Obstetrician & Gynaecologist/Midwife

A Report by the

Health and Disability Commissioner

(Case 00/03447)

HDC

Health and Disability Commissioner

Parties involved

Mrs A	Consumer
Mr B	Consumer's husband
Dr C	Obstetrician and gynaecologist / Provider
Ms D	Midwife / Provider
Ms E	Clinical Advisor, ACC
Dr F	General Practitioner
Dr G	Obstetrician and gynaecologist
Dr H	Obstetrician and gynaecologist
Ms I	Medical Records Officer, A Public Hospital
Ms J	Director of Nursing, A Private Hospital

Independent expert advice was obtained from Mrs Joyce Cowan, midwife, and Dr David Cook, obstetrician and gynaecologist.

Complaint

On 30 March 2000 the Commissioner received a complaint from Mrs A about Dr C and Ms D. The complaint is that:

Dr C did not provide an appropriate standard of care to Mrs A during and after her pregnancy in 1997. In particular:

- *On Friday 10 January 1997 Dr C failed to detect that Mrs A's waters had broken; instead he advised that the amniotic sac was intact and the baby was probably pushing on the bladder.*
- *On Friday 10 January 1997 Dr C did not advise Mrs A that he was going away for the weekend that evening and that his midwife had already gone away for a week.*
- *Although Mrs A was in constant pain and had difficulty walking after the birth, Dr C advised that this was normal and did not detect that she had an infection in the uterus.*
- *After Mrs A had haemorrhaged, Dr C performed a D & C although an admission to hospital and treatment with intravenous antibiotics may have been sufficient treatment.*
- *Dr C informed Mrs A that "retained products" had caused the haemorrhage, although she later discovered that the case notes stated that no retained products had been found.*

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

- *Although Mrs A was in considerable pain while she was in hospital and for at least three months afterwards Dr C did not investigate the causes of this pain. Instead he advised Mrs A that everything was normal and she would have no problem in conceiving again.*

Ms D did not provide an appropriate standard of care to Mrs A during and after her pregnancy in 1997. In particular:

- *When Mrs A telephoned Ms D on 12 January 1997 as her waters had broken and contractions had started, she was advised that Ms D was away. However, Ms D had not informed Mrs A that she would be away, provided any contact details or made alternative arrangements for her care while she was away.*

- *After Mrs A haemorrhaged at home 14 days after her baby's birth she telephoned Ms D at her home. However, Ms D arrived nearly two hours later after Mrs A had telephoned her three times.*

- *Although Mrs A was in considerable pain while she was in hospital and for at least three months afterwards Ms D did not investigate the causes of this pain.*

An investigation was commenced on 28 June 2000.

Information reviewed

- Medical notes and documentation held by Dr C;
- Medical notes and documentation held by Dr F;
- Medical notes and documentation held by Ms D;
- Medical notes and documentation held by the public hospital;
- Medical notes and documentation held by Dr H;
- Medical notes and documentation held by Dr G;
- Documentation held by ACC in relation to claims by Mrs A.

Information gathered during investigation

Consultation on 10 January 1997
In January 1997 Mrs A was a 28-year-old first time mother with no significant previous medical history. She was under the care of Dr C, a specialist obstetrician who was sharing care with Ms D, a midwife, and Dr F, a general practitioner.

On the evening of 9 January 1997, Mrs A, who was 37 weeks pregnant, noticed that she was leaking a continuous small trickle of fluid and thought that her waters must have broken. Because she was not experiencing any contractions, Mrs A did not contact her obstetrician, Dr C, until the following morning. Mrs A phoned Dr C at daybreak on 10 January 1997 and he asked to see her in his rooms at 4.00pm.

At 4.00pm on 10 January 1997 Mrs A saw Dr C. Mrs A advised Dr C that the trickle of fluid had ceased. Dr C conducted an ultrasound examination and noted that the volume of liquor within the amniotic sac was normal and that there had been no depletion, which would have been seen if the membranes had ruptured and liquor had leaked. Dr C stated that these results led him to believe that the membranes remained intact and that the leakage was probably from the bladder, because the baby's head was noted to be engaged in the pelvis. Dr C was able to see the foetal heart on the ultrasound and noted that the heart rate was normal. Dr C arranged for a midstream urine test, in order to eliminate the possibility of a urinary tract infection. The results of this test were normal.

Providers' absence and contact details
After leaving Dr C's rooms, Mrs A remained uncomfortable and began to experience contractions two days later, in the early hours of 12 January 1997. Mrs A rang Ms D and was advised that she was away. Mrs A then rang Dr C's residence and was informed that he was also away. Mrs A telephoned a public hospital and was told to come in immediately.

Dr C advised me that he had arranged to go away for the weekend of 11 and 12 January 1997, but had organised cover from another obstetrician and gynaecologist. Mrs A stated that Dr C did not advise her that he was going away for the weekend, or that her midwife, Ms D, was going to be away for the following week.

Ms D advised me that she had seen Mrs A on 4 December 1996 and at this consultation had made a further appointment on 15 January 1997. Ms D cannot specifically recall informing Mrs A that she would be away, but stated that the fact that she had made an appointment to see her separately (ie, not at Dr C's rooms) on 15 January 1997 suggests she indicated that she would be absent on holiday from 24 December 1996 until 13 January 1997. Ms D stated that her invariable practice is to inform women she works with of any prolonged absence, such as a holiday.

In response to my provisional opinion, Mrs A stated:

> "At no time was I informed by [Ms D] that she would be out of town over the Christmas period. If I had been told this, I, as a first time mother, would have attributed the utmost importance to it. This statement by [Ms D] is untrue."

Ms D stated that she did provide Mrs A with her home telephone number and her cell-phone number early in the pregnancy; her practice is to inform all women she works with that if she is not at home, they should call her on the cell-phone. When she is absent, Ms D leaves a message on her cell-phone which advises the period of her absence, and the name and contact details of the midwife providing cover. Ms D stated that she followed her usual practice in Mrs A' case and that all the relevant details were available on her cell-phone. While Ms D was away in early January 1997, her daughter and a friend were at her home and one of them may have answered the telephone. Ms D stated that her daughter knew the arrangements for pregnant women who might telephone and would have given an appropriate response.

Delivery and non-detection of uterine infection
On arrival at the public hospital Mrs A was induced and a healthy son was delivered at 6.30pm on 12 January 1997 by ventouse and forceps. At approximately 10.00pm Mrs A and her son were transferred to a private hospital. Mrs A reported that following the delivery, she remained in constant pain.

Ms J, Director of Nursing, the private hospital, advised me that during her admission, Mrs A experienced perineal pain and swelling and enlarged haemorrhoids, requiring regular analgesia, Anusol suppositories, Proctosedyl ointment and Xylocaine gel. Ms J advised that Mrs A's obstetric notes indicate baseline recordings were within normal parameters and that involution of her fundus (return to its pre-pregnancy state) was normal. Lochial (post-delivery vaginal discharge) loss was also noted.

Dr C stated that Mrs A was kept under close observation at the private hospital because of the significant pain she suffered, and that he felt there were three reasons for her pain:

- The episiotomy repair was very uncomfortable.
- Mrs A had developed haemorrhoids.
- Mrs A had developed a nasty rash on her buttock, perineum and vulval area.

Various treatments were given for these problems, and some measure of relief was achieved, but Mrs A suffered significant, ongoing discomfort. Dr C advised that consideration was given to the possibility that there might be an intrauterine infection. However, the lochia remained clear and non-offensive and this was reported repeatedly by hospital nursing staff. Dr C advised that if there had been an intrauterine infection, the lochia would have been purulent and odiferous and a fever would have been noted.

On the third day following delivery, 15 January 1997, it was noted that Mrs A had a rash on her feet and that pustules had formed on her right foot. Ms J stated that Dr C was informed and a swab was sent for culture. Mrs A was referred to a dermatologist the following day.

Mrs A was reviewed by Dr C and Ms D on 20 January 1997 and was noted to be breastfeeding well; her uterus was involuting and she was feeling much more comfortable. Ms J advised me that Mrs A's baby, had required phototherapy for jaundice, but he had

gained weight, his serum bilirubin (a pigment of bile, testing of which indicates the level of jaundice) had reduced to 270 and he appeared to be progressing satisfactorily. Mrs A was discharged from the private hospital later that day.

Dr C saw Mrs A at his rooms on a regular basis following her discharge from the private hospital. Dr C first saw her just two days after her discharge, on 22 January 1997 for a routine check, because he was concerned about Mrs A's ongoing discomfort. Dr C noted at this consultation that Mrs A's perineum had been very painful from the episiotomy repair. He further noted that there was no obvious infection and prescribed Voltaren tablets as an analgesic and anti-inflammatory, to be used twice daily. Dr C arranged for Mrs A to return to see him one week later. However, later events prevented this appointment and Dr C re-scheduled it to 24 February 1997.

Haemorrhage and dilation and curettage operation

Mrs A advised me that on 25 January 1997 she experienced a massive haemorrhage at home. She was unable to leave the toilet and was very distressed. She said that at 8.00am her husband, Mr B, telephoned Ms D, who lived 200 metres away. Mrs A said that she could hear her husband yelling "get here, get here" down the telephone to the midwife. Mrs A advised that despite several more telephone calls being made, Ms D did not arrive until 10.00am.

Mr B advised me that he made three telephone calls to Ms D, the first at around 6.00am. He informed Ms D that his wife was bleeding a lot, was stuck in the lavatory and could not move. Mr B advised the midwife that blood was coming out in chunks and Mrs A was curled up in pain. He also advised that it was very urgent and he was very worried.

Ms D reported that she received a telephone call from Mr B at 8.00am on 25 January 1997 and was advised that Mrs A had passed a blood clot into the toilet. Ms D said she advised that Mrs A should wear a sanitary pad and that she would visit her at approximately 10.00am. Ms D stated that she also advised that she should be phoned again if Mr B and Mrs A had any continuing concerns. Ms D stated that she did not receive further telephone calls from either Mr B or Mrs A. As it was a Saturday morning she went back to sleep for a while and later spoke to her sister in Australia. Ms D said that after speaking to her sister, she attempted to telephone Mr B and Mrs A but got no reply. Ms D stated that when she arrived at Mr B and Mrs A's house at 10.00am, she was informed that their telephone was out of order. On arrival, Ms D examined Mrs A and determined that she was experiencing more than average blood loss, with some clots. Ms D contacted Dr C and arranged for Mrs A to be seen at a public hospital. Ms D followed Mrs A to a public hospital, where Dr C met them. At this point the care of Mrs A was passed to Dr C.

Mr and Mrs A advised me that at no time on 25 January 1997 was their telephone not working.

Dr C examined Mrs A on her admission to the public hospital and noted that although she was bleeding heavily, her temperature was normal. Dr C made a provisional diagnosis of retained placental products and arranged for the operating theatre to be made ready so that uterine evacuation by suction could be carried out. Mrs A was taken to theatre where Dr C

carried out an examination under anaesthesia, evacuation of retained products of conception and a re-suturing of the episiotomy. The uterus was enlarged to a size of about 14 weeks, which Dr C regarded as consistent with normal involution two weeks' post partum. Dr C stated that the cervical os (opening into the uterus) was open and copious amounts of blood, both fresh and old, were noted to be coming through the cervix into the vagina. Dr C performed a dilatation and curettage using a soft suction catheter, which is designed to minimise trauma to the uterus under these conditions and carries with it a much lower rate of complication from uterine perforation or uterine damage, and therefore a much reduced likelihood of Asherman's syndrome (the absence of menstruation in a hormonally normal woman caused by damage to the endometrial cavity).

Dr C advised me that if he had not performed a uterine evacuation Mrs A would have continued to bleed and haemorrhage. He stated that there had been no lessening of the bleeding rate during the time between Mrs A's admission and her being taken to the operating theatre, so there was no sign of spontaneous resolution of the bleeding process. Dr C also stated that if a uterine evacuation had not been performed the blood loss could have continued to the extent that emergency hysterectomy might have become necessary.

Dr C advised that Mrs A's bleeding settled following the evacuation procedure and that she was returned to the ward in good condition. She was very anaemic because of the blood loss before and during the procedure. Mrs A's haemoglobin was measured at 74, which is significantly low, and four units of blood were required by transfusion. Dr C also advised that intravenous antibiotics were administered prior to the evacuation process and continued into the post-operative period for about four or five days.

Mrs A advised me that she was informed after the operation that "retained products" had caused her bleeding. Mrs A later reviewed her case notes and found that they clearly stated that no retained products were found. Dr C informed me that after the operation he forwarded a sample of the debris removed from Mrs A's uterus for examination. He stated that the histology report indicated that the sample contained myometrium with regenerating endometrium but this did not preclude the possibility that there were retained products of conception in her uterus. He explained that the sample taken by the pathologist for the purpose of making histology slides is a representative sample only and it is quite possible that there was in fact placental debris, which was missed during the slide-making process. Dr C stated that when he spoke to Mrs A after the operation he had not received the histology report, and that he was not attempting to conceal the contents of the report from Mrs A.

Post-operative care

Mrs A advised me that following discharge from hospital she remained in considerable pain, and found walking painful. She said that she was continually "fobbed off" by both Ms D and Dr C, and simply told everything was normal and that she would have no problem in conceiving again.

Dr C stated that on 24 February 1997 he saw Mrs A for a check, including a post-natal check. He noted that the episiotomy area was still tender and there was a small sinus at the

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base of the episiotomy repair. Dr C further noted a significant rash around the anal area and he encouraged Mrs A to have salt baths on a daily basis and to seek fortnightly follow-up until the condition had resolved.

Dr C advised me that at no time did he state to Mrs A that everything was "normal". In fact, he wrote to a specialist dermatologist and Mrs A's general practitioner for further follow-up. Dr C made an appointment with Mrs A on 11 March 1997, but she did not attend. Dr C instead saw Mrs A on 14 March 1997 and said that at this appointment Mrs A stated that she had been quite comfortable for a week or two, but had gone for a long walk and everything had turned bad again. By this time Dr C considered the main problem to be chaffing of the buttocks, just alongside the peri-anal area. Examination showed that there was still a small defect at the episiotomy site, but this appeared to be clean and was healing nicely. Dr C further noted a rash around the peri-anal area, and the presence of haemorrhoids. He prescribed Ultraproct suppositories and ointment and arranged to see Mrs A on a weekly basis rather than fortnightly.

Mrs A returned to see Dr C on 21 March 1997. The Ultraproct ointment had worked and the rash had settled down. Dr C noted that there was still a small defect over the episiotomy repair, but that he expected this to heal quickly. He further noted the defect to be nice and clean and that there was therefore nothing more to be done in the way of medication. He asked Mrs A to return in three weeks' time for a final check of the episiotomy repair.

Mrs A returned to visit Dr C on 11 April 1997. Dr C noted that Mrs A still had a rash, which made walking very difficult. Dr C recorded in his notes that nothing so far had really helped, and prescribed Daktacort cream in the hope that this would bring about improvement. He asked Mrs A to return if the problem did not resolve. Mrs A did not return to see Dr C.

Concerned that her periods had not returned, Mrs A was referred by her general practitioner to Dr H, obstetrician and gynaecologist. After extensive examination and surgical intervention, Dr H diagnosed Asherman's syndrome on 31 August 1998 and informed Mrs A that she would not be able to conceive again.

Independent advice to Commissioner

During the course of the investigation, the following expert advice was obtained from an independent midwife, Mrs Joyce Cowan:

> **"1. Concerning [Ms D's] arrangements for cover while on leave.**
>
> [Ms D] had organised midwifery cover to be provided by her colleague [Ms K] during her leave. It seems she had also notified the Delivery Ward at [a public hospital] that these arrangements had been made as they called [Ms K] to provide midwifery care for [Mrs A] when she was admitted in labour.

[Ms D] stated in her letter that she had given her mobile phone number to [Mrs A] during an antenatal visit. [Ms D] stated 'The fact that I made a separate arrangement for me to see [Mrs A] at home on 15 January suggests that I indicated to her that I would be absent on holiday from Christmas Eve 1996 until 13 January 1997.' As [Ms D] stated that it has always been her practice to inform women of absence due to holidays I assume she did in fact inform [Mrs A]. However it does not appear that this was very clear to [Mrs A] and it was not documented in the antenatal notes provided for me to read. Sometimes as a practitioner one can assume that the client has understood a matter discussed but in fact unless it is clearly documented in the antenatal notes or the care plan it may not be clear at a later date.

There was no answer phone available at [Ms D's] home but had a client called the mobile phone number during her holiday, the recorded message would have provided back up arrangements.

It seems that perhaps a friend of [Ms D's] daughter answered the phone when [Mrs A] rang in labour and was not told of the back up plans, but the information was available either by phoning the mobile phone or by phoning the delivery ward. It is usual practice for a list of practitioners covering for those on leave to be kept in the labour ward office.

In summary, [Ms D's] arrangements for cover while on leave were satisfactory. However, it does seem that it was not clear to [Mrs A] that [Ms D] was away on the day that she started her labour. It would be unreasonable to expect that every person who may possibly answer the phone during a midwife's holiday should know exactly what information to give regarding cover. However clearer communication between [Ms D] and [Mrs A] antenatally regarding the holiday would have made it less stressful for [Mrs A] when trying to notify her midwife.

In my opinion, whilst the communication regarding holiday arrangements proved to be, in retrospect, less than ideal, I do not consider that Ms D failed to maintain a reasonable standard of care.

2. **Concerning [Ms D's] attendance when advised that [Mrs A] was haemorrhaging.**

This matter is difficult to comment on because of conflicting accounts of the initial phone call. The account of the haemorrhage described by [Mrs A] and her husband in their letter to ACC dated 18 February 1997 suggests an increasingly severe bleed from the initial blood loss at 6am on 18 January 1997. (I presume this is an error and should have read 25 January 1997).

[Mr B] called the midwife at 8am, and according to the letter to ACC, [Mrs A] was 'losing blood at an alarming rate.' In contrast to this, [Ms D] wrote in her letter to the Health and Disability Commissioner, dated 11 July 2000:

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> "On Saturday 25 January 1997 (14 days after delivery) I received a telephone call from [Mr B] at 8am. He advised that his wife had passed a blood clot into the toilet. My advice was that she should wear a sanitary pad, that I would visit her at approximately 10am and that I should be telephoned back if they had any continuing concerns in the interval."

I would find it difficult to believe that a midwife would arrange to visit a woman in two hours time if she had in fact been told that the woman was losing blood at an alarming rate. A single blood clot may be passed in the postnatal period and may not be serious but in some cases may be the beginning of a more serious bleed. It was indeed unfortunate that the phone became out of order following the initial call, as obviously the bleeding became increasingly severe and [Mr B] tried in vain to contact [Ms D] again. Also [Ms D] did try to phone to check on [Mrs A] between the initial phone call and her visit but was unable to contact the couple because of the phone being out of order.

I can only assume from the documentation I have read that [Ms D] did not understand from [Mr B's] comments that the situation was serious at 8am. A secondary postpartum haemorrhage is an obstetric emergency that demands prompt attention and I do not believe that a midwife would delay in responding if told that a woman was losing blood at an alarming rate. In fact the usual response would be to call an ambulance to the house immediately and attend as quickly as possible.

There are no details about the questions that [Ms D] may have asked [Mr B] at the time of the phone call but I assume she was under the impression that the bleeding was not heavy and continuous at the time. She did ask him to phone back if concerned.

In summary, had [Ms D] known that [Mrs A] was having a secondary postpartum haemorrhage she most definitely should have acted more quickly. Because there is a discrepancy between what [Mr B] reports to have said during the phone call and what [Ms D] has written about the conversation, it is difficult to advise on this question. As I stated earlier, it is highly unlikely that a midwife would not respond urgently to a phone call reporting bleeding at an alarming rate.

If [Ms D] was correct in understanding that the extent of the bleeding at 8am was just a blood clot in the toilet, it was reasonable to arrange a visit for two hours hence with the instruction to phone with any further concerns. It was responsible of her to try to phone later to check on [Mrs A's] condition.

3. Concerning further investigation regarding pain.

It is my understanding from reading the clinical notes that [Ms D] frequently checked [Mrs A's] perineum and had checked that the uterus was involuting (returning to the pre-pregnancy size) at a normal rate. There is nothing in any of

the records to indicate postpartum uterine infection or retained products of conception prior to the haemorrhage.

There are indeed several entries written by [Ms D] regarding perineal pain in [Mrs A's] notes. The pain of severe haemorrhoids added to the pain from the perineal trauma. In fact, from entries in the clinical notes by several people involved in the care of [Mrs A], it would seem that most of the pain was attributed to the thrombosed haemorrhoids. From the first postnatal day until the day before readmission to hospital for haemorrhage there are multiple entries concerning perineal pain. It was observed that there was a lot of swelling and bruising but healing seemed to be progressing and there was no infection. The haemorrhoids were being treated with several products including a local anaesthetic, ice packs, anusol suppositories and ultraproct cream. They were observed to be improving on day 12, ie 24 January 1997.

[Mrs A's] perineal pain and swelling pain persisted for longer than would usually be seen. It is possible that this could have been due to tight sutures and as the sutures were removed and the perineum was resutured at the time of D&C it seems that this could have been a major contributing factor to the severe discomfort that she experienced. In most cases an episiotomy would be healed at two weeks and the suture material dissolved. As the tissues would be united a repeat episiotomy would have to be done. As stated by [Dr C] the taking down of the episiotomy allowed access to the cervix and uterus so this may have been the reason it was done. However, this is not usually necessary.

Another reason for excessive pain after an episiotomy repair could have been an allergic response to the suture material.

[Ms D] did contact [Dr C] about the problem and as she stated he was contracted to provide obstetric care for [Mrs A]. [Ms D] was authorised by [Dr C] to provide midwifery care for his patient. [Mrs A] wrote that [Dr C] visited once or twice, to advise on the pain experienced by [Mrs A]. According to [Mrs A] he said, 'it was perfectly normal'. In my experience, it is not normal for a woman to have constant perineal pain and difficulty walking by the ninth day postpartum. [Dr C] stated in his letter to [the Commissioner], dated 7 September 2000 that he did not state that [Mrs A's] discomfort was normal. A follow up visit was arranged for [Dr C] to see [Mrs A] following her initial discharge from hospital on 20 January 1997. Analgesic and anti-inflammatory medication was prescribed, and a further follow-up appointment was arranged.

There is nothing further that [Ms D] should have done during the period of time between the birth and readmission to hospital. Following discharge from hospital on 28 January 1997, [Mrs A's] care was transferred to her general practitioner. At this stage [Mrs A] was also visited several times by [Ms D] who subsequently discharged her to the care of the Plunket nurse on 31 January 1997 at 19 days postpartum. There did not appear to be any need for further investigation at that

time. The clinical notes written by [Ms D] at discharge indicate that [Mrs A's] haemorrhoids were much improved and the perineum was healed.

[Mrs A] saw [Dr C] some three weeks later for her postnatal check. At that stage she had developed a painful perianal rash which required medical treatment and follow up. [Dr C] arranged to see [Mrs A] two weeks later. By this stage [Ms D] was no longer involved in [Mrs A's] care. In summary, there were no further investigations that [Ms D] should have conducted regarding [Mrs A's] pain.

4. Concerning other issues.

It may not be my role to comment on the ACC claim but I feel that the following issue needs to be discussed.

The original ACC claim which was declined concerned events surrounding the possible retained products of conception and secondary haemorrhage. The claim was motivated by a need to have financial support for assistance during the time that [Mrs A] was incapacitated due to severe pain. This claim was made just a few weeks after the birth.

Since that time [Mrs A] has been diagnosed with Asherman's syndrome and is consequently unable to have more children. This has caused her and her husband great distress. It may be worthwhile for an ACC claim to be lodged concerning the Asherman's syndrome on the grounds of possible medical mishap. The outcome is certainly both rare and severe and is probably not the result of medical error.

I feel that [Mr B] and [Mrs A] need to be aware of this matter.

5. Concerning Midwifery Standards

In reference to the New Zealand College of Midwives Handbook for Practice, I have considered the midwifery care provided by [Ms D] for [Mrs A] in particular with regard to the above questions.

I recognise that in the misunderstanding between [Ms D] and her client concerning (1) cover during leave and (2) the serious bleeding at the time of the phone call from [Mr B] on 25 January, communication may have been less than ideal. However, having considered the other factors involved I do not think that [Ms D] failed to reach a reasonable standard of care as defined in the Handbook.

Both issues relate to Standard One – **The midwife works in partnership with the Woman.**

I have also considered Standard Six in relation to [Ms D's] response to the telephone call regarding bleeding – **Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk.**

Had [Ms D] clearly understood the extent of bleeding during the time between receiving the phone call and visiting [Mrs A], she definitely would have failed to reach this midwifery standard. However, because of the differing accounts of bleeding described by [Mr B] and [Ms D] in their correspondence concerning the phone call, it is not possible to make a fair assessment on this issue. To return to my earlier comment, I cannot imagine a midwife failing to act promptly when called about severe bleeding. It seems that either the situation was not clearly understood by [Ms D] or that the bleeding increased dramatically after the phone call when it became difficult for [Mr B] to alert [Ms D] because the phone was out of order."

The following additional expert advice was obtained from Ms Cowan:

"You asked me for the following advice:

- Should [Ms D] have attended [Mrs A] more quickly when advised that she was haemorrhaging on 25 January 1997?

  1. Based on the assumption that [Mr B] and [Mrs A's] recollection of the events is correct.

  2. Based on the assumption that [Ms D's] recollection of the events is correct.

[Mr B] and [Mrs A's] recollections of the events and phone calls of January 25 1997 are significantly different from the recollections of [Ms D].

1. My opinion based on the assumption that [Mr B] and [Mrs A's] recollection of events is correct.

The information provided for me regarding [Mr B] and [Mrs A's] recollection of the events is from the following sources:

(a) A letter written by [Mrs A] to [Ms L], Clinical Advisor to ACC, written on 18th February 1997, approximately three weeks after the haemorrhage.

(b) A transcript of a telephone conversation between [an] Investigation Officer for the HDC and Mrs A, dated 31 July 2001 and … [Mr B] on 14 August 2001.

In the letter to [ACC], [Mrs A] recalled that she began haemorrhaging at about 6am. She stated 'My husband called the midwife, [Ms D] at about 8am to come over as I was losing blood at an alarming rate. By the time she arrived I had significant loss of blood and low blood pressure …'

On 31 July 2001 [an Investigation Officer for HDC] telephoned [Mrs A]. [Mrs A] recalled the events of 25 January 1997 when she was bleeding and her husband had

called the midwife. She said that she was unable to call the midwife as she could not leave the toilet and was very distressed. She said that she could hear her husband saying that it was urgent and yelling 'get here, get here' to [Ms D] by phone. [Mrs A] does not specify in her letter whether this urgent conversation was the first one with [Ms D] or the final one before her arrival at the house.

On 14 August 2001 [Mr B] had a telephone conversation with [an Investigation Officer for HDC] about his recollection of the phone calls made to [Ms D] on 25 January 1997. He remembered making three calls, and one of these calls resulted in a message being left on [Ms D's] answerphone. [Mr B] was asked about what he said when he spoke to Ms D and what he said in his messages. This was [Mr B's] response:

> 'I said that [Mrs A] was bleeding a lot. I said that she was stuck on the lavatory and couldn't move. I remember saying that the blood was coming out in chunks and that there was lots of it. I said she was in a lot of pain and was curled up. I said that it was urgent, very urgent. I was really worried.'

When asked what [Ms D] said, [Mr B] answered:

> 'She did say she didn't phone back because she was on the phone to somebody in Australia, I think it was her sister. She also said that she had gone back to sleep after our first call because she had a delivery late the night before and was very tired.'

It is not absolutely clear from the information I have but it seems very likely that the conversation between [Mr B] and [Ms D], in which [Mr B] described his wife curled up in pain and losing a lot of blood, including large clots ('chunks') was the **third** phone call. **If this *were* the case, then it would appear that [Ms D] *did* attend to this call without undue delay, and acted appropriately. In saying this I am making the assumption that the conversation that occurred during the first phone call did not convey to [Ms D] the same degree of urgency as the final phone call so obviously did.**

However, if the aforementioned conversation concerning severe pain, a lot of blood and clots, had occurred during the first phone call then [Ms D] *should have* attended immediately as there was obviously cause for alarm as [Mrs A] was haemorrhaging very seriously.

On reading the letter mentioned in (a) [Mr B] said that when he phoned the midwife at 8am, his wife was losing blood at an alarming rate. If this recollection is correct and he did in fact convey the above information to [Ms D] at the time of the first phone call, she most certainly should have attended urgently.

2. My opinion based on the assumption that [Ms D's] recollection of events is correct.

The information provided for me concerning [Ms D's] recollection of the events is as follows:

(a) The clinical notes written at the time by [Ms D]
(b) The letter written by [Ms D] to the Health and Disability Commissioner dated 11 July 2000.

In her letter to the Health and Disability Commissioner, dated 11 July 2000, [Ms D] recalled a telephone from [Mr B] at 8am on 25 January 1997, and the details of this call were as follows:

> 'I received a telephone call from [Mr B] at 8am. He advised that his wife had passed a blood clot into the toilet. My advice was that she should wear a sanitary pad, that I would visit her at approximately 10am and that I should be telephoned back if they had any continuing concerns in the interval.'

In my experience, it is not uncommon for women to pass a blood clot in the first week or two after childbirth. Often women are frightened when they see the clot and on many occasions when a woman has told me she has passed a large clot I find that my interpretation of 'large' differs from that of the woman. Therefore, on many occasions when I examine a clot that has been described as 'large' or 'huge' by a woman I find it to be small and insignificant, although there is always the need to be vigilant as further bleeding may follow.

If the only concern conveyed to [Ms D] at 8am was the fact that [Mrs A] had passed a blood clot into the toilet, with no further excessive bleeding, it was reasonable to arrange to visit two hours later with the instruction to phone back if there were any concerns in the interval.

My assumption, from the knowledge that [Ms D] instructed [Mrs A] to wear a sanitary pad and call back during the next two hours prior to her visit, should there be any cause for concern, is that there was no excessive bleeding or pain at the time of the first phone call. Of course, if there had been any excessive bleeding or pain at that stage, [Ms D] should have attended immediately.

Therefore I conclude that if [Ms D's] recollection of the events is correct that she acted reasonably."

During the course of the investigation the following expert advice was obtained from an independent obstetrician and gynaecologist, Dr David Cook:

Names have been removed to protect privacy. Identifying letters are assigned in alphabetical order and bear no relationship to the person's actual name.

"In January 1997, [Mrs A] was a 28 year old Primigravida with no significant previous medical history. She was under the care of [Dr C], a specialist Obstetrician who was sharing care with [Ms D], a Midwife and [Dr F], a GP.

The pregnancy was uncomplicated until 10/1/97 when [Mrs A] attended [Dr C's] surgery at 36 weeks gestation with a history of leaking fluid from the vagina. [Mrs A] reports 'a continuous trickle of fluid' whilst [Dr C] established that only a small amount of fluid had been lost and that this had ceased by the time of attending his clinic. There were no apparent problems on history and examination and an ultrasound scan demonstrated a normal liquor volume.

Comment

[Mrs A] was a low-risk Primigravida with no risk factors for pre-term labour or membrane rupture. The history appears to be of a small amount of fluid loss and this was not considered significant by [Dr C]. This is a very common issue in obstetrics and in many cases of reported rupture of membranes there is no evidence to support this. In unconfirmed cases the presumed source of the fluid is leaking of urine from the bladder or thin vaginal discharge. Conversely it is often the case that patients with a convincing history of membrane rupture and in labour are later found to have intact membranes which require artificial rupture.

The gold standard method of assessment is a 'sterile' speculum examination of the vagina to identify pooling of liquor in the posterior aspect of the vagina, loss of fluid from the cervix on coughing and/or a 'washed out appearance' of the vagina due to the normal vaginal discharge being rinsed away by the leaking amniotic fluid. However this procedure is often omitted if the history is unconvincing as it spares the patient an unnecessary internal examination. Ultrasound examination evaluates the total liquor volume and may indicate substantial fluid deficits however it is not particularly sensitive in determining membrane rupture, particularly if the head is deeply engaged (as in this case) and obstructing the flow of fluid from the cervix.

Two types of membrane rupture are also described. The more common fore-water rupture involves leakage from a rent in the bag of membranes in front of the baby's head and adjacent to the cervix and vagina. This potentially allows ascending infection by vaginal bacterial although with the outward flow of amniotic fluid and the minimum (preferably nil) vaginal examinations this risk is quite low. The alternative is a hind-water leak where the rent in the membranes is located some distance within the uterus and thus not in close proximity to the vagina and its bacterial load. The history is often of a small and intermittent loss and it is generally regarded as less significant than fore-water rupture although differentiating the two can be difficult.

> Thus the diagnosis and management of potential ruptured membranes requires careful consideration to avoid underestimating the problem and equally over-reacting to a benign presentation.
>
> In the absence of persistent fluid loss and any other signs of pregnancy complications and with the identification of normal amniotic fluid volume on ultrasound scan, I would consider [Dr C's] management appropriate.

A conservative approach was adopted with the plan for routine antenatal care. [Dr C] was away for the ensuing weekend and had arranged for [Dr M] to cover in his absence. Regrettably [Ms D], [Mrs A's] Midwife, was also away at this time.

[Mrs A] went into spontaneous labour on 12/1/97. She was apparently unaware of the absence of either [Dr C] or [Ms D] and had some difficulty obtaining advice. Ultimately she contacted a public hospital where [Dr M] and Midwife [Ms K] then supervised the labour. On initial examination the membranes were absent indicating that rupture had occurred at some previous point. The labour required epidural analgesia, syntocinon augmentation and ultimately an assisted delivery with episiotomy.

There was no pyrexia during the labour and no apparent difficulty with the third stage, delivery of the placenta or repair of the episotomy.

> **Comment**
> A wait and see approach was appropriate although it would have been prudent for [Dr C] to ensure a clear plan of action if further problems occurred over the weekend particularly as he was going to be unavailable. Alternative contact advice is often provided at an earlier point in the pregnancy to contend with the possibility of unavailability though no explicit comment on this is provided in the documentation.
>
> The labour was complicated by slow progress and the need for assisted delivery, a common scenario in first labours. Despite this there were no exceptional difficulties and certainly no indication of infection. It should be noted that in uncomplicated cases of ruptured membranes it is usual to wait for 24 hours to allow the natural onset of labour. In pre-term patients with ruptured membranes prolonged delay (days-weeks) is often preferred to allow increasing maturity of the fetus despite the risk of ascending infection. In short it appears that membrane rupture probably occurred prior to labour but there was no evidence of infection as a result or any adverse effect on the labour or new-born baby.

During the post-natal phase the notes are very concise but indicate that [Dr C] visited on alternate days (with additional visits by the Midwife) and was well aware of the perineal soreness and haemorrhoids. Significantly there was no raised temperature throughout the seven post-natal days and the uterus was reducing in size adequately.

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Comment

Supervision in the postnatal phase appeared adequate. Perineal soreness and haemorrhoids are very common and unpleasant features following delivery particularly when this was complicated by assisted delivery and episiotomy. In the absence of infection or serious complications of haemorrhoids (thrombosis or strangulation) conservative management is indicated.

On 25/1/97, [Mrs A] experienced a secondary post-partum haemorrhage at home. She described this as massive haemorrhage whilst [Ms D] recorded at 8am that she had 'passed (a) clot into toilet'. There was again some difficulty with communication due to a phone fault but on assessment by the midwife at 10am a history of clots and persisting bleeding was elicited. Observations of blood pressure and pulse were satisfactory although [Mrs A] was pale and felt unwell.

[Dr C] was concerned at the amount of blood loss and, in the absence of raised temperature assumed the most likely cause to be retained products of conception. He therefore arranged for evacuation of the uterus (D&C) under general anaesthesia. The procedure revealed a large volume of blood clot and presumed placental material in the uterus which was removed using a plastic suction cannula. At the same time the episiotomy repair was broken down and resutured although the exact reason for this is unstated. Estimation of a 1000ml blood loss and identification of significant anaemia indicated the need for blood transfusion. Antibiotic treatment was instituted with the procedure and continued thereafter.

Comment

Secondary post-partum haemorrhage is most commonly due to retained products of conception. Invariably there is some degree of endomyometritis (infection within the lining and wall of the uterus) and often this is the sole cause of bleeding although in these cases it is not usually heavy. [Dr C] correctly identified that a significant haemorrhage was occurring and elected for immediate evacuation of the uterus. This proved appropriate as a large volume of intrauterine clot was removed and provided an immediate, substantial reduction in blood loss. [Dr C] recognised the role of infection in these cases and provided antibiotic treatment. He also recognised the (rare) possibility of Asherman's syndrome following curettage of the post-partum endomentrium and consequently employed a plastic suction cannula.

It is likely that a low grade endomyometritis developed sometime after delivery and allowed bleeding into the uterine cavity. The clots would provide a perfect culture medium for bacteria and both would hinder involution of the uterus and eventually result in secondary haemorrhage. The absence of placental tissue in the histology result is irrelevant since the retained clots were enough indication for evacuation of the uterus.

Alternative management was to commence antibiotic treatment and perform an ultrasound scan to identify the presence of retained products. The problem with this approach is a significant delay allowing further and

> potentially dangerous bleeding whilst a scan would almost certainly report the intrauterine clots as retained products indicating the need for evacuation of the uterus. Effective treatment would thus have been hindered.

The secondary haemorrhage responded well to uterine evacuation and antibiotic therapy whilst a blood transfusion restored the blood count. There were ongoing problems with pain around the perineum and [Dr C] reviewed [Mrs A] on several occasions providing various treatments and arranging a Specialist Dermatological opinion.

> **Comment**
> The problem was clearly quite complex with a healing episiotomy, the presence of haemorrhoids and a rash over the buttocks. Expectant management with simple local treatment was appropriate in the circumstances as natural healing would be expected and further aggressive management risk exacerbating the situation. A second opinion from a Specialist Dermatologist was very appropriate.

Asherman's syndrome is rare and most commonly a result of excessive curettage of the endometrium with a sharp, usually metal curette. Infection may also play a causative role. The presence of myometrium in the histological sample is unusual although not unheard of. This feature strongly suggests that the evacuation procedure contributed to the development of Asherman's syndrome in [Mrs A]. Use of a plastic suction cannula aims to minimise the risk of curettage being too deep however the uterus damaged by infection or possibly with a pre-existing disorder may be at increased risk.

Comment
The evacuation procedure was appropriate and correctly performed. The development of Asherman's syndrome in this case must be regarded as an unfortunate and unavoidable complication.

Summary
[Mrs A] has experienced a very unfortunate series of complications following her birth, some of which are quite common and others rare. There is no apparent unifying disorder underlying these and they appear to be quite independent. Difficulties with availability and communication with her care providers at the time have exacerbated the situation.

[Dr C] apparently failed to provide a clear plan of action whilst on leave but this did not directly lead to any of the subsequent complications. He did make adequate arrangements for cover in his absence. Otherwise his medical care was entirely satisfactory and appropriate. The long term complications of Asherman's syndrome and infertility represent a rare complication of evacuation of the uterus but were not a result of any error of management."

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.*

Opinion: No Breach – Dr C

Right 4(1)

Consultation of 10 January 1997

Mrs A stated that Dr C failed to detect that her waters had broken on 10 January 1997. Dr C advised that he saw Mrs A, established that only a small amount of fluid had been lost and that the flow had ceased, reviewed her history, conducted an ultrasound examination and ordered a midstream urine test. My obstetrician and gynaecologist advisor, Dr Cook, outlined the different circumstances in which fluid loss may occur in pregnant women. He concluded that the diagnosis and management of ruptured membranes requires careful consideration and found Dr C's management appropriate in the absence of persistent fluid loss and any other signs of pregnancy complications, and with the identification of normal amniotic fluid volume on ultrasound scan.

Non-detection of uterine infection

Mrs A stated that Dr C advised her that the constant pain and difficulty she experienced when walking after she had given birth was normal, and that he did not detect an infection in her uterus. Dr C advised that he was aware that Mrs A was in considerable pain and distress. He considered three sources for Mrs A's postnatal pain: the episiotomy repair, haemorrhoids and a nasty rash on her buttock, perineal and vulval areas. Dr C also considered the possibility of intrauterine infection; however, the lochia remained clear and inoffensive and Mrs A did not develop a fever.

My obstetric advisor, Dr Cook, considered it likely that a low-grade endomyometritis developed sometime after delivery, allowing bleeding into the uterine cavity. Dr Cook advised me that these clots would provide a perfect culture medium for bacteria and would hinder involution of the uterus and eventually result in secondary haemorrhage. Dr Cook further stated that the symptoms experienced by Mrs A after giving birth arose from an unfortunate series of complications with no apparent unifying disorder underlying them. My advisor stated that although Mrs A suffered painful and unpleasant symptoms, Dr C's conservative management of her condition was appropriate.

Dilatation and curettage operation

Mrs A complained that Dr C informed her that "retained products" caused her to haemorrhage on 25 January 1997, although the case notes stated that no retained products had been found. Mrs A further stated that in response to the haemorrhage, Dr C performed a surgical procedure (dilatation and curettage) when an admission to hospital and treatment with intravenous antibiotics may have been sufficient treatment.

My obstetric advisor informed me that secondary post-partum haemorrhage is most commonly due to retained products of conception. Dr C's assumption was therefore reasonable. I note, however, that once the histology results arrived, Dr C should have contacted Mrs A to explain their significance.

Although no placental tissue was found during the dilatation and curettage (D&C), an intrauterine blood clot was found. This would have provided a culture for bacteria to

develop and cause infection. Dr Cook stated that Dr C's management of this was appropriate. Dr Cook advised that although antibiotic treatment and ultrasound scan alone, without operation, was an option, this would have led to a delay during which further, and potentially dangerous, bleeding could have occurred. Dr Cook also stated that an ultrasound scan would almost certainly have shown the blood clots as retained products, indicating the need for a dilatation and curettage operation in any event.

Given the information available to him on 25 January 1997, I am satisfied that Dr C acted appropriately in surmising that Mrs A's haemorrhage was caused by retained products and performing a dilatation and curettage operation. Dr Cook stated that Dr C performed this operation appropriately and with the correct precautions.

Post-operative care
Mrs A stated that she was in considerable pain for at least three months after giving birth, and that Dr C did not investigate the causes of this pain. Instead he advised Mrs A that everything was normal and she would have no problem in conceiving again. After her discharge following the dilatation and curettage operation, Dr C saw Mrs A on several occasions. Dr C noted that Mrs A was suffering from tenderness and a rash and provided various local treatments and arranged a specialist dermatological referral. My obstetric advisor noted that the simple local treatments provided by Dr C were appropriate as natural healing would be expected and more aggressive treatments might have exacerbated the situation. My advisor stated that referral to a specialist dermatologist was also appropriate. It appears that Dr C did continue to investigate the cause of Mrs A' pain appropriately.

Summary
Mrs A suffered very unfortunate complications following the delivery of her son. However, I accept my expert advice that Dr C provided appropriate obstetric services to Mrs A. In these circumstances Dr C did not breach Right 4(1) of the Code.

Opinion: No Breach – Ms D

Right 4(1)

Telephone contact on 25 January 1997
There is significant disagreement about what Ms D was told on the morning of 25 January 1997. Mrs A stated that after she haemorrhaged at home, Mr B telephoned Ms D and informed her that his wife was bleeding heavily, but that it took two more telephone calls and almost two hours before the midwife arrived. Ms D stated that she received only one telephone call, at 8am on 25 January 1997, and that she was simply informed that Mrs A had passed a blood clot.

Mrs Cowan, my midwife advisor, reported that if Ms D was informed that Mrs A was suffering severe pain and bleeding heavily at 8am, she should have attended immediately. However, if Ms D was simply informed that Mrs A had passed a blood clot, she acted

appropriately in arranging a consultation later that morning and advising Mrs A to wear a sanitary pad and to ring back with any further concerns.

In light of the conflicting information I am unable to form an opinion whether Ms D breached the Code in relation to the telephone contact on 25 January 1997. I do not believe that further investigation will be able to resolve this conflict, and have therefore decided to take no further action in relation to this matter under section 37(2) of the Health and Disability Commissioner Act 1994. I remind Ms D of her professional obligation to provide immediate assistance when necessary. Mrs Cowan advised me that if Mr B and Mrs A recollection of events is correct, Ms D's actions were clearly not appropriate.

Follow-up care
Mrs A complained that although she was in considerable pain while in hospital and for at least three months after having a uterine evacuation performed on 25 January 1997, Ms D did not investigate the cause of her pain.

Clinical records indicate that Ms D frequently checked Mrs A' perineum and checked that her uterus was involuting (returning to pre-pregnancy size). There are also entries in the notes to indicate that Mrs A was suffering from perineal pain and severe haemorrhoids. Local anaesthetic, ice packs, Anusol suppositories and Ultraproct cream were used to treat the pain. Ms D also contacted Dr C and advised him of the problem. Mrs Cowan informed me that in these circumstances there was nothing more that Ms D could reasonably be expected to have done.

I accept my expert midwifery advice that Ms D provided follow-up care to Mrs A with reasonable care and skill. In these circumstances, Ms D did not breach Right 4(1) of the Code.

Other Comment

Mrs A complained that at the consultation of 10 January 1997, Dr C did not advise her that he was going away for the weekend that evening and that Ms D had already gone away for a week. In addition, Mrs A complained that at no time did Ms D advise her that she was going on holiday.

It is clear from their responses that Ms D and Dr C did formulate alternate care plans for Mrs A in their absence. However, it appears that they did not successfully communicate these arrangements to Mrs A. When Mrs A began to experience contractions on 12 January 1997, she was unsure what to do when she could not contact either Dr C or Ms D. This is clearly not satisfactory and would have contributed to Mr B and Mrs A understandable anxiety as first-time parents. I encourage Dr C and Ms D to review the manner in which they explain to women what arrangements (including names and contact details) they have made for cover in their absence.

Actions

- Copies of this opinion will be sent to the Medical Council of New Zealand and the Nursing Council of New Zealand.
- A copy of this opinion will be sent to the Accident Compensation Corporation with a recommendation that a review be undertaken of Mrs A's entitlement to cover for medical mishap.
- A copy of this opinion, with identifying features removed, will be sent to the Royal Australasian College of Obstetricians and Gynaecologists and the New Zealand College of Midwives and placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes.