Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009

Complaint

The consumer, Ms A, complained that the Public Hospital, Midwife Ms C, Obstetrician and Gynaecologist Dr B, and Senior House Officer Dr D failed to provide appropriate services between 12 June 1997 and 18 August 1997. She complained in particular that:

- *On 15 July 1997 Ms A was told that her partner could not accompany her during transportation to the base hospital, as a support person, because a student midwife wanted to go with Ms A.*
- *Ms A was not advised of the results of tests carried out on a blood clot passed on 16 July 1997, following the birth of her baby.*
- *Ms A was not fully informed of the risks of a dilatation and curettage prior to the procedure being carried out on 16 August 1997.*
- *Ms A's uterus was perforated during a dilatation and curettage carried out on 16 August 1997.*

Investigation Process

The complaint was received on 16 October 1998 and an investigation was commenced on 23 November 1998. Information was obtained from:

Ms A	Consumer
Dr B	Obstetrician and Gynaecologist / Provider
Ms C	Midwife / Provider
Dr D	Senior House Officer, Public Hospital / Provider
Ms E	Chief Executive Officer, Public Hospital
Dr F	Acting Chief Executive Officer, Public Hospital
Mr G	Legal/Risk Advisor, Public Hospital

Ms A's relevant medical records from the public hospital were viewed.

The Commissioner obtained advice from an independent obstetrician and gynaecologist.

Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Information Gathered During Investigation

On 11 June 1997 the consumer, Ms A, at that time 31 weeks' pregnant and resident in the city, found herself discharging blood and mucus. The following day Ms A became further concerned by a small, but continual, blood flow and irregular tightening feelings and consulted her general practitioner, Dr H. Ms A was referred to the public hospital in the city and travelled there by ambulance with her partner, Mr I.

On arrival at the base hospital on 12 June 1997 Dr J, senior house officer, examined Ms A. Ms A advised the Commissioner that she was informed her baby was "*on its way*". The clinical notes of this examination record "*apparently uncomplicated pregnancy but itinerant and has been seen in* [the city] *and* [rural centre] *prior to moving to* [the town]" and a diagnosis of "*possible early labour*" was made. An attempt to conduct an internal examination using a speculum (an instrument for inserting into and holding open a cavity in the body) was made but adequate visualisation could not be obtained. Dr J consulted Dr K, obstetrician and gynaecologist, who conducted a second examination and confirmed that the baby was in a breech (in which the child emerges feet, knees or buttocks first) position. Dr J and Dr K discussed Ms A's presentation with Dr B, obstetrician and gynaecologist. Ms A was treated with steroids and tocolysis (suppression of premature labour). Ms A stated to the Commissioner that no-one informed her that her child was in the breech position.

During the course of the investigation the Commissioner sought advice from an independent obstetrician and gynaecologist. The advisor stated that:

> "*Preterm labour occurs in about 8% of pregnancies. Many presenting cases are 'false alarms' however and ultimately progress uneventfully to term. If the cervix is changing then treatment with steroids and tocolysis is often appropriate.*

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Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Information Gathered During Investigation *continued*

In this case the signs and symptoms were not entirely compelling but treatment was instituted presumably to be safe. This may have been suggested by the patient's 'itinerant' status and previously erratic antenatal care which increase the risk of adverse outcome such as preterm labour. Her significant geographical distance from the base hospital was an additional risk factor."

On 13 June 1997 Ms A began vomiting, began to experience a rapid pulse and felt an extreme stinging sensation in her vaginal passage.

Ms A's symptoms began to abate and on 16 June 1997 she was discharged home. Ms A's discharge notice stated:

"*Recommendation to patient: Please take things very quietly at home and get as much rest as possible. Try and get your feet off the ground for a couple of hours each afternoon. Do not return to work until after delivery. Please see your G.P. weekly and seek immediate medical attention if further bleeding or contractions ….*"

My obstetric advisor stated that:

"*There were no signs of a specific pregnancy complication and no signs of progressing labour. Treatment was discontinued but cautious management by way of inpatient observation adopted over the ensuing 4 days. Appropriate advice was provided before discharge with encouragement to attend for regular antenatal checks.*"

On 30 June 1997 Ms A noticed she was again discharging blood and began to experience tightenings which became regular by evening. A clear warm liquid was discharged while Ms A was standing. Believing these to be her waters breaking, Ms A and Mr I went to the local hospital where a decision was made that she should be taken to the base hospital. Ms A advised that she was given Pethidine, which she did not request and which caused her to vomit, and taken to the base hospital by ambulance.

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Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Information Gathered During Investigation *continued*

Upon admission at the base hospital, Dr L, senior house officer, examined Ms A. A CTG scan showed nothing unusual, no fluid was seen and Ms A's cervix was noted to be closed and long. The notes of this consultation record "*Impression … ?leaking membrane. Not in labour.*" Ms A stated to the Commissioner that on admission she was informed by a nurse that she was in labour, but was later informed by medical staff that she was not in labour, and instead was experiencing Braxton Hicks (false labour). Ms A was subsequently admitted to a ward for observation.

Ms A's discharge notice dated 1 July 1997 stated that:

> "*Recommendation to patient: Please take things very quietly at home. You need to get as much rest as possible. Eg have your feet off the ground for a couple of hours each afternoon. Drink plenty of fluids and please finish the course of antibiotics. As discussed, it is possible that you will need to come back down to* [the base hospital] *if there are further concerns about possible early labour (the baby needs to be born in a base hospital such as* […] *if it arrives before 37 weeks). Please see your G.P. for a check up next week.*"

My independent obstetric advisor stated that:

> "*There was no evidence of ruptured or progressive labour. At 33 weeks the merit of stopping labour with tocolysis and administering steroids is less compelling than at the previous admission.*"

On 2 July 1997 a specialist at the base hospital, assessed Ms A. Results of a swab taken during her previous admission to the base hospital were received and these revealed the presence of Gardnerella Vaginalis. Another specialist prescribed Metronidazole (an antibiotic).

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Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Information Gathered During Investigation *continued*

My obstetric advisor stated that:

> *"Gardnerella vaginalis is a marker for the presence of anaerobic vaginitis infection which usually causes a smelly vaginal discharge and vulval irritation. In pregnancy it is a well recognised cause of chorioamnionitis (infection of the membranes) and preterm labour. In the current context treatment of this infection was indicated and it was reasonable to ascribe the presenting problems as resulting from it."*

On 3 July 1997 Ms A was assessed by Dr B, obstetrician and gynaecologist, at the base hospital. Dr B reviewed Ms A's symptoms of persistent abdominal pain and made a diagnosis of an irritable uterus and prescribed further antibiotics.

The tightening pain continued over the following two weeks and on 15 July 1997 Ms A went to the public hospital in the town. After a scan and examination she was informed she was in labour and would be transported to the base hospital by helicopter. Staff initiated tocolysis.

Ms A advised the Commissioner that she asked whether Mr I could accompany her as a support person and was informed that he could. Ms A stated that Mr I went home to collect his bags, but before he could return she was informed there was no room in the helicopter for Mr I as a student midwife wished to go.

Ms C, midwife, advised the Commissioner that there was only room on the helicopter for the pilot, the patient on a stretcher, and two others. She further stated it was accepted practice for the patient to be accompanied by two caregivers and in this case the student was an experienced registered nurse in her final year of a midwifery degree.

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Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Information Gathered During Investigation *continued*

Ms E, Chief Executive Officer of the Public Hospital, advised the Commissioner that procedures for the transfer of obstetric patients by helicopter during July 1997 required that two medical staff were present. Ms E advised that this was because of the potential for there to be two patients (mother and child) present during the transfer. This procedure has now been incorporated into a recently developed formal policy for patient transfers.

On arrival at the base hospital staff ruptured Ms A's membranes at 8.45pm. An offensive liquor was noted and Augmentin (an antibiotic) was administered.

Ms A gave birth to her son at 11.26pm on 15 July 1997.

My independent obstetric advisor stated that:

> "*The patient was clearly in preterm labour and tocolysis was indicated only to facilitate transfer to the base hospital. The offensive liquor suggests chorioamnionitis as the cause of preterm labour and antibiotic treatment was therefore appropriate.*"

On the morning of 16 July 1997 Ms A's heart rate climbed to over 200 beats per minute and she was transferred to the Coronary Care Unit until her heart rate settled. Ms A stated to the Commissioner that while changing her clothing in the Coronary Care Unit, a nurse noted something unusual in the colour of her blood and informed her that something may be wrong.

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Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Information Gathered During Investigation *continued*

Ms A advised the Commissioner that on 19 July 1997 she passed two large blood clots and informed a nurse about this. She reported that a nurse collected the second of these clots and told her that this was to be sent to the lab for testing. Ms A stated she was not informed of the results of this test. There is no record of a blood clot being sent to the laboratory for testing on 19 July 1997, however Dr B advised the Commissioner that placental tissue was sent to the laboratory for histological testing. Dr B stated that the results of this test were received after Ms A's discharge from the public hospital. Dr B stated that the results were forwarded to Dr H, Ms A's general practitioner. Dr B also reported that these results were "*normal*" and did not alter Ms A's clinical management.

The nursing notes from the evening shift on 19 July 1997 stated:

> "[Ms A] *buzzed from bathroom, large clot hanging down from vagina, piece broke off about the size of a lemon, no tissue or membrane seen. Clot still inside vagina,* [Ms A] *would prefer to try and pass this herself rather than have it removed manually, so have suggested using bidet. No offensive smell from clot or* [cannot be read], *already on antibiotics – apyrexial* [no fever], *for FBC* [full blood count] *tomorrow a.m.*"

A full blood count had been performed in the morning of 19 July 1997 and it appears that an additional test was not performed on 20 July 1997. The results of the full blood count indicated that the number of red cells appeared normal and that the level of platelets was mildly, but not significantly, increased.

Ms A and her baby were discharged on 22 July 1997.

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Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Information Gathered During Investigation *continued*

My obstetric advisor stated that:

> "*The records suggest that the lochia (blood loss following delivery) was moderate rather than light and there was one episode when blood clots were passed. Whilst raising suspicion that there might be retained placental fragments or residual infection within the uterus this was not significant enough to warrant further investigation as lochia is very variable from one patient to another and the placenta had been considered at the time of birth to be delivered in its entirety.*
>
> *The patient was anaemic but not to a worrying degree. The haemoglobin level had not changed significantly following delivery (103g/l on 1/7/97, 100g/l on 19/7/98).*
>
> *These small concerns were eclipsed by the added complication of supraventricular tachycardia* [increased heart rate] *requiring admission to the Coronary Care Unit presumably as a result of her known Wolff-Parkinson-White Syndrome* [irregular heart beat]. *Nevertheless when this condition had been stabilised the vaginal loss was reviewed and considered to be resolving normally. Ferrogradumet (iron supplements) were prescribed on discharge because of the mild anaemia.*"

Ms A advised the Commissioner that she continued to suffer abdominal pain and bleeding after her discharge. She also began to feel faint after standing. Ms A stated she consulted Dr H on 12 August 1997 and was prescribed antibiotics. When these did not work Dr H referred Ms A back to the base hospital on 15 August 1997.

Ms A was admitted to the base hospital on 15 August 1997. The admission notes made by Dr L record that Ms A was stable but had a mild tenderness over the abdomen. On examination, Dr L noted fresh blood in Ms A's vagina along with abnormal tissue and the possibility of a cervical tumour was raised. Dr L made a diagnosis of a secondary post-partum haemorrhage associated with retained placental tissue, and an ultrasound scan was arranged for the following day.

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Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Information Gathered During Investigation *continued*

My independent obstetric advisor stated that:

> "*Secondary post-partum haemorrhage usually occurs within four weeks after delivery often associated with infection if there are retained products of conception.*
>
> *Abnormal tissue was identified on or within the cervix at vaginal examination and the possibility of a cervical tumour raised. The situation was stable and the plan was for an ultrasound scan on the following day to further evaluate the problem.*"

Dr B reviewed Ms A on 16 August 1997 at 9.30am and decided that the best course of action would be to perform a dilatation and curettage (D & C, a widening of the uterine cervix and scraping of the endometrium of the uterus). Dr B therefore cancelled the scheduled ultrasound appointment.

My obstetric advisor stated that:

> "[Dr B] *decided to circumvent the ultrasound scan as the probability of retained products was high and the scan would shed no light on the abnormal cervical appearance which required careful examination and possibly biopsy.*
>
> *It is arguable that a repeat vaginal examination by a more experienced clinician such as* [Dr B] *would have correctly identified the 'cervical tumour' as a placental cotyledon in the cervix which could probably have been removed immediately without recourse to anaesthesia. The decision for examination under anaesthesia was probably influenced by the previous series of complications and the patient's geographical distance from the base hospital. In hindsight the decision was supported by the presence of placental tissue within the uterus and the unusual vaginal band* [an abnormality in the vaginal tract] *which would have complicated a routine vaginal examination.*"

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Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Information Gathered During Investigation *continued*

Dr B advised the Commissioner that he met with Ms A prior to the operation and that, although he could not recall the exact conversation, it was his standard and routine practice to discuss the risks of anaesthesia and surgery prior to obtaining consent. Dr B stated that it was unlikely that the specific risk of uterine perforation was mentioned as the chance of it occurring is so small.

Dr D, senior house officer, stated to the Commissioner that he asked Ms A to sign a consent form for the operation. Dr D advised the Commissioner that it was his standard and routine practice to ask a patient to read the consent form and to ensure they understand it prior to asking them to sign. The consent form signed by Ms A contained the statement:

> "*I understand that other unexpected treatments or procedures are sometimes necessary and I agree to these if considered to be in my best interest by current standards of medical practice.*"

Ms A advised that she signed the consent form under the impression that the operation was simple and that nothing could go wrong, and would not have signed had she known the risks. The preoperative checklist contained the question "*Is the patient well informed of the proposed surgery?*" and this was ticked and signed by a registered theatre nurse.

Ms A stated to the Commissioner that an anaesthetist informed her of the risks of anaesthesia, but no-one informed her of any other risks involved in the surgery.

Ms A advised the Commissioner that Dr B was provided with Mr I's phone number and that Mr I was available on this number throughout the surgery.

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Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Information Gathered During Investigation *continued*

The dilatation and curettage operation was performed by Dr B at around 2.00pm on the afternoon of 16 August 1997. Dr B stated that a moderate amount of retained placental debris was removed from the soft uterus. He also noted the presence of a vaginal band. Dr B stated that during the operation he felt there was a possibility there had been a perforation of Ms A's uterus and he thought it prudent to check. Dr B stated that after making this decision he attempted to contact Mr I but was unable to reach him.

After completing the dilatation and curettage, Dr B performed a laparoscopy (examination of the abdominal structures using an illuminated tubular instrument inserted through a small incision in the wall of the abdomen) and noted a small 1cm perforation of the uterine fundus but found no fresh bleeding. Dr B performed a laparotomy (an operation involving a surgical incision) and repaired the perforation with two sutures.

The clinical notes recorded in relation to this operation that:

> *"EVA – D+C*
> *Laparoscopy*
> *Laparotomy*
> *Repair uterine perforation*
>
> *Small (1cm) uterine perforation – 10ml blood loss*
> *Uncomplicated repair*
>
> …
>
> *Tried to contact husband – failed*"

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Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Information Gathered During Investigation *continued*

My independent obstetric advisor stated that:

"*Vaginal bands are not an uncommon occurrence. They may be linked to other abnormalities in the genital and/or renal tracts and this raises the suspicion that an intrinsic abnormality of the uterus was responsible for the preterm labour and retained placenta. Without further investigation this is hypothetical.*

The presence of a large volume of tissue debris and the time elapsed since the delivery would almost certainly mean the presence of infection within the uterus. Whilst this had been recently treated with antibiotics this would probably contribute to making the uterine wall soft and easier to perforate, a well recognised risk when exploring the uterus in this context. The risk of perforation is probably below 1% however and most Obstetricians would not include discussion of this during pre-operative counselling unless the risk was deemed to be considerably elevated (delivery by caesarean section, abnormal uterine shape).

[Dr B] *was clearly aware of the complicated nature of the preceding pregnancy and delivery and the problem of the patient's domicile being distant from the base hospital. Laparoscopy to identify a possible uterine perforation was entirely appropriate. Such perforations can be associated with fatal haemorrhage and possibly disseminated infection.*

On identifying the perforation [Dr B] *was presented with three alternatives:*

1. *If not bleeding, do nothing and observe the patient for 24-48 hours. Although the area was not bleeding* [Dr B] *was unhappy to pursue this course because of the preceding complications and the small but definite possibility of late haemorrhage.*

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Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Information Gathered During Investigation *continued*

2. *Suture the area using a minimally invasive technique and not all Surgeons have the skills and/or equipment to perform this. Other factors may also mitigate against a laparoscopic approach e.g. poor access to the perforation site.*
3. *Perform a laparotomy and suture the area in the traditional fashion. Whilst subjecting the patient to a major operation and scar this provides the safest approach allowing thorough exploration of the area and confident haemostasis.*

Again [Dr B's] *decision for laparotomy was driven principally by safety considerations in what was a very complicated pregnancy. Recognising the gravity of this decision he did attempt to discuss the situation with the patient's next of kin but without success. The impact on future births was already established by the presence of the perforation and further management would not influence this.*"

In conclusion, my obstetric advisor stated that:

"*This patient presented with threatened preterm labour and vaginal infection. She eventually went into preterm labour and delivered at 35 weeks. She developed mild anaemia and acute supraventricular tachycardia requiring admission to the cardiac care unit. She subsequently presented with a secondary post-partum haemorrhage due to retained placental tissue. Compounding these medical problems was a domicile distant from the base hospital and an erratic attendance for antenatal care.*

This was therefore a very complicated pregnancy requiring careful judgement.

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Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Information Gathered During Investigation *continued*

The preterm labour was managed appropriately so that the baby weighed over 2.5kg at birth (after initial admission at 30 weeks). Infection and anaemia were detected and treated correctly. Regular Specialist input was provided throughout. There was an efficient and effective response to her problem of supraventricular tachycardia. The notes reveal careful attention to all aspects of post-natal care with thorough discharge planning and documentation.

At the final re-admission with secondary post-partum haemorrhage [Dr B] *correctly chose to explore the uterus and remove retained placental tissue. The expectation at this point would be a brief and uncomplicated procedure. However perforation of the uterus, whilst unusual, is a well-accepted complication and is often not recognised, occasionally with significant consequences.* [Dr B] *was astute enough to suspect perforation and perform the traditional interventions of laparoscopy to make the diagnosis and laparotomy with oversewing to correct it. Variations on this approach would be no oversewing as this area was not bleeding or attempting to suture the area via the laparoscope, although both these approaches, in their different ways, could carry a higher risk than that adopted by* [Dr B].

Apart from some minor quibbles (stated above) which did not materially influence the outcome, I would regard the management provided at [the base hospital] *to be prompt, appropriate and effective.*

Further investigation is indicated to assess normality of the uterus but based on this it is quite possible that she [Ms A] *will be able to deliver another baby by the vaginal route although this will require careful antenatal planning and intrapartum care.*"

Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Response to Provisional Opinion

In response to my provisional opinion Dr B stated:

> "*I wish to emphasise the four positive statements from the Obstetric Advisor.*
>
> 1. *'This was a very complicated procedure requiring careful judgement.'*
> 2. *'I regard the management provided to be prompt, appropriate and effective.'*
> 3. *'The incidence of perforated uterus is less than 1%.'*
> 4. *'Most obstetricians would not include discussion of this complication ….'*
>
> *I wish to comment on some aspects of the proposed opinion to provide full and written information regarding complications (even those less than 1% risk).*
>
> a. *Most surgeons in New Zealand do not provide such written information to all patients pre operatively.*
> b. *We would have practical difficulties with serious emergency operations such as a prolapse cord requiring an emergency caesarean section.*"

Dr B provided a written apology for not informing Ms A, prior to her operation, of the risks of perforation.

In response to my provisional opinion Dr D stated:

> "*I am disappointed in your conclusion that I had breached* [Ms A's] *rights in not informing her of the risk of perforation, when both* [Dr B] *and your independent obstetric advisor both state that most obstetricians would not include discussions of this during pre-operative counselling.*

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Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Response to Provisional Opinion *continued*

As [Dr B] *had already explained the procedure and its risks to* [Ms A] *in my presence during the ward round that morning, I viewed my obtaining her signature on the consent form, within the following hour, as a continuation of* [Dr B's] *discussion with* [Ms A]. *As a junior member of the obstetric team (being a paediatric senior house officer cross-covering obstetrics out of routine hours), I do not feel that it would be appropriate for me to mention further rare operative complications, which the consultant surgeon performing the operation did not feel he would counsel a patient about.*"

In response to my provisional opinion Mr G, Legal/Risk Advisor for the Public Hospital, stated:

> "[The Public Hospital] *has, as part of its drive for quality improvement, recognised the desirability of providing sufficient information to patients to enable them to make informed choices as to their treatment options.*
>
> *However, one of the issues with the provision of information is: 'exactly how much information does one provide?' Obviously, as you point out, Right 6(1) of the Code provides some guidance on this point, in that information should be what the consumer, in their circumstances, would expect to receive. However, this must be tempered with some pragmatism, something that is recognised by clause 3 of the Code.*
>
> *The general guideline that I understand most clinicians use, is to inform patients of:*
>
> - *risks which have a probability of more than 1% of occurring;*
> - *risks which the patient has specifically asked about, regardless of the probability of their occurrence;*
> - *risks which are less than 1%, but which would be of a significant and/or permanent effect for the patient.*

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Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Response to Provisional Opinion *continued*

The 1% level of risk is implicitly supported by the Accident Insurance Act 1998, which provides that medical mishap (as opposed to medical error – e.g. negligent consenting), occurs when the probability of risk eventuating is less than 1%. Patients are also provided with the opportunity to express specific concerns that they may have about the surgery, so that risks that are significant to the patient may be further explored.

Indeed, Right 6(1) is merely a codification of the principle enunciated in the Australian High Court case of Rogers v Whitaker (1992) 109 ALR 625. The risk of the adverse event (sympathetic ophthalmia causing blindness) that occurred in that case was 0.007%, and it was held that the patient should have been informed of the risk. There were some significant points of difference in this case however:

- *the plaintiff was almost blind in one eye prior to the surgery;*
- *the plaintiff had expressed a keen interest in avoiding harm in her good eye;*
- *the patient repeatedly asked about risks;*
- *had the patient been told of the risk, she would not have proceeded with the surgery.*

In [Dr B's] *case none of these factors were present. Further the dilatation and curettage was performed in an acute setting, as opposed to an elective setting, so that the full liberty of time was not available as was the case in the Rogers litigation. The recommendation must, in our view, be reconsidered in light of these factors.*

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Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Response to Provisional Opinion *continued*

It appears that [Ms A] *never advised* [Dr B] *of a desire to know about the risk of intra-uterine perforation (a risk which in* [Dr B's] *case history of 5000 Dilatation and Curettage, this being the first occurrence, amounts to 0.02%). The logical concern which arises from the recommendation that you propose to make in your finding, is that clinicians must now volunteer information to patients about risks that have a probability of eventuating of less than 1%, whether or not they may be of a significant or permanent nature. They must also assume, without the benefit of hindsight, which particular risks the patient wishes to know about.*

The proposed recommendation obviates a need for longer consultation times with patients, to ensure all risks, no matter how infinitesimal, are discussed with patients, to ensure they have no grounds to complain that they have been provided with insufficient information. The defensive medicine practice which the recommendation will force upon clinicians will undoubtedly lead to them seeing [fewer] patients per clinic sessions, which will lead to longer waiting lists. This obviously has resourcing implications for not only [public hospitals], *but all health providers.*"

Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4
Right to Services of an Appropriate Standard

2) Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards.

RIGHT 6
Right to be Fully Informed

1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including –

…

b) An explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option;

…

f) The results of tests; …

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

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

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Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Code of Health and Disability Services Consumers' Rights *continued*

RIGHT 8
Right to Support

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

Clause 3 Provider Compliance

1) *A provider is not in breach of this Code if the provider has taken reasonable actions in the circumstances to give effect to the rights, and comply with the duties, in this Code.*
2) *The onus is on the provider to prove that it took reasonable actions.*
3) *For the purposes of this clause, "the circumstances" means all the relevant circumstances, including the consumer's clinical circumstances and the provider's resource constraints.*

Opinion: No Breach Midwife, Ms C

Right 8 of the Code entitles consumers to have one or more support persons of his or her choice present, except when the consumer's safety may be compromised or another consumer's rights may be unreasonably infringed. I am advised that during the consumer, Ms A's, transfer to the base hospital on 15 July 1997 there was space on the helicopter for the pilot, the patient and two others. I am informed by midwife, Ms C, and Chief Executive Officer, Ms E, that it was standard practice for two caregivers to be present during the helicopter transfer.

In my opinion, the decision not to allow Ms A's partner, Mr I, to accompany Ms A on the helicopter was made in the interests of patient safety. I accept that it was very distressing to Ms A that Mr I, her partner and sole support person, was unable to travel with her by helicopter. However ultimately, as Right 8 recognises, patient safety must prevail. In my opinion, Ms C's refusal to allow Mr I to accompany Ms A during the helicopter transfer on 15 July 1997 did not breach Right 8 of the Code.

Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Opinion: Breach Obstetrician and Gynaecologist, Dr B

Dr D, as senior house officer, disclosed some information to the consumer, Ms A, about her proposed dilatation and curettage. I note that while it is common practice and makes good sense for the senior house officer to undertake this role, as the clinician performing the procedure, the obstetrician and gynaecologist, Dr B, was ultimately responsible for ensuring that sufficient information had been given to Ms A, and that her consent was an informed choice.

Dr B advised that it was his standard and routine practice to outline the risks of surgery and anaesthesia prior to obtaining a patient's consent for dilatation and curettage under general anaesthesia, but that it was unlikely that he mentioned the specific risk of uterine perforation as it was so small.

My obstetric advisor noted that the risk of perforation is below 1% and that "*most obstetricians would not include discussion of this during pre-operative counselling unless the risk was deemed to be considerably elevated*", which does not appear to have been the situation in Ms A's case.

The legal standard for information disclosure set by Right 6(1)(b) is consumer-centred – what a reasonable consumer, in the particular consumer's circumstances, would expect to have explained about "*expected risks*". Although the usual practice of health professionals in disclosing risks is relevant, it is not finally determinative.

My obstetric advisor commented that perforation is a "*well recognised risk*" when exploring the uterus of a post-partum woman who has recently been treated with antibiotics. In such a case the uterine wall is "*soft and easier to perforate*". My obstetric advisor further noted that perforation of the uterine wall "*can be associated with fatal haemorrhage and possibly disseminated infection*".

The probability of a risk eventuating is one factor to be weighed in considering the need for disclosure. However, the magnitude of the potential harm and the availability of other options must also be considered.

Continued on next page

Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Opinion: Breach Obstetrician and Gynaecologist, Dr B ***continued***

In my opinion, it is entirely appropriate that a woman be warned of the slight but well recognised risk of uterine perforation, which can be associated with serious complications. A reasonable consumer in Ms A's circumstances would expect to be informed of this risk, even though it was less than 1%. I refute the alarmist suggestion that this finding will require all risks, no matter how infinitesimal, to be disclosed, and will force clinicians to adopt the practice of defensive medicine, leading to longer waiting lists.

Dr B remained personally responsible, as the operating surgeon, for ensuring that adequate information had been given to his patient, Ms A, and that her informed consent had been obtained. In my opinion, the information provided to Ms A prior to the operation of 16 August 1997 did not fulfil the requirements of Right 6(1)(b) of the Code, and Ms A was unable to give her informed consent in terms of Right 7(1) of the Code.

In these circumstances, Dr B breached Rights 6(1)(b) and 7(1) of the Code. Dr B's written apology for this failure will be forwarded to Ms A.

Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Opinion: No Breach Senior House Officer, Dr D

Dr D, as senior house officer, disclosed some of the information to the consumer, Ms A, about her proposed dilatation and curettage.

In response to my provisional opinion Dr D stated that the obstetrician and gynaecologist, Dr B, discussed the risks associated with the procedure to Ms A in his presence less than an hour prior to his own discussion with Ms A about the consent form. Dr D stated that he regarded his discussion with Ms A as a continuation of Dr B's visit and did not feel that it was appropriate to mention risks which the consultant surgeon did not feel he would counsel a patient about.

I accept that as the clinician performing the procedure, Dr B was ultimately responsible for ensuring that sufficient information had been given to Ms A, and that her consent was an informed choice. In my opinion, although Dr D failed to provide adequate information to Ms A prior to requesting that she sign the consent form, he acted reasonably in the circumstances and did not breach Right 6(1)(b) or 7(1) of the Code.

Opinion: No Breach Obstetrician and Gynaecologist, Dr B

I accept the advice of my obstetric advisor that the obstetrician and gynaecologist, Dr B's, surgical management of the consumer, Ms A, complied with professional standards and that Dr B provided "*prompt, appropriate and effective*" care. I am informed that while dilatation and curettage was expected to be a brief and uncomplicated procedure, perforation of the uterus was an unusual but accepted risk. During the procedure a large amount of tissue debris was found and my advisor informed me that this, coupled with the length of time elapsed since delivery, is likely to be indicative of infection within the uterus. My advisor stated that the risk of uterine perforation was likely to have been increased by the presence of infection, as this would have made the uterine wall soft and easier to perforate. I accept that once he suspected perforation, Dr B acted appropriately in performing a laparoscopic examination and then, on observing the perforation, conducting a laparotomy to repair it. In my opinion, the care of Ms A provided by Dr B in relation to her surgical management was consistent with the requirements of Right 4(2) of the Code.

Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Opinion: No Breach The Public Hospital

Right 6(1)(f) of the Code gives every consumer the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including the results of tests. The consumer, Ms A, stated that on 19 July 1997 a blood clot was taken for examination. There is no record that any examination was performed on this clot, however a histological examination was performed on a sample of placental tissue and full blood counts were conducted during her time of admission. The results of the placental tissue examination were received after Ms A's discharge from the public hospital on 22 July 1997. The obstetrician and gynaecologist, Dr B, stated to the Commissioner that the results of this test were "*normal*" and that they did not affect the clinical management of Ms A. The Public Hospital forwarded these results to Ms A's general practitioner, Dr H. Similarly the results of the full blood count were not significant and had no impact on Ms A's management.

It is reasonable practice for a hospital to forward test results to a consumer's general practitioner, who is effectively the consumer's agent to receive such information. In my opinion the Public Hospital took "reasonable actions in the circumstances" (in terms of clause 3 of the Code) to give effect to Ms A's reasonable expectations to receive test results. Accordingly, the Public Hospital did not breach Right 6(1)(f) of the Code.

Public Hospital / Midwife, Ms C / Obstetrician and Gynaecologist, Dr B / Senior House Officer, Dr D

Opinion – Case 98HDC19009, continued

Actions

I recommend that the obstetrician and gynaecologist, Dr B, take the following actions:

- Ensure that he, or a designated medical practitioner member of his surgical team, provides sufficient oral and written information prior to any proposed operation to comply with his obligation to adequately inform his patients, and to enable them to make an informed choice about a proposed surgical procedure.

- Ensure that he, or a designated medical practitioner member of his surgical team, is available to meet with all patients after surgery to discuss their operation and to answer any questions.

Other Actions

A copy of this opinion will be sent to the Medical Council of New Zealand. An anonymised copy will be forwarded to the New Zealand College of Obstetricians and Gynaecologists and the Royal Australasian College of Surgeons for educational purposes.