HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA

Failure to obtain informed consent before performing a Caesarean section

1. On 17 January 2025, the Health and Disability Commissioner (HDC) received a complaint via the Nationwide Health & Disability Advocacy Service regarding the care provided to Miss A by Health New Zealand | Te Whatu Ora Waitaha Canterbury (Health NZ) at Christchurch Women's Hospital.

2. On 9 December 2024, Miss A presented to Christchurch Women's Hospital for a planned Caesarean section (CS). A CS was considered necessary because Miss A had previously had a CS and because – when the surgery was booked – her baby was in a breech position. She had declined an external cephalic version (ECV, a procedure that attempts to turn a breech baby to a head-down position to allow a safe vaginal birth) because of the discomfort and risk.

3. On the morning of the CS, Dr B, consultant obstetrician and gynaecologist, spoke to Miss A to gain her consent to the procedure. Dr B explained that an ultrasound would be conducted prior to the CS to check the position of the baby. Dr B requested her registrar (another doctor) to undertake that ultrasound. Dr B delegated this task to her registrar because, in addition to her surgical duties, she was rostered for a gynaecology ward round that morning.

4. Miss A told HDC that the position of the baby was critical information for her because she had experienced a traumatic emergency CS 18 months earlier, and she wanted to have a normal vaginal birth, which was not recommended if the baby was breech.

5. As it happens, the registrar did not undertake the ultrasound. Health NZ noted that, if Dr B had not had to leave the birthing suite (where the CS theatre is located), it is likely she would have ensured an ultrasound was completed.

6. By the time Dr B arrived at the operating theatre, spinal anaesthesia had already been administered to Miss A, and her partner was present (special arrangements had been made for him to attend via the Department of Corrections). A 'time out' to check the consent was undertaken, and no mention was made that the baby's presentation had not been checked with an ultrasound. However, just before the operation started, the registrar advised Dr B that he had forgotten to check the baby's presentation. She made the decision to proceed with the CS as planned.

7. Dr B told HDC that it was her understanding that the baby's breech position was not the primary reason for the decision to proceed with a CS; rather, it was one of several clinical factors (previous CS less than 18 months ago, previous CS when patient was fully dilated, and wound infection following previous CS), meaning that Miss A would have a decreased chance of a successful vaginal birth. Dr B said that she also believed it was unlikely that Miss A's partner would be granted further leave if the baby's birth was delayed. Nevertheless, Dr B acknowledged that, at this point, she should have paused and informed Miss A that the

baby's position had not been checked and confirmed whether she wanted to proceed with the CS.

8. Miss A's baby was successfully delivered without complications at that time. However, it became apparent during the delivery that the baby was head down and not in the breech position as thought. Postoperatively, Miss A was extremely upset to learn of this, as it meant she was denied the potential option of vaginal delivery. She later went on to develop an infection in her CS scar, necessitating hospital admission. Miss A believes her CS was unnecessary, and she feels traumatised by what occurred.

9. Dr B and Health NZ have apologised to Miss A for her experience and the breakdown in communication. Dr B advised that she accepts the criticisms outlined in this report and has 'carefully considered and taken on board' the comments made about the care she provided.

10. Miss A was given the opportunity to comment on the provisional opinion. Miss A told HDC, 'A sorry is [not going to] help anything. The trauma is already there.'

11. Dr B and Health NZ were given the opportunity to comment on the provisional opinion.

12. Health NZ told HDC that both they and Dr B had interpreted that the main reason for a CS in Miss A's case was that she had previously had a CS and that presentation of breech was more a secondary indication.

13. Health NZ expressed regret that its senior staff often had to both cover ward patients and undertake clinical sessions such as the CS list, noting that if Dr B had not had to leave the birthing suite area (where the CS theatre is situated) to attend the gynaecology ward, it is likely she would have facilitated an ultrasound scan being completed. Health NZ said it is sincerely sorry that Dr B found herself in this position. The registrar who had been tasked with completing the ultrasound was also busy carrying out CS procedures, preparing notes, and consenting other patients for procedures. At the 'time out' to discuss consent for Miss A's CS, none of the people present raised concerns that an ultrasound had not been carried out to check the baby's position. Health NZ acknowledged systematic failures for Miss A that meant she progressed so far towards CS without confirmation of the baby's position and advised that it accepts the findings and recommendations in this report.

14. Health NZ emphasised that Dr B has deeply reflected on these events and her communication with patients. It said that Dr B is a 'highly competent, caring and patient-centred clinician' and there have been no further concerns about Dr B's practice, including her informed consent process, since the events.

Dr B – breach

15. Right 6 of the Code of Health and Disability Services Consumers' Rights (the Code) states that every consumer has the right to information that a reasonable consumer in that person's circumstances would expect to receive before making an informed choice and giving consent. That includes an explanation of the options available, including the risks, side effects, and benefits.

16. The issue in this matter is Dr B's decision to proceed with the CS when she became aware that the position of the baby had not been checked. Up to that point, Miss A's consent had been given on the understanding that her baby was apparently in a breech position but that the baby's position would be specifically checked before the surgery. I have carefully considered the factors that influenced Dr B's decision to proceed to CS, including that arrangements had been made for Miss A's partner to be present under strict conditions associated with him being on compassionate leave from prison, that spinal anaesthesia had already been given by the time Dr B came into theatre, and that she understood that the baby's position was not the prime reason for Miss A's decision to proceed with the CS. In addition, there were strong clinical reasons for a CS being the likely preferred birthing option. I also have little doubt that Dr B believed she was acting in Miss A's best interests in deciding to proceed. However, on balance, I consider the decision to proceed to CS without further discussion with Miss A denied her the information she needed to make a truly informed choice about the surgery. This was not an emergency situation, and there was time for Dr B to have checked with Miss A whether she wanted to proceed with the CS and to have canvassed with her the risks and consequences associated with not proceeding, as well as options for trying to ascertain the position of the baby.

17. That this did not occur is a breach by Dr B of Right 6(1) of the Code and, consequently, Right 7(1) of the Code, the right to make an informed choice and give informed consent. Put simply, Miss A's consent was not informed by relevant information she was entitled to receive.

Health New Zealand – adverse comment

18. Although I consider that the prime responsibility for ensuring that Miss A was fully informed about her options sits with Dr B, I am concerned that Health NZ's systems contributed to that failure.

19. I acknowledge that senior medical officers are frequently called upon to attend to patients in the wards as well as in the birthing suite at Christchurch Women's Hospital, and I also acknowledge the busy workload of the Registrars. Dr B's Registrar had been instructed to undertake an ultrasound. It did not occur. During the 'time out', none of the people present raised any concern about the omission. These systemic failures enabled Miss A to progress to the point where she was in theatre, a spinal anaesthetic was in place, and surgery was about to begin before the error was identified. Health NZ Waitaha Canterbury advised that it has now amended its electronic checklist documentation to include a prompt to confirm that a baby's position has been checked before proceeding to CS. I agree that this action will, in part, avoid this situation occurring in the future.

Recommendations

20. In my provisional opinion, I recommended to Dr B that:

    a. She apologise in writing to Miss A for the breach of the Code identified in this report. The apology was to be provided to HDC within three weeks of the date of the final report for forwarding to Miss A;

b. She undertake HDC's e-learning module on informed consent and provide evidence to HDC of completion of that module within two months of the date of the final report.

21. In response to those recommendations, Dr B provided an apology to Miss A and evidence of the completion of HDC's e-learning modules.[1] I therefore consider the above recommendations complete. I wish to acknowledge Dr B's response, which I consider both sincere and mindful of the hurt and distress caused to Miss A, and I commend her for taking responsibility at an early stage of the complaint process.

22. Health NZ said that it continues to advocate for improved levels of staffing and that the Women's Health clinical leadership continue to advocate to Health NZ for better funding of the Women's Health department at Waitaha Canterbury, where it has identified unmet need in all areas.

23. Health NZ Waitaha Canterbury advised that it has amended its electronic checklist documentation, which will prompt a check to confirm a baby's position before proceeding to CS. I agree that this action will, in part, avoid this situation occurring in the future.

24. I recommend to Health NZ Waitaha Canterbury that it provide a copy/screenshot of the prompt and undertake an audit for compliance with this new prompt over a period of three months to ascertain whether babies' positions have been checked before proceeding to CS. A copy/screenshot of the prompt and a summary of the audit findings (with corrective actions to be implemented should non-compliance be identified) are to be provided to HDC within six months of the date of this report.

25. A copy of the sections of this report that relate to Dr B will be sent to the Medical Council of New Zealand, and a copy of this report with details identifying the parties removed, except for Health NZ Waitaha Canterbury, will be sent to the Medical Council of New Zealand and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Morag McDowell
Health and Disability Commissioner

[1] Dr B completed the HDC e-learning modules titled 'How the code of rights improves health and disability services', 'What you need to know about informed consent', and 'Complaints management and early resolution'.