibility in the use of these criteria:
…
3. It is also recognised that GP Lead Maternity Carers have developed skill and experience in particular areas, eg forceps. The criteria marked with an @ indicate that some Lead Maternity Carers may routinely use their discretion regarding referral when this is an area they have particular skill and experience and if necessary additional training.

…

Timing of Referrals
Referral to a specialist should occur as soon as a problem is suspected or identified.

Continued on next page

General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Other Relevant Standards *continued*

The Referral Process

…

These guidelines for referral define three levels of referral and consequent action.

1. The Lead Maternity Carer may recommend to the woman (or parents in the case of the baby) that a consultation with a specialist is warranted given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. The specialist will not automatically assume responsibility for ongoing care. This will depend on the clinical situation and the wishes of the individual woman.
2. The Lead Maternity Carer must recommend to the woman (or parents in the case of the baby) that a consultation with a specialist is warranted given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. The specialist will not automatically assume responsibility for ongoing care. This will depend on the clinical situation and the wishes of the individual woman.
3. The Lead Maternity Carer must recommend to the woman (or parents in the case of the baby) that responsibility for her care be transferred to a specialist given that her pregnancy, labour, birth or puerperium (or the baby) is or may be affected by the condition. In most circumstances the specialist will assume ongoing responsibility and the role of the primary caregiver will be agreed between those involved. This should include discussion about timing of transfer back to the primary practitioner.

…

Continued on next page

General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Other Relevant Standards ***continued***

LABOUR AND BIRTH – FIRST AND SECOND STAGE

…

Condition Heading	Measure of Severity	Level of Action
…	…	…
Instrumental Deliveries Forceps	Station above 0 and/or foetal head palpable above the brim	3
Instrumental Deliveries Forceps	Low	2@
Instrumental Deliveries Forceps	Station 0 to +2	2
…	…	…
Meconium in Liquor (thick)		3
…	…	…
3rd Degree Laceration … laceration involving anal sphincter	Requiring suturing	2

Guidelines for Consultation with an Obstetric Specialist (Royal New Zealand College of Obstetricians and Gynaecologists April 1994).

…

Roles:

An obstetric specialist can expect to be consulted when it is anticipated that a situation may develop (or when a situation has developed) that is beyond the expertise of the caregiver.

On occasion this will mean consultation between specialists but more commonly it will be between a general practitioner and a specialist or a midwife and a specialist.

Continued on next page

General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Other Relevant Standards ***continued***

INTRAPARTUM

…

- Condition

Presence of meconium (particularly thick meconium and preterm)
Associated Risk/Rationale
Foetal compromise, risk of meconium aspiration, perinatal death.

…

- Condition

All instrumental deliveries except low (station +2) forceps or low ventouse.
Associated Risk/Rationale
Risk of trauma to mother and foetus.

…

- Condition

Third degree tear
Associated Risk/Rationale
Faecal incontinence, fistula formation.

…

General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Opinion: No Breach General Practitioner, Dr B

Right 4(1)

Caesarean section

I accept my advisor's opinion, which I note concurs with ACC's conclusion, that the general practitioner, Dr B's, decision to refuse the consumer, Miss A's, request for a caesarean section was reasonable and clinically appropriate.

When Miss A requested a caesarean section, she was fully dilated and the baby's head had descended sufficiently to allow an instrumental delivery. There was no foetal distress, (although there had been meconium in the liquor, the baby's heart rate remained satisfactory) or failure to progress through the labour, so there was no clinical need to expedite delivery. I note that a caesarean section is major abdominal surgery and as such has the potential for serious complications. It also takes time to organise such surgery, during which Miss A may well have delivered vaginally anyway.

In my opinion, Dr B's decision not to accede to Miss A's request for a caesarean section was reasonable, and in this respect he did not breach the Code.

Diagnosis of foetal position

It is clear that an error was made in assessing the position of the baby's head during delivery. Dr B concluded after a vaginal examination at 9:00am that Miss A's baby was in an occipito anterior position (OA), which is a position suitable for a forceps delivery to be attempted. However, when the baby was delivered "*face to pubes*", it was apparent that she had in fact been in the occipito-posterior position (OP).

My advisor explained that when a baby is in a posterior position it presents a wider part of its head to the maternal pelvis, which makes delivery more difficult, and increases the likelihood of maternal injury. The correct way to manage a labour when a baby presents OP is either to request specialist consultation if immediate delivery is necessary (to decide between caesarean section or instrumental delivery), or conservative management (which includes either awaiting normal progress or using Oxytocin to improve uterine contractions and to encourage the baby to rotate).

Continued on next page

General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Opinion: No Breach General Practitioner, Dr B *continued*

Had Dr B correctly diagnosed the baby's position and managed the labour accordingly, or had the baby actually been OA presentation, the trauma and complications suffered by Miss A would probably have been significantly reduced.

However, I was advised that an accurate diagnosis of the position of the baby's head can be extremely difficult, and that a misdiagnosis of this type is one that even the most experienced practitioner can make. Dr B performed a vaginal examination at 9:00am, just before commencing the forceps delivery. He concluded that the baby was presenting OA.

In my opinion Dr B did not fail to act with reasonable care and skill in assessing the baby's position as OA.

Pulling between contractions
There is insufficient evidence for me to determine whether Dr B applied traction to the forceps while Miss A was not having contractions, thus increasing her pain and trauma. Miss A said that he did. Dr B stated that he did not. Ms C stated that although she had the impression that Dr B had pulled on the forceps while Miss A was not having a contraction, she cannot now be 100% certain of this. I note that the situation was highly emotional by that time, and my advisor's comment that inadequate maternal pain relief would have increased any perception Miss A had that the force used was excessive. I also note the absence of trauma to the baby, which may have been evident if excessive force had been applied.

In all the circumstances there is insufficient evidence for me to conclude whether Dr B pulled on the forceps while Miss A was not having a contraction.

Right 8

Under Right 8 of the Code Miss A had the right to have one or more support persons of her choice present while she gave birth, except if safety may have been compromised in the process, or another consumer's rights may have been infringed.

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Opinion: No Breach General Practitioner, Dr B *continued*

Miss A was concerned that Dr B' actions resulted in her partner, Mr E, leaving the delivery suite so that she lost his support during the birth of their child.

Dr B explained that he asked Mr E to move out of the way as he was leaning over Miss A and preventing Dr B from being able to adequately examine Miss A's abdomen.

Midwife, Ms D, explained that Mr E was very concerned for Miss A, became upset and threatened Dr B, telling him to leave Miss A alone. Ms D took him out of the delivery suite so that he could calm down.

All parties present agree that the atmosphere was very tense that morning. I note that although Miss A's partner left the delivery suite, her mother was still present.

In my opinion Dr B did not breach Right 8 of the Code. He did not tell Mr E to leave, rather to move out of the way. Dr B needed to assess and examine Miss A's condition, and Mr E's behaviour was making that difficult. This was a safety issue. Additionally, I note that Miss A was not left alone with Dr B; her mother and two midwives were still present. In all the circumstances I am satisfied that Dr B did not breach Miss A's right to have one or more support persons present while she gave birth to her baby.

General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Opinion: Breach General Practitioner, Dr B

In my opinion Dr B breached the Code of Health and Disability Services Consumers' Rights as follows:

Right 4(1)

The consumer, Miss A, had the right to have maternity services provided to her with reasonable care and skill. I accept my independent advisor's opinion that Dr B did not exercise reasonable care and skill when managing the delivery of Miss A's child on 5 March 1997, for the reasons set out below.

Pain relief
I accept my advisor's opinion that Dr B did not provide Miss A with adequate pain relief.

During the first phase of the second stage of Miss A's labour she was distressed, tired, and quite vocal about wanting the delivery to end. Dr B acknowledged that had Miss A received better pain relief, such as an epidural, the forceps would have been more comfortable and the delivery less unpleasant.

My advisor explained that the correct course of action in this situation, in the absence of foetal distress or an abnormally prolonged second stage, is to provide appropriate pain relief. This allows the mother to cope while either a normal vaginal delivery occurs or the head descends sufficiently to facilitate other intervention. If delivery is not imminent or if an instrumental delivery is likely, an epidural is the preferred method of pain relief. (An epidural is an injection of local anaesthetic into the spaces surrounding the spinal cord in order to suppress sensation in the lower part of the body.)

I was also advised that a mid-cavity forceps delivery, as occurred in this case, usually requires an epidural to provide adequate pain relief. A pudendal nerve block such as Miss A had is considered adequate for a low forceps delivery, but not a mid-cavity forceps delivery, unless an epidural is not available or the need for urgent delivery outweighs the advantages of waiting for more appropriate pain relief.

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Opinion: Breach General Practitioner, Dr B *continued*

I note that there is conflicting information about the amount of Lignocaine that Miss A was given as pain relief. However, whatever the amount, it was the incorrect type of pain relief for this situation.

In this case, delivery took place in a hospital, with easy access to anaesthetic and specialist assistance. There were no signs of foetal distress and the labour had progressed rapidly, so there was no need for an urgent delivery. The public hospital advised me that at the time Miss A was in labour, anaesthetic assistance would have taken only five to 15 minutes to provide. Dr B stated that in his experience anaesthetic assistance is not usually available at the public hospital within this timeframe. However, he made no attempt to request anaesthetic assistance or to ascertain its actual availability on this occasion.

Dr B decided to expedite delivery due to Miss A's distress and insistence, and in failing to provide adequate pain relief he significantly aggravated her distress. I note that Miss A was demanding immediate delivery, but there was no clinical need for this baby's birth to be expedited. Dr B should have responded to Miss A's distress with appropriate pain management, and either continued to manage her labour conservatively or requested specialist assistance.

Forceps

I accept my advisor's opinion that Dr B's decision to perform a mid-cavity forceps delivery was not a reasonable one to make in the circumstances.

Had Miss A's labour been prolonged, a forceps delivery would have been an appropriate course of action. However, my advisor explained that full dilation occurred somewhere between 8:05am and 9:00am, and delivery was at 9:24am. The average duration of the second stage in labour (which begins with full dilation) for a woman having her first baby is about one and a half hours. My advisor estimated the second stage of Miss A's labour to have been, at most, just under one hour in duration — an abnormally short second stage.

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Opinion: Breach General Practitioner, Dr B *continued*

I note that Dr B may have been given inaccurate information concerning the duration of the second stage of labour, and that this may have contributed to his decision. However, this showed poor attention to an important detail.

A forceps delivery for an OP presentation baby is not recommended, as it increases the likelihood of maternal injury. However, as discussed above, I accept that Dr B took reasonable actions in the circumstances to ascertain the baby's position before proceeding with the forceps delivery, and that his misdiagnosis was not unreasonable in the circumstances.

Dr B assessed the baby to have descended to "station 0", which meant that its head had reached the level of the ischial spines in the maternal pelvis. My advisor explained that a mid-cavity forceps delivery occurs when the baby's head is between this level and 2cm below the ischial spines.

My advisor stated that the forceps delivery Miss A experienced was at the upper range of what is acceptable for safe obstetric practice, assuming the baby had been in OA position. It is only in rare circumstances or in certain obstetric emergencies that it would be appropriate for a general practitioner to perform a forceps delivery when the head is at station 0.

Dr B has described himself as experienced at conducting forceps deliveries and stated that this delivery was within his expertise.

Dr B's access agreement with the public hospital required compliance with the Regional Health Authority Guidelines for Referral to Obstetric and Related Specialist Medical Services (1993). Copies of these guidelines are no longer available. However, I have consulted the replacement guidelines issued by the Transitional Health Authority in July 1997 and the RNZCOG's guidelines current at that time. These give an indication of accepted practice standards at the time, with particular reference to when handover of care to an obstetric specialist would have been expected or warranted. Both these guidelines state that for a forceps delivery when the baby's head is at station 0, the LMC must recommend to the woman that consultation with a specialist is warranted. I also note that the presence of meconium in liquor and severe maternal tears are also indicative of the need for specialist assistance.

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Opinion: Breach General Practitioner, Dr B *continued*

This delivery took place in a hospital and specialist assistance or advice was readily available. In my opinion Dr B should not have undertaken this forceps delivery himself, but should have sought a specialist opinion if he believed immediate delivery was required.

Postnatal care and complications

Miss A's baby was delivered, by forceps, via an episiotomy. Miss A also sustained a laceration to her perineum. Dr B repaired these wounds after the birth, but has acknowledged that in hindsight, the repairs could have been better.

Miss A suffered severe injuries and has had significant ongoing problems as a result of this delivery. However, my expert explained that most of these problems cannot be attributed to the use of excessive force with the forceps. I note that the baby was not injured by the forceps delivery. As already discussed, there is insufficient evidence for me to be able to conclude whether excessive force was in fact applied.

The OP position itself would probably have contributed to the trauma that was inflicted on maternal tissues. Disruption of the anal sphincter, injuries to the tailbone and urinary incontinence may occur during instrumental deliveries and may not necessarily be due to mismanagement. Separation of the abdominal wall is not a known complication of forceps delivery. In my opinion, it is not reasonable to hold Dr B responsible for these injuries.

However, a rectal examination after the perineal repair to search for any further injury to the rectum would have enabled early diagnosis of a situation that needed immediate and skilled repair. The severe pain Miss A suffered postnatally was probably indicative of more extensive trauma than had already been noted and repaired.

Dr B pointed out that Miss A refused to let him examine her again after the birth. This would not however have prevented him from referring her to another practitioner for ongoing care.

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Opinion: Breach General Practitioner, Dr B *continued*

Although Dr B had minimal involvement with Miss A's postnatal care, and therefore only a limited opportunity to assess and repair the damage, I do not consider that he managed Miss A's postnatal injuries with reasonable care and skill. Again, no referral was made to specialist care for her injuries, although this was indicated in the circumstances. Had Dr B carried out a thorough examination of Miss A's injuries directly following the birth, and had the repairs to her perineum been of an acceptable standard, the severity of her ongoing problems may have been significantly reduced.

Conclusion

In my opinion Dr B did not manage Miss A's labour and delivery on 5 March 1997 with reasonable care and skill. In spite of Miss A's insistence on immediate delivery, Dr B's decision to proceed with a forceps delivery rather than providing pain relief and allowing the labour to take its natural course was not reasonable in the circumstances. He did not provide her with adequate and appropriate pain relief for a mid-cavity forceps delivery. Finally, his management of Miss A's postnatal injuries was sub-optimal.

Right 6(1)

Miss A had the right to receive the information that a reasonable consumer in her circumstances would expect to receive, including an explanation of her condition and the options available.

Towards the end of her labour Miss A was exhausted and distressed, and she requested a caesarean section in order to end it. Dr B refused her request and proceeded to organise a forceps delivery.

I accept that his decision was a clinically appropriate one to make, but Miss A had a right to receive an explanation. Dr B did not explain to Miss A why a caesarean section was not appropriate, nor what he proposed to do, in a way that enabled Miss A to understand what was happening and why.

In not providing this information to Miss A, Dr B breached Right 6(1) of the Code.

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General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Opinion: Breach General Practitioner, Dr B *continued*

Rights 7(1) and 7(7)

Right 7(1) of the Code states that services may be provided to a consumer only if that consumer makes an informed choice and gives informed consent. Right 7(7) gives consumers the right to refuse services or to withdraw consent to services.

Miss A stated that the forceps delivery was very painful and distressing for her, and that she was screaming and asking Dr B to stop. Midwife, Ms D, confirmed that Miss A asked Dr B to leave her alone. Ms D described Miss A as fearful and said that she crawled backwards up the bed as Dr B approached her. Miss A begged Ms D to help her and to stop Dr B from doing anything to her. Ms C also confirmed that Dr B did not respond to Miss A's repeated requests to stop the forceps delivery.

Dr B, however, continued with, and completed the forceps delivery. Dr B stated that given Miss A's distress he felt it was best to carry out the forceps delivery under pudendal block (pain relief).

In my opinion, and in the opinion of my independent advisor, this was unacceptable. There was no clinical urgency. Appropriate pain relief had not been given. Specialist assistance was available. Miss A clearly and repeatedly asked Dr B to stop. She had the right to withdraw her consent to Dr B providing her with maternity services and it is clear that she did precisely that.

In continuing to use forceps to deliver Miss A's baby after she had clearly withdrawn her consent, Dr B breached Rights 7(1) and 7(7) of the Code.

General Practitioner, Dr B

Opinion – Case 99HDC12423, continued

Actions

I recommend that the general practitioner, Dr B, take the following actions:

- Apologises in writing to the consumer, Miss A. This apology is to be sent to the Commissioner and will be forwarded to Miss A.
- Reviews his practice in light of this report.

Other Actions

- A copy of this opinion will be sent to the Medical Council of New Zealand.
- Copies of this opinion with identifying features removed will be sent to the Royal New Zealand College of General Practitioners.