General Practitioner

A Report by the

Health and Disability Commissioner

(Case 01/05191)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Dr B	Provider, General Practitioner
Ms C	Midwife
Ms D	Maternity Team Leader, a public hospital
Mr E	Consumer's partner
Dr F	Gynaecologist

Independent expert advice was obtained from Dr William Ferguson, general practitioner, and Dr David Cook, obstetrician.

Complaint

On 11 May 2001 the Commissioner received a complaint from Ms A about Dr B. The complaint is that:

When performing an episiotomy on Ms A following the birth of her baby on 24 December 2000, Dr B, general practitioner, failed to:

- *Stitch Ms A immediately after the episiotomy*
- *Wait until the local anaesthetic was in place before suturing Ms A*
- *Suture Ms A correctly resulting in her:*
  - *perineum incorrectly healing*
  - *not being able to have sexual intercourse*
  - *having pain around her perineum for 4 months after the birth.*

Additionally Dr B failed to get Ms A treatment for her altered skin integrity in a timely manner.

An investigation was commenced on 24 July 2001.

Information reviewed

- Letter of complaint from Ms A
- Letter of response and associated medical records from Dr B
- Letter from Ms A's partner, Mr E
- Letter from Ms A's mother, Ms G
- Note of interview with Ms C, midwife
- ACC report

Information gathered during investigation

At 3pm on 24 December 2000 Ms A's labour was induced by an artificial rupture of the membranes (breaking the waters) and insertion of 1mg of prostaglandin (used to stimulate uterine muscle). Contractions commenced and labour established, and at 8.25pm the cervix (neck of the womb) was fully dilated. The second stage lasted 57 minutes and an episiotomy (cut in the perineum to make the opening bigger) was performed by Ms C, midwife, because of foetal bradycardia (slowing of the baby's heartbeat) during the previous contraction. Following the episiotomy the baby was born at 9.22pm. Ms C noted that the baby's left arm was presenting alongside its neck. Twenty-four minutes after the birth of the baby and following the administration of intramuscular oxytocin (synthetic hormone that causes the uterus to contract after delivery) the placenta (afterbirth) was delivered.

Ms C stated that although she could remember Ms A quite clearly she could not recall having performed an episiotomy, which she considered strange as she seldom performs episiotomies. Ms C added that for her to have done an episiotomy the doctor must have been standing right beside her and have told her to do it, as she would not normally do one. Ms C also stated that if she had done an episiotomy it would only have been a medio-lateral (cut starting at the midline and angling 45 degrees, usually to the right) as she had never done, and would never do, any other type of episiotomy.

Dr B stated that the episiotomy was in his experience "a much smaller episiotomy cut than I would normally expect". He was surprised at the amount of discomfort from what he considered to be a relatively small amount of tissue damage.

Ms A stated that after the birth, Dr B asked whether she minded if he returned in about one hour to suture the episiotomy, as he had to collect his children. Ms A said that when Dr B returned to suture the episiotomy, "he seemed in a hurry as he did not wait for the anaesthetic

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to have time to take effect before he began stitching and I swore as it was painful and I told him it was not working yet".

Dr B stated that he would normally prefer to suture an episiotomy immediately but that he did not believe that the delay impacted on the effectiveness of the repair. In response to my provisional opinion, Dr B said that the delay in suturing was due in part to his awareness that the family needed time together to enjoy the baby before he proceeded with the suturing. He said that as time went on he realised he had a personal commitment and sought permission to be excused. He recalled that the repair was painful and advised me that perineal infiltration can sometimes be incomplete. Dr B acknowledged that suturing with an incomplete anaesthetic would have been an unpleasant experience and that he should have been more diligent in this respect. He said that further infiltration of the episiotomy could have been equivalent in discomfort and denied that Ms A was not sufficiently relaxed. Ms C recorded in the clinical notes that the episiotomy was sutured with vicryl (a synthetic stitch). Ms D, Maternity Team Leader at a public hospital, stated that vicryl rapide was the preferred suture material at the hospital. Dr B did not record any details of the repair he undertook.

Ms A stated that on 25 December 2000 the episiotomy "felt as though it wasn't right" and she asked her midwife to check it for her. She also asked for a mirror so that she could check the area for herself. Ms A described what she saw:

> "Dr B had stitched the area with the skin pulled overlapping in a criss-cross which I thought looked a mess and also there was a large lump of excess skin that he had tied off in a knot."

Ms A stated that Ms C, after looking at the episiotomy, just said, "Hopefully it should heal ok." Ms A stated that she felt as though any pressure on the perineum would make it "rip open" and that she asked Ms C to reassure her that it was "okay to have a bowel motion". According to the clinical record of 25 December, in the morning the perineum was noted to be tender and Panadol was given regularly, and in the afternoon the perineum was tender and the episiotomy clean and healing well. On 26 December, before Ms A was discharged home, Ms C wrote in the clinical notes that the perineum was clean and healing. According to the clinical record, Ms C visited Ms A at home on 27 December and noted that the perineum was fairly comfortable. On 28 December a further home visit was made and Ms A's perineum was noted to be healthy.

On 29 December Ms A returned to the maternity unit for a routine check of the baby. She asked Ms C to check the perineal area again, as she felt there was something wrong. Ms C advised her that it would hopefully be all right after it had had time to heal. According to the clinical record, Ms C noted that the perineum was healthy and there were no other concerns. Ms C stated that she could not remember anything specific about the perineum but remembered that Ms A was keen to inspect her perineum and vagina and that she had in fact done this herself, a fact Ms C found unusual. Ms C stated that "she [Ms A] was obviously very concerned about her appearance there".

According to the clinical record, Ms A was visited at home by the public hospital team midwives on 31 December 2000, and 2, 4 and 8 January 2001, and no comment was made about Ms A's perineum.

Ms A advised that her partner, Mr E, checked the area and informed her that he thought it looked strange the way the skin had been pulled so the entrance of her vagina was overlapping. Mr E stated that when he looked at the episiotomy a few days after the birth "the skin was sewn so the vagina skin was overlapping".

Ms A visited Dr B for a six-week check on 2 February 2001. Ms A stated that she did not bother to get Dr B to check her perineum as she had not attempted to have sex and had thought that as the appearance had not changed, the area must still require time to heal. Ms A stated that Dr B told her "it should be fine to attempt sexual intercourse after six weeks". Ms A stated that she informed him she was worried that her episiotomy still did not feel right and might rip and he advised her that this was a common fear for women after childbirth. Dr B's clinical record of this visit makes no mention of any perineal problems.

Approximately seven to eight weeks after the birth of their baby, Ms A and her partner attempted to have sexual intercourse but the area ripped and began to bleed.

Ms A rang the practice nurse on 13 February to advise that she had had difficulty attempting sexual intercourse. She saw Dr B on 14 February and explained what had happened when she and her partner had attempted to have sex. Ms A said that she told Dr B the area had been sewn so that it was overlapping and asked him to check it. Ms A stated that Dr B agreed with her that "the area had been wrong" and referred her to a gynaecologist. Ms A rang the local gynaecologist, but an appointment was not available for three months, so she rang Dr B and asked to be referred to someone else sooner. Ms A said that Dr B was not helpful and advised that she would have to pay to be seen privately. He supplied a list of gynaecologists for Ms A to select from.

According to Dr B's contemporaneous medical records Ms A advised Dr B on 15 February that she had made an appointment with a gynaecologist, Dr F, for 16 February and Dr B wrote a referral letter to Dr F on 15 February. In the referral letter Dr B described Ms A's problem as "uncomfortable coitus associated with a band of episiotomy repair scar tissue".

On 16 February Ms A saw Dr F, who advised her that sexual intercourse would have been impossible because of the band of scar tissue, which was the result of a deranged healing process.

On 21 February Ms A and her mother, visited Dr B to tell him that Ms A was unhappy with her treatment and wanted an accident compensation claim form signed. Dr B signed the form stating that he had incorrectly stitched the episiotomy. The 'ACC Injury Claim Form', filled out by Ms A but signed by Dr B, records:

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> "An episiotomy during childbirth was incorrectly repaired with stitches causing injury which needs to be repaired again by a specialist."

Ms A stated that Dr B told her and her mother that it was medical error rather than medical misadventure. However, Dr B noted on the claim form, "Not sure if this comes under medical misadventure or medical error." The ACC claim for medical misadventure on this complaint was declined.

On 28 March 2001 Ms A was admitted to a public hospital for repair of her episiotomy by Dr H.

Independent advice to Commissioner

General practitioner
The following independent expert advice was received from Dr William Ferguson, general practitioner:

"**1. Please comment on the time delay between the episiotomy and suturing the perineum.**

The time delay, whilst not ideal in terms of the patient's comfort (as some of the initial local anaesthetic used for the episiotomy may have worn off), was of no clinical significance and had no bearing on the outcome of this case. It is quite common for the events of childbirth to lead to a delay of up to one hour before a perineum is sutured (eg doctor needing to attend to a complication such as bleeding, or a problem with the baby). It would be unwise to leave a wound for 6 hours or more before suturing it in view of increased risks of infection.

2. If [Ms A] was still in pain during the suturing what courses of action were open to [Dr B]?

Patients vary quite a lot in terms of the volume of local anaesthetic required to induce local anaesthesia, and the time taken for this to be effective. [Dr B's] options were to either wait longer for the local anaesthetic to take effect, infiltrate more local anaesthetic, or both in order to achieve adequate pain relief.

3. Was it appropriate for [Dr B] to continue to suture in this instance?

[Dr B] should have followed one of the above courses of action. It is easier to repair an episiotomy when the patient is relaxed and comfortable. However if the local anaesthetic was not initially having it full effect, then presumably it would only have been a few minutes of discomfort before it was effective.

4. Is it possible to suture an episiotomy with the skin overlapping as described by [Ms A]?

I have a measure of uncertainty about this situation without actually having observed the repair, or seen the results. Whilst the patient clearly described a distortion of the normal anatomy, it cannot be ignored that several different midwives as well as a specialist obstetrician did not perceive it as such. Nevertheless I suspect that in reconstituting the normal anatomy there was not a perfect alignment of the various muscle and skin layers, such that the skin layer at the fourchette was stretched to close the remaining defect, without the appropriate and matching alignment of the muscle layers beneath it.

5. Is it likely that the manner in which the perineum was sutured contributed to the 'deranged' healing process?

Despite the postnatal observations of apparent normality I believe the fact that a subsequent surgical division of a skin bridge was necessary, proves that the anatomical reconstitution was not perfect.

6. Please comment on pain in the perineum four months after the birth.

Women suffer very substantial morbidity after childbirth relating to trauma to the perineum and pelvic floor. Several large surveys of women postnatally reveal that at 2 months postpartum between 10 and 20% will still be suffering from perineal pain after a spontaneous vaginal delivery. One study at 6 months postpartum still reported 21% of women with perineal pain. Painful intercourse was reported in various studies to be a problem for between 12 and 15% of women at 5 months postpartum. Another study reports a 15% incidence at 3 years, regardless of the use of episiotomy. There is no clear relationship between the use of episiotomy and the persistence of perineal pain. But it does relate to some degree to mode of delivery (eg forceps) and method of repair (certain suture materials are more problematic).

Thus the significant problems [Ms A] experiences must be viewed within the context of this being a common and unfortunate complication of childbirth. We could conclude from this that either lots of women have badly repaired perineal tears, or that even faultless technique does not guarantee that there will be no problems. I believe that both these observations are true.

7. Did [Dr B] refer [Ms A] to a gynaecologist appropriately?

[Dr B] did everything that was possible within the limits of the public and private health systems to refer [Ms A] appropriately. The fact that there was no replacement for the only local hospital-based gynaecologist (who was on sick leave) limited the available options.

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8. Are there any other issues raised in the information you have received that require comment?

The difficulty that this case presents rests on two issues. The first is unpredictability of outcome. It is common clinical experience to see perineums completely shattered by difficult deliveries make complete and painless recovery in terms of structure and function, even with unskilled repairs. Conversely even a meticulous repair following minimal trauma can be associated with pain and disability that may still be present three years later.

The second issue is that repairing an episiotomy or a damaged perineum can be technically quite difficult. It is a task that is greatly underrated in terms of the amount of training and experience needed for a practitioner to be proficient. The medio-lateral episiotomy cut is unusual in a surgical context in that it is made diagonally across the natural lines of skin tension, and through several different muscle layers, all aligned in different directions. Once the division is made tensional forces within the tissues pull the wound apart and out of alignment. Whilst there are obstetric necessities for this, a Surgeon or Plastic Surgeon would normally avoid making such an incision at all costs in view of the predictable problems with repair and scarring. I believe it took me ten years of practical experience after my training, plus an interest in minor surgery, before I felt I was good at repairing this sort of wound. I have seen specialists do poor perineal repairs, and I have seen pictures in textbooks purporting to teach the correct technique of repair that were frankly horrifying. Amongst all primary providers of maternity care there has been a substantial trend in recent years to diminishing clinical experience in this important skill, and I predict that there will be an increasing number of such cases in the coming years.

SUMMARY

It is natural for someone to assume when they have a baby that they will not be having pain and discomfort 6 months later, and to assume that such problems will be the inevitable consequence of inadequate care. However there is evidence that this is not necessarily the case. Despite this I feel that [Ms A's] complaint is best explained by less than perfect realignment of the perineal muscle and skin layers. This is not always easy to achieve and I am sure huge numbers of maternity care providers would at some time have been guilty of it.

I don't believe that [Dr B's] actions were intentionally harmful or negligent in any way. However I believe if he is continuing to provide intrapartum maternity care when he returns to New Zealand then he may benefit from the opportunity to repair several episiotomies under Specialist supervision."

Obstetrician
The following independent expert advice was received from Dr David Cook, obstetrician:

"Clinical history

[Ms A] was a primagravida with an apparently uneventful antenatal course. She went into labour at 41 + weeks on 24/12/01. Labour was initially slow but artificial rupture of the membranes enhanced progress and the duration of the first stage was ultimately a relatively brief seven hours.

There was some concern about fetal well-being during the second stage and a medio-lateral episiotomy was performed by the attending Midwife (under the supervision of [Dr B]) to expedite delivery.

A healthy 3280g girl was delivered at 2143.

[Dr B] undertook Perineal repair just over an hour later. The episiotomy was considered to be quite small and the repair surgically unremarkable although uncomfortable for the patient.

A number of comments over the ensuing five days indicated that the perineum was healthy and not unduly painful. On 8/1/01 there were no apparent problems and care was handed over from Midwife to the GP.

Episiotomy [refer to figs. 1 and 2, p 13]

The incidence of episiotomy has generally reduced over the last decade. One of the few reasonable indications is the need to expedite delivery where there is concern about fetal well-being, as in this case.

Episiotomy [dotted line in fig.1, attached] divides the skin at the fourchette and cuts through the skin of the lower part of the vagina internally and the skin of the perineum externally. Deep to the skin the underlying muscles are divided to a greater or lesser extent depending on the depth of the episiotomy.

Episiotomy may be midline or medio-lateral.

Midline episiotomy is directed in a straight line from the fourchette (vaginal entrance) towards but not encroaching on the anus. It is usually less painful and easier to repair than medio-lateral episiotomy but may not be as effective and may extend to and damage the anus.

Medio-lateral episiotomy commences in the midline but then angles about 45 degrees (usually to the right) to veer away from the anus. It is probably more effective in expediting delivery and theoretically reduces the likelihood of extension to the anus but it is more extensive, more difficult to repair and usually more painful.

As the indications to perform episiotomy have become more restricted to high-risk cases the most effective method (medio-lateral) is generally preferred.

Perineal repair

Repair of episiotomy involves the following manoeuvres:

1. Injection of local anaesthetic or regional analgesia e.g. epidural. Complete analgesia is not usually feasible as some of the pain in the area is due to stretching and bruising of the tissues. In the majority of cases injection of local anaesthetic and a gentle technique is usually sufficient to allow adequate repair;

2. Identification of the apex of the vaginal incision internally;

3. Suturing from the apex to the fourchette aligning the hymenal remnants to achieve anatomical repair;

4. Reconstituting the deep muscles ensuring that the anal sphincter mechanism has not been encroached upon and that no sutures penetrate through the ano-rectal wall;

5. Reconstituting the superficial muscles ensuring that the fourchette is well supported;

6. Approximation of the perineal skin.

The choice of technique and suture material differs from one surgeon to another although dissolving sutures are now virtually universal and a buried, subcuticular suture to the skin is preferred.

Precise anatomical alignment is often very difficult particularly if there are tears in addition to the episiotomy. Some degree of malalignment is quite common and usually of no long-term significance.

Episiotomy repairs may also be compromised if there is a need for haste e.g. troublesome bleeding from the area or major concerns for patient well-being. Inadequate analgesia, increased sensitivity, patient's anxiety and restlessness may also demand abbreviation of the repair process with less attention to anatomical perfection.

In the great majority of cases such a compromise will not be associated with any long-term problems.

Post-natal healing

Because of a generous blood supply to the area healing is usually rapid and uncomplicated. Some swelling of the area can occur in the first few days making the sutures tighter and more painful. Use of subcuticular suture running below the nerve-rich skin layer often alleviates this problem.

Some degree of superficial inflammation and even mild infection is not uncommon and perhaps not surprising given the close proximity to the anus. No specific management is required unless there is clear evidence of spreading infection: redness, increasing pain, prominent offensive discharge. In these instances antibiotic therapy would be indicated.

Occasionally an episiotomy, particularly if infected, may dehisce and re-open. Management is conservative, allowing the episiotomy to heal naturally albeit with a degree of laxity at the vaginal entrance that may prove a problem in later life.

Unless causing problems episiotomy wounds do not require close inspection during the postnatal phase. Removing 'tight sutures' is of dubious value and is now largely irrelevant with the increasing use of subcuticular closures. Some degree of swelling and irregularity around the introitus is usual during the puerperium and over-zealous scrutiny may be anxiety provoking for the patient.

Symptoms and function are the important indications of perineal dysfunction.

Long-term outcome

Some change in the anatomy of the perineum and vaginal entrance is invariable following normal childbirth. This usually has no short-term impact but may contribute to prolapse problems in later years and sometimes loss of sexual sensation if the introitus is particularly lax.

Pain in the area and/or pain with coitus (dyspareunia) for a few days to weeks are quite common following perineal tears or episiotomies. Both symptoms tend to subside with the passage of time. This is likely to be due to ongoing healing, natural dilatations of the vaginal entrance with coitus and growing confidence on the part of the patient.

Occasionally however perineal pain and/or dyspareunia do not subside spontaneously and will need further management. Precise statistics are not available but such cases are not uncommon with an estimated incident of 2-5% following vaginal birth.

These symptoms may be due to:

1. Tender scarring following an otherwise normal healing process. This may be due to the presence of abnormally sensitive nerve endings within the scar tissue.

2. An unsupported ridge of skin at the fourchette which is easily traumatised during coitus. This is due to lack of muscle support at the introitus either because of sub-optimal repair or a peculiarity of the healing process where the skin has healed but the underlying muscles have dehisced.

3. More profound anatomical problems with malalignment of the labia, severe narrowing of the vaginal entrance due to adhesions and vaginal bands running across the vaginal lumen.

4. Hypo-oestrogenism secondary to the prolactic hormone release involved in breast-feeding. The vagina may be poorly lubricated and tender during coitus.

5. Psychosexual problems.

The anatomical problems 1, 2 & 3 are well recognised and management would include one or more of advice regarding sexual technique, use of lubricants, use of vaginal dilators, injection of local anaesthesia and/or steroid and surgical correction.

The commonest surgical technique is a Fenton's procedure in which the perineal skin and, if necessary, the perineal muscles are divided longitudinally and repaired transversely thus widening the introitus. The extent of this procedure is entirely proportional to the degree of vaginal narrowing. Small skin ridges at the introitus can occasionally be divided under local anaesthesia.

Case Commentary

Although episiotomy has been over-employed in the past there was a good indication for performing the procedure in this case.

A relatively small episiotomy was performed by the Midwife with no apparent difficulties or immediate problems.

There was some delay in repairing the episiotomy due to [Dr B] having another commitment. Whilst this may have made the subsequent repair more uncomfortable this should not have influenced the ultimate anatomical result. There was no indication in the case records that the perineal repair was in any way complicated.

The postnatal records repeatedly indicate normal appearance and healing of the perineum in the immediate aftermath of the delivery.

Some comments by the attending Midwife suggest that [Ms A] was unusually attentive to the perineum despite the apparently normal postnatal course. This suggests that the patient may have been particularly anxious about the area and more likely to have an adverse perception towards any perineal symptoms.

The skin ridge (or 'web') described by the Gynaecological Specialist [Dr F] is a fairly common complication following perineal repair and is often associated with painful coitus. Poor surgical repair can contribute to such anatomical defects and compromised function. However even the most expert of repairs can heal adversely and result in subsequent problems. This may be due to increased scarring, inclusion of sensitive nerve endings in the scar tissue, infection or failure of deeper layers to heal adequately. These are well-recognised hazards of any surgical procedure.

Ultimately repair of the problem was easy and successful as is usual in such cases. The procedure was performed some three months following delivery. Conservative management using lubricants, appropriate coital techniques and possibly vaginal dilators would often be pursued for up to six months after birth so this could be regarded as a relatively early surgical correction.

Conclusion

The supplied information describes a relatively common outcome following episiotomy. There is no indication that surgical repair was inadequate and the ultimate anatomical defect is quite consistent with a mildly defective healing process. This was easily and successfully corrected within a relatively short time frame.

Whilst the 'suspicion' of the General Practitioner expert advisor that 'there was not a perfect alignment of the various muscle and skin layers' is probably true (as it is rare to achieve such perfection) the occurrence of the skin ridge at the fourchette does not indicate sub-standard management as this problem can arise despite expert surgical repair."

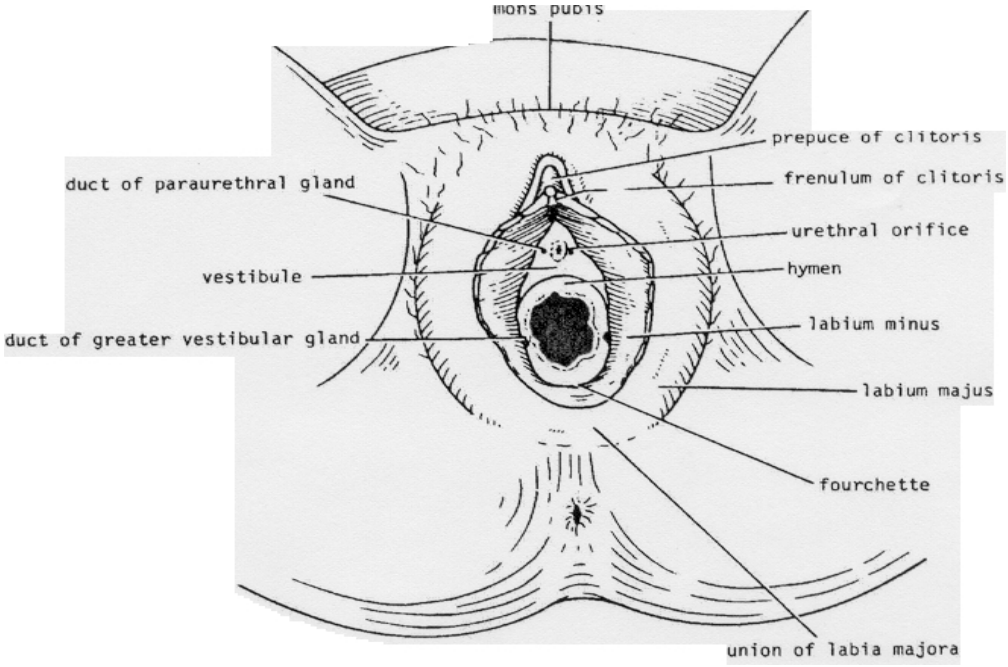
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Fig.1

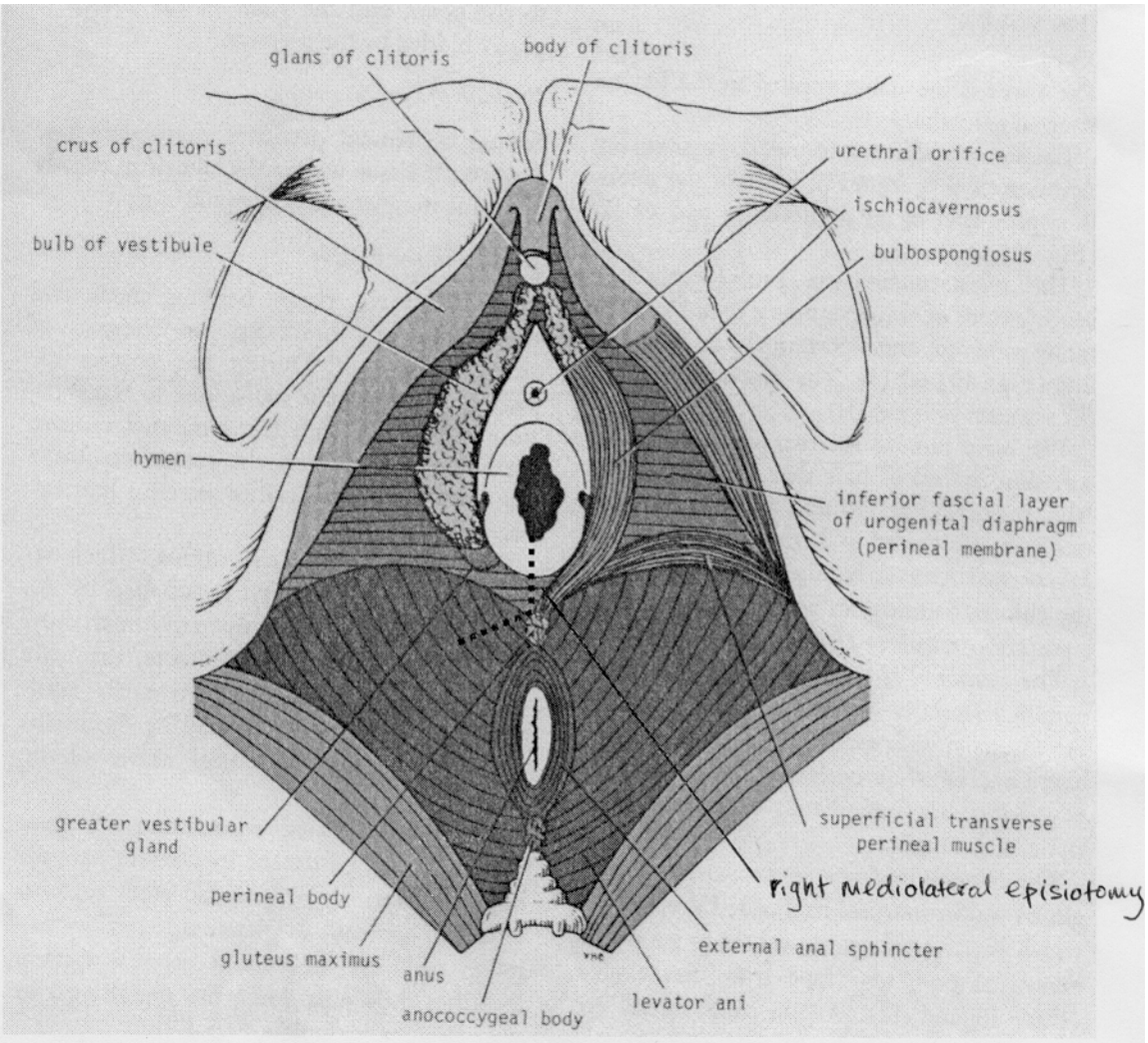

Fig.2

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

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.

…

3) Every consumer has the right to have services provided in a manner consistent with his or her needs.

Opinion: Breach – Right 4(3)

Delay in suturing and pain management
Dr B was required to provide Ms A with postnatal care in a manner consistent with her needs. However, Dr B left Ms A for approximately one hour after she gave birth, to complete a personal errand. While I acknowledge Dr B's response to my provisional opinion and his stated concern to allow a period of bonding before proceeding with suturing the episiotomy, my expert advised that the delay in suturing Ms A's episiotomy was not ideal in terms of patient comfort.

On his return, Dr B was aware that a period of time had elapsed and that the anaesthetic he had administered was inadequate. Dr B admitted that he would normally complete a perineal repair immediately and recalled that the repair was painful for Ms A. Ms A confirmed that she found the procedure painful because the anaesthetic was not working.

My expert advised that in such circumstances Dr B had the option of administering more local anaesthetic or waiting longer for what had already been administered to take effect, or both. Dr B acknowledged that having a repair with an incomplete anaesthetic would have been an unpleasant experience and that he should have been more diligent. In response to my provisional opinion, Dr B said that administering more anaesthetic may have caused an equivalent amount of pain. However, my expert advised that the delay in suturing increased the likelihood of some of the initial anaesthetic wearing off and that Dr B should have been cognisant of this when making his decision.

In my opinion, Dr B failed to perform the suturing of Ms A's episiotomy in a manner consistent with her needs, and accordingly breached Right 4(3) of the Code.

Opinion: No Breach – Right 4(3)

Referral to gynaecologist
Ms A complained that Dr B failed to refer her for repair of her episiotomy within an acceptable time frame.

Ms A contacted Dr B's practice nurse on 13 February 2001 and told her that she had had difficulty attempting sexual intercourse approximately seven or eight weeks after the birth of her baby. Ms A saw Dr B on 14 February 2001. The gynaecologist, to whom Dr B would normally refer, was on leave. Dr B advised Ms A that there was a wait of three to four months in the public system, which was the next option, and suggested Ms A be seen privately to expedite the process. Dr B supplied a list of gynaecologists for Ms A. Ms A advised Dr B on 15 February that she had made an appointment with Dr F for 16 February, and Dr B wrote a referral letter to Dr F on 15 February 2001.

In my opinion Dr B acted expeditiously in ensuring that Ms A was seen by a gynaecologist for her problem and accordingly did not breach Right 4(3) of the Code.

No further action

Suturing of episiotomy
Ms A complained that Dr B did not suture her episiotomy correctly and as a result her perineum healed incorrectly causing a prolonged period of pain and difficulties with sexual intercourse postnatally.

It is clear that because of the delay and problems in pain management, Dr B did not suture the episiotomy in optimal circumstances. His inability to achieve adequate anaesthesia of the perineum before beginning to suture and his disregard for Ms A's complaints of pain meant that she was distressed and tense during the procedure. My general practitioner advisor stated that "it is easier to repair an episiotomy when the patient is relaxed and comfortable". My obstetric advisor noted that inadequate anaesthesia, haste, patient anxiety and restlessness all undermine optimal anatomical repair. However, inadequate anaesthesia is only a contributing factor in suboptimal repair of the perineum.

Dr B performed a medio-lateral episiotomy on Ms A. The medio-lateral cut is diagonal, starting at the perineal midline and angling to the side. My general practitioner advisor noted that the nature of such an incision in an area under pressure (bulging and distension caused by baby's head descending) causes the wound to pull apart and out of alignment. My obstetric expert advised that while such an approach is generally preferred, as it is more effective in

speeding up the birth, it is also a more extensive cut, more difficult to repair and usually more painful.

There is a variety of information available about the quality of the repair of Ms A's episiotomy. I list the more relevant information as follows:

- My general practitioner advisor stated: "I believe the fact that a subsequent surgical division of a skin bridge was necessary, proves that the anatomical reconstitution was not perfect." However, this observation is qualified by the comment that "even a meticulous repair following minimal trauma can be associated with pain and disability that may still be present three years later".
- My obstetric advisor stated: "There is no indication that surgical repair was inadequate and the ultimate anatomical defect is quite consistent with a mildly defective healing process." Furthermore, it is often difficult to achieve "precise anatomical alignment"; some malalignment is not uncommon and usually has no long term significance and a skin ridge or web is a "fairly common complication following perineal repair". Although a poor repair can cause anatomical defects and compromise function, expert repairs can also heal badly with subsequent problems.
- Ms A and her partner were concerned about the appearance of Ms A's perineum.
- Other health professionals involved in Ms A's care did not note or record anything untoward in the appearance of her perineum in the contemporaneous clinical records.
- The ACC clinical advisor noted: "Damage to the perineum is a very common consequence of childbirth … dyspareunia (painful sexual intercourse) often follows irrespective of the skill used to repair the tear or episiotomy."

In this case, there is doubt about the cause of the adverse outcome. My general practitioner advisor summed up the situation well when he commented: "I have a measure of uncertainty about this situation without actually having observed the repair." Having reviewed all the available evidence, an element of doubt remains. In my opinion, further investigation is unlikely to resolve this matter. Accordingly I propose to take no further action on this aspect of Ms A's complaint, or in relation to her related complaints about not being able to resume sexual intercourse and experiencing ongoing perineal pain.

Actions

I recommend that Dr B take the following actions:

- Apologise to Ms A for his breach of the Code. A copy of this apology should be sent to the Commissioner's Office and will be forwarded to Ms A.

- Review his practice in light of this report.

Further actions

- A copy of this report will be sent to the Medical Council of New Zealand.

- An anonymised copy of this report will be sent to the Royal New Zealand College of General Practitioners, the New Zealand College of Midwives, and the Maternity Services Consumer Council, and placed on the Health and Disability Commissioner's website, www.hdc.org.nz, for educational purposes.

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