# Care provided prior to premature birth; appropriateness of decision not to resuscitate baby (03HDC13975, 13 October 2004)

*Public hospital ~ Obstetric registrar ~ Neonatal paediatrician ~ Premature birth ~ Neonatal intensive care ~ Not for resuscitation ~ Standard of care ~ Communication ~ Hospital guidelines ~ Rights 4(1), 4(5), 5(2)*

A 34-year-old woman complained about the standard of care she received from an obstetric registrar and a neonatal paediatrician during and following her pregnancy in 2002. The woman had a history of miscarriage and premature births. During this pregnancy, she was admitted to hospital several times from 20 to 23 weeks' gestation with vaginal bleeding. Ultrasound scans were performed and indicated oligohydramnios (reduced amniotic fluid volume) and occasional evidence of intrauterine bleeding. The paediatric team at the public hospital was contacted to discuss with the patient the potentially lethal developmental anomalies that can result from the problems she was experiencing. The neonatal paediatrician noted that he advised that the situation was "hopeless" and recommended no active intervention.

The woman's last scan revealed normal fetal growth but a complete absence of amniotic fluid. Following the scan she was distressed and wished to speak to a doctor. The obstetric registrar discussed the poor prognosis associated with a premature birth of this kind, and the risks entailed with aggressive resuscitation of the newborn. This discussion occurred in the presence of friends and whanau, whom the doctor believed were present for support. The patient's notes state that steroids were offered but declined.

The following day the woman's bleeding increased and was associated with abdominal pain. Steroid treatment was initiated and antibiotic therapy continued. Early the next morning the woman gave birth to a baby girl with a single push. The neonatal paediatrician saw the mother and baby shortly after birth and relayed to the mother his belief that her baby would die within an hour, irrespective of resuscitation attempts. He was not aware that the woman did not want to follow his recommendation not to treat the baby. Despite the poor prognosis, the baby continued to breathe on her own and, at around two hours after birth, she was transferred to the Neonatal Intensive Care Unit and a treatment plan commenced. The baby has since survived and is expected to have no adverse outcome.

The Commissioner accepted expert advice that the neonatal paediatrician's recommendations were appropriate, and that his decisions were "within accepted standards". Further, his prompt actions upon learning that the baby was still alive after two hours were also acceptable. Accordingly, he was held not to have breached Right 4(1).

The woman had complained that the obstetric registrar: informed her of the baby's poor prognosis in front of friends and family; performed a painful vaginal examination on her; refused to give her a steroid injection at 23 weeks, 6 days' gestation; and failed to comply with her wishes to have the baby resuscitated if any signs of life were present. No further action was taken on these complaints. A satisfactory explanation was received from the obstetric registrar as to why he thought the friends and family were present for support; he was unaware and apologetic that the woman was in pain during his examination; and the patient's notes did not support her claim that she was refused steroids. Although her wishes about resuscitation were not recorded and made

known to those involved in her care, “the failure to do so was a systemic one not attributable to [the obstetric registrar] alone”.

It was found that a systems failure had caused the baby to be left without reassessment or resuscitation for two hours after birth. The failure related to a lack of designated responsibility for clarifying and documenting the patient’s wishes with regard to resuscitation, and a lack of continued check-ups on the baby’s condition. The hospital was found in breach of Right 4(1) in failing to have in place a process whereby neonatal staff are required to regularly reassess a baby in such circumstances, or guidelines clarifying the situations in which delivery suite staff should contact the neonatal team.