Obstetrician, Dr B

Paediatrician, Dr C

A public hospital

A Report by the

Health and Disability Commissioner

(Case 03HDC13975)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Mrs A	Consumer / Complainant
Baby A	Consumer's daughter
Dr B	Obstetric Registrar / Provider
Dr C	Neonatal Paediatrician / Provider
Dr D	Obstetric Registrar
A public hospital	Provider

Complaint

On 18 September 2003 the Commissioner received a complaint from Mrs A about the care provided by Dr B, Dr C and a public hospital. The issues investigated are summarised as follows:

Dr B
Whether Dr B provided Mrs A and Baby A with services of an appropriate standard. In particular:

- *the appropriateness of informing Mrs A about the results of her scan on 8 July 2002 in the presence of friends and whanau, and recommending termination of pregnancy*
- *whether the internal examination he performed on Mrs A on 10 July 2002 was of an appropriate standard*
- *the appropriateness of the decision not to resuscitate the baby against the parents' wishes*
- *the appropriateness of refusing to give Mrs A steroids when the foetus was one day less than 24 weeks' gestation*
- *the appropriateness of leaving the baby for over two hours after birth before beginning resuscitation.*

Dr C
Whether Dr C provided Mrs A and Baby A with services of an appropriate standard. In particular:

- *the appropriateness of the decision not to resuscitate the baby against the parents' wishes*
- *the appropriateness of leaving the baby for over two hours after birth before beginning resuscitation.*

An investigation was commenced on 23 January 2004.

Information reviewed

- Mrs A's medical records from another public hospital and the public hospital
- Response from Dr B
- Response from Dr C
- Response from the Chief Executive, the public hospital

Independent expert advice was obtained from neonatologist Dr Lindsay Mildenhall.

Information gathered during investigation

Overview
In 2002 Mrs A was pregnant for the ninth time. Baby A was born at a gestational age of 24 weeks on 10 July 2002. Her estimated date of delivery had been 1 November 2002. Mrs A has a history of premature births. She had previously suffered a miscarriage at 18 weeks (12 December 1988), and delivered another child at 35 weeks' gestation (24 December 1995).

When Baby A was born, the clinicians responsible for her care believed that she was unlikely to survive more than one hour. Accordingly no immediate efforts were made to resuscitate or warm her. After 2½ hours Baby A was still alive. A decision was made to provide her with full support. Baby A is now two years old.

Dr C, paediatric neonatologist at the public hospital, provided the following information by way of background to the clinical management and statistics for extremely premature babies born at A public hospital.

> "**Background Information**
>
> A public hospital has no written guidelines regarding the resuscitation of extremely preterm infants. Infants of gestation less than 24 weeks are rarely resuscitated. Infants of 24-25 weeks' gestation are resuscitated if there are no obvious risk factors and the infant is in good condition at birth (i.e. minimal bruising, good heart rate and respiratory effort, no significant congenital malformation) as judged by a pediatrician. However, the public hospital has had plenty of experience and has developed a practice regarding this situation. I understand it is also consistent with the practice of other institutions.
>
> In the past 10 years (1993-2003) 75 infants of gestation 24 weeks have been delivered at the public hospital. In 11 cases no resuscitation was offered because of associated risk factors. Ten infants died shortly thereafter in Delivery Suite ([Baby A] is the exception).

> Over the same 10 year period, three other infants of 24 weeks' gestation with pulmonary hypoplasia were resuscitated and admitted to the Newborn Unit. All three died at age less than 12 hours.
>
> Of the 75 infants of gestation 24 weeks, 44 (58.7%) survived to hospital discharge. Follow-up information is available at age 2 years for 20 of these infants – 4 are normal, 7 have a mild disability, 1 a moderate disability and 8 have a major disability.
>
> It is against this background and experience of high mortality and morbidity that the recommendation not to initially proceed with resuscitation for [Baby A] was made.
>
> The Fetus and Newborn Committee of the Paediatric Society of New Zealand have been unable to agree on guidelines for resuscitation of infants < 26 weeks' gestation. Neonatologists in New Zealand have varying attitudes and approaches, but I am aware that the practice which we have followed at [the public hospital] as above discussed and as recommended with [Baby A's] situation, is a recognised and accepted practice even though some may adopt a different approach."

2002 Pregnancy

As stated above Mrs A's estimated delivery date was 1 November 2002. She was admitted to the public hospital with a threatened miscarriage on 13 June 2002. She remained overnight and was discharged the following morning.

An ultrasound (USS) taken on 14 June noted:

> "Severe oligohydramnios [reduced amniotic fluid volume]. Therefore the foetal anatomy could not be adequately assessed … A sub-membraneous haematoma is present extending down to the internal os. ? partial abruption of the placenta."

Mrs A returned to the city public hospital with vaginal bleeding on 17 June, on referral from the registrar from a regional public hospital, who estimated that Mrs A was approximately 20 weeks' gestation. The referral letter stated:

> "This lady was seen on 13/6 through A&E and admitted to Ward 51 after heavy bleeding. Scan showing abruption of placenta – self discharged before receiving feedback from scan. Phoned with further bleed (dark red soaking/continence sheet) in night. Pregnancy uneventful until this past event. Has had three pregnancies prem labours at 34 and 36/40 otherwise routine pregnancies and deliveries."

The admitting locum house surgeon at the public hospital recorded Mrs A's obstetric history as follows:-

> "Self-admission of 19/40 pregnant. …. was in hospital for PV bleeding last Friday/ Saturday bleeding stopped in hospital. Had USS ? result ? nothing in the old notes. left hospital against medical advice.
>
> …
>
> This morning (17 June 2002) has had heavy PV bleeding, no clots, no tissue and no abdominal pain / bleeding stopped now good baby movement yesterday but no baby movement today."

The plan was to admit Mrs A, commence her on intravenous fluids and keep her "nil by mouth", monitor the baby's heart rate, and inform the obstetric registrar that she had been admitted.

An ultrasound scan (USS) taken on 18 June reported the following:

> "There is a single live foetus in utero presenting variable.
>
> … A detailed foetal anatomy assessment was performed with severe oligohydramnios again noted. No other foetal abnormalities were identified. The deepest pocket of amniotic fluid measured 1 cm. No retroplacental haematoma was noted on today's scan."

At 8.40am on 18 June Mrs A was seen by a doctor (designation unknown) during ward rounds. The doctor discussed with her the implications of oligohydramnios, noted the bleeding was settling and agreed to discharge Mrs A the following day. The doctor who visited her that evening noted that Mrs A was keen to go home and that support had been arranged. Accordingly, Mrs A was discharged.

On 29 June 2002 Mrs A was again admitted to the public hospital with heavy vaginal bleeding which had begun at 7.30pm the previous evening. Her observations were stable and the foetal heart rate was recorded at 160 bpm. Mrs A was seen by the house surgeon, later that day. From the USS Mrs A was thought to be 22 weeks two days' gestation. Later that afternoon she was assessed by the house surgeon, who discussed the case with the obstetric registrar, Dr D. The following morning Dr D saw Mrs A and suggested she could go home and return in two weeks for an USS. Mrs A was discharged later that day.

On 6 July 2002 Mrs A was transferred from the regional public hospital to the city public hospital delivery suite as she was haemorrhaging and passing clots. She had no abdominal pain and, on examination, her fundus (top of the uterus) was estimated at 20 weeks' gestation. However, by dates she was estimated at 23 weeks four days' gestation. The foetal heart rate remained normal. Mrs A was admitted for observation.

Obstetric registrar Dr B examined Mrs A at 1.50pm on 6 July. Mrs A complained that Dr B hurt her during the examination, but she did not tell him that she was uncomfortable at the

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

time. In response to Mrs A's complaint Dr B explained that he was not aware of her discomfort at the time or that she was upset by his examination. He said that although he could not recall the actual procedure, the speculum examination may have taken him longer than usual because it is difficult to visualise the cervix of a woman when pregnant; if he had known that he hurt her during the examination, he would have offered his apologies.

Dr B noted that when Mrs A had been admitted previously, she had received counselling about the poor prognosis for her baby, the plan to review her at 23 weeks' gestation and to commence steroids at 24 weeks' gestation. He recorded in the notes:

"Soft non tender uterus
No tightenings, pain last night. FM [foetal movement] yes
Speculum
– pool of blood in vagina
– closed cervix
Plan
– Stay in for present.
– Steroids at 24/40
– For d/w parents re outline for delivery @ 24 to 26 weeks"

Dr B requested that the paediatricians discuss with Mrs A the likely prognosis if her baby was delivered at 24-26 weeks.

Dr C advised me:

"1. Mrs A had been under the care of the Obstetric department, at the city public hospital for this pregnancy. An ultrasound scan on 14th June 2002 had shown severe oligohydramnios, a condition that is often associated with pulmonary hypoplasia, a potentially lethal developmental anomaly.

2. Mrs A's pregnancy had also been complicated by repeated antepartum haemorrhage an additional risk for increased mortality and morbidity in the infant.

3. I first became aware of Mrs A's pregnancy approximately a week prior to Baby A's birth. I was contacted by the Obstetric department seeking advice regarding the likely outcome for an infant of 23 weeks' gestation with oligohydramnios since 19 weeks and recurrent antepartum haemorrhages. I advised that the situation was hopeless and I recommended no active intervention."

On 7 July Mrs A rested most of the day. She continued bleeding, needing to replace a pad every one and a half hours or so. The baby's heart rate remained within normal limits.

Dr B saw Mrs A on 8 July. He wrote:

"Well, 23+6 still bleeding; no tightenings present

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I do not recommend discharge at this moment in time – await scan, steroids from tomorrow."

Later in the day Mrs A had an USS. The report stated:

"Single live fetus in utero presenting cephalic. The placenta is fundal in location without evidence of previa. There is no evidence of retroplacental clot. There is no amniotic fluid seen. Anhydramnios [absence of amniotic fluid] present. Limited anatomy survey was performed and no fetal anatomic abnormalities were identified.

Conclusions: Fetal growth has been appropriate for gestational age but with anhydramnios and bleeding the prognosis is extremely poor."

At 2.40pm Mrs A returned from the ultrasound. The nurse recorded in her notes: "Returned from ultrasound, distressed at results. Wishes to talk to a doctor."

Dr B recalled:

"Following the scan, I was asked to speak to [Mrs A] by one of the staff midwives. [Mrs A] was distressed by the scan findings that had been explained to her and wished to speak to me regarding the scan. Prior to speaking with Mrs A I spoke to [Dr …] regarding [Mrs A] and the scan report. [Dr …] decided that she felt discontinuation of pregnancy was probably not a suitable option just yet. She stated that the prognosis was poor and that steroids should still be offered along with antibiotics. She recommended a frank discussion regarding outlook, mode of delivery and whether or not resuscitation should take place. She also recommended that [Mrs A] should stay in hospital."

Dr B recorded the following in Mrs A notes:

"Note scan findings re
↓ EFW [estimated foetal weight]
Anhydramnios
Severe bleeding
Very poor prognosis

d/w [Dr …]

- TOP is not a suitable option at this time
- Prognosis is still poor
- Still for steroids & antibiotics.
- To d/w parents re outlook for the baby & mode of delivery / based upon need for resuscitation at birth
- to stay in."

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Dr B knew that Mrs A had already been informed of the poor prognosis for her baby prior to speaking with her on 8 July. When he arrived in the room, she was being comforted by her friends and whanau. He understood they were present to support her during the discussion and help her to reach her decision. Dr B recalled his discussion with Mrs A as follows:

> "I mentioned that full management would entail steroids, monitoring the labour, a possible Caesarean section and active resuscitation of the baby, I also explained that though such measures may have good outcomes, a more realistic outcome would be a Caesarean section with a dead baby or the parents ending up with a severely damaged baby after a long time spent in an intensive care unit. I also explained that a more conservative approach would entail not intervening in labour and assessing the baby at birth, assuming it survived labour.
>
> I tried to explain that the problem with aggressive resuscitation is that it sometimes converts a dead baby into a damaged baby, and that [Mrs A] should be aware that parents can and do regret resuscitation attempts that have resulted in damaged infants. I explained that the course of recovery in SCBU [special care baby unit] puts parents under tremendous stress and sometimes leads to family break-ups. I explained that it was her right to let nature take its course if she so chose (eg declining all management offered including steroids).
>
> I again requested that SCBU [staff] spoke to [Mrs A] regarding outcomes at the public hospital's SCBU so she could make as informed a decision as possible regarding management. I explained that if maternal health was compromised through infection or excessive bleeding, the labour may have to [be] brought on for maternal health reasons and that sometimes people chose termination of pregnancy in situations of mid trimester rupture of membranes because outcomes were so bleak. I did not recommend termination of pregnancy, but I did raise the issue of termination so that [Mrs A] would be aware of all possible options.
>
> I never intended to imply that [Baby A] was anything other than a cherished baby and that with 7 children already she would be less valued. I had tried to explain that the recovery process of babies in SCBU places tremendous strain on families, sometimes splitting them apart and that this was another factor to place into consideration when deciding what to do."

Mrs A said that she was offended by Dr B's information, and understood that he was recommending she terminate the pregnancy. She told Dr B she would rather wait until the baby came naturally. She said that Dr B had told her that because she had been bleeding for so long, when the baby was born she would not last long and that they would not insist on resuscitating her. She asked him, if there was any sign of life and the baby was attempting to breathe on her own, to do all that they could to save her and Dr B agreed. She recalled that she asked him for steroids but he refused because she was only 23 weeks and 6 days

(steroids are not given until 24 weeks). When she told him that she would be 24 weeks' gestation the following day, he replied that steroids would not make any difference. She was very keen to go home, especially as the outlook for the baby was so poor, but Dr B advised her to stay in hospital for her own health.

Dr B advised me that babies born at 24 weeks' gestation, with no additional risk factors, have an extremely poor prognosis. One in four babies will die, one in four will have severe handicap, one in four will have mild disabilities and one in four will essentially have a normal life. Babies born before 24 weeks have a worse outcome and in circumstances where the membranes have been ruptured the outlook is even worse. Dr B stated:

> "Anhydramnios resulting from rupture of membranes leads to the worst outcomes with very low survival rates and very high handicap rates. Anhydramnios also increases the maternal risk for chorioamnionitis [infection of the foetal membranes]. For [Mrs A], the anhydramnios was a new development [from previous scans]."

At about 5.30pm Mrs A asked if she could get a leave pass, but Dr D was too busy to come to the ward. At 6.30pm a nurse recorded the following:

> "[Mrs A] and family still coming to terms with the events of the day. Have arranged for a paediatrician from Newborn Unit to come and to talk with her. [Mrs A] now talking about going home and 'letting nature take its course'. Still losing fresh blood which appears to have increased since 3pm. Antibiotics started."

At 8.30pm the nurse recorded that "the Newborn Unit had no staff to discuss the prognosis of the babe with [Mrs A] at present and any further questions should be through the obstetric teams please".

Mrs A was out of the ward from 7.30pm and returned about 9.30pm, according to the nursing records. Mrs A told the nurse that she had met a friend downstairs, with a similar complaint, who was given steroids. Mrs A requested a steroid injection. The nurse paged Dr D, who suggested that, as it was 10pm, she could discuss steroids with Dr B in the morning. A nurse from the Newborn Unit advised the nursing staff caring for Mrs A that a paediatrician would not be coming to see Mrs A "as by rights she should be seen by the Obstetrician and Gynaecology registrar".

On 9 July 2002 at 9.10am Mrs A's bleeding increased and she reported pain over the left side of her abdomen, radiating around her back. Dr B was notified. Dr B recorded in Mrs A's notes: "Situation fully explained to patient/patient declines steroids at present (steroids offered) check CBC [complete blood count]."

Dr B's recollection and that of Mrs A clearly differ as to whether she wanted steroids on 9 July. However, at 10.30am Mrs A was seen by another doctor (the signature is illegible), who discussed the poor prognosis if she was to go into labour and deliver soon. The doctor recorded:

> "Not for monitoring or Caesarean section if foetal distress in labour.
>
> Not for suppression of labour at this stage. Slim chances for baby but probably worthwhile to give steroids. Will discuss with NBU & ask if they will see her today."

Mrs A was given Celestone 11.4mg, a steroid, at 11.10am. The Newborn Unit indicated that they would have room to take the baby if she survived and the registrar would come to the ward to discuss the situation with Mrs A. By 1.30pm Mrs A was experiencing continued moderate bleeding, bright red in colour, and a CTG scan revealed a decreasing foetal heart beat (to 94). At 1.45pm Mrs A was transferred to the delivery suite.

Delivery

The same doctor who had seen her that morning recorded: "No monitoring of foetal heart rate in labour. Newborn Unit aware. Will see [Mrs A] and assess baby at the time of birth. May not survive labour." The doctor asked for Mrs A's haemoglobin to be checked that afternoon and for two units of blood to be cross-matched. Mrs A refused pain relief.

By 5pm Mrs A's contractions had settled and the blood loss seemed to be easing. The antibiotics, which had been commenced the day before, were continued and the baby's heart rate was recorded at 158. At 11.45pm Mrs A was given medication to help her sleep. Mrs A continued bleeding throughout the night with little change in the baby's heart rate.

On 10 July Mrs A was 24 weeks' one day gestation. Dr B said that at 8.20am he was called to the delivery suite because Mrs A started bleeding heavily. A locum consultant obstetrician was with him. Dr B examined Mrs A, who had lower abdominal and back pain, and found her to be fully dilated with the baby's head on view. At 8.25am Mrs A delivered a female child, Baby A, with a single push. Baby A weighed 540gm at birth.

Resuscitation

In attendance at Baby A's birth were Dr B and the midwife. Dr B advised that "the paediatricians had arrived and resuscitation commenced" soon after. The baby made some effort to breathe and was said to be "well perfused" but her muscle tone was poor. A Neonatal nurse practitioner went to the delivery ward to assess Baby A, recording the following (in retrospect at 11.50am):

> "Female infant born approximately 0830 hours today. Baby was several minutes old when we arrived, and was being cuddled by mum. Cyanosed and making some respiratory effort. HR around 100. IPPV given with bag and mask with good effect, pinked up, heart rate less than 100 and developed grunting resps.
>
> Dr C called, assessed baby and in view of probably hypoplastic [underdeveloped] lungs decision was made to leave baby with mother, and not pursue any active treatment. …"

Dr B advised that he was not involved in this decision.

Dr C recalled:

> "[At] approximately 0830 hours on 10th July 2002 I received a call from Delivery Suite that [Mrs A] was about to deliver. The pregnancy had now reached 24 weeks' gestation. As I was assessing another infant in Neonatal Intensive Care Unit at the time, I sent two experienced Neonatal Nurse Practitioners [… and …] to assess the infant following the birth.
>
> [Baby A] was born by vaginal delivery at 24 weeks' gestation with a birthweight of 540 grams.
>
> I arrived shortly after [Baby A's] birth and my initial assessment determined that [Baby A's] appearance was consistent with a gestation of 24 weeks. Despite having a normal heart rate, she was in significant respiratory difficulty.
>
> Given the adverse prognostic features and also my direct experience and knowledge of other cases […] which demonstrate a very poor prognosis for these children, I had no doubt [Baby A] would die within the hour irrespective of resuscitation attempts. I conveyed this to [Mrs A]. I was not aware that she was insistent [Baby A] be resuscitated. If I had had any such indication I would have respected and complied with the mother's request. To the contrary, I thought Mrs A was in agreement with my recommendation that I considered it to be in [Baby A's] best interests, in the circumstances, to not initiate resuscitation steps. I also endeavoured to relay this information to [Mrs A] in a compassionate manner and as her letter of complaint acknowledges, I indeed did express my regrets to her about the situation. She is also correct that I said I would leave her and the family with [Baby A] so that they could have time with [Baby A] alone before her expected and imminent death."

Dr C explained that given Baby A's extreme prematurity and antenatal history her prognosis, despite resuscitation attempts, was very poor. He advised Mrs A and staff that resuscitation cease and the baby be left alone with her family where he expected that she would die within the hour.

The Midwife recorded that Baby A was "given to [Mrs A] to cuddle until baby passes away". A very close friend of Mrs A's was in attendance at the time.

However, [Baby A] continued to breathe by herself unaided for the next hour or so, her muscle tone improved, and she remained well perfused. The Midwife discussed the situation with the locum consultant obstetrician and the acting manager of Women's Health, before taking her morning tea break. In the meantime the Neonatal Nurse Practitioner arrived. She recalled:

> "I went back to the delivery suite at around 1030 hours to see mum. Baby pink, active, cold with regular grunting resps.
>
> Discussion with Dr C who came to delivery suite to see baby and decision made to bring baby to NICU for CPAP fluids and warming in incubator.
>
> In NICU SaO2 [oxygen saturation] on air 76, CPAP commenced in 100% O2 [oxygen] CPAP [continuous positive airways pressure] with improvement and oxygen saturation into 90s. Temperature 30°C on admission. IV inserted. 10% dextrose commenced. Stab abg/ph 6.45 BE 39.6, volume given."

Dr C recorded the following in the notes at 1pm:

> "Difficult situation which is still not clear. History of absent liquor from 19/40 scan (? cause). Mum admitted … it was agreed (with obstetric team) not to offer support to infant given poor prognosis. Reached 24/40 yesterday and antibiotics steroids given. Delivered vaginally in delivery suite this morning at 8.45am [should be 8.25am], weight 540gm, pink with heart rate 100/min and gasping. Called to see age 5 minutes … breathing, heart rate 100/m but given poor prognosis not intubated and left with mother."

The plan was to repeat the tests for Baby A's arterial blood gases in one hour, continue to slowly warm her and review her after the blood gas results were available. In relation to Mrs A's complaint that these steps were not implemented and Baby A was not taken to NICU until she was two hours old, Dr C informed me:

> "I cannot now remember leaving specific instructions with the Delivery Suite staff (and nor do I in any way blame them) but certainly they would be aware that if any developments occurred I was able to be summoned immediately. I remained in the outpatient clinic at the hospital.
>
> In your letter you have enquired as to the appropriateness of leaving [Baby A] for over two hours after birth before beginning resuscitation. As above, I had not expected [Baby A] would survive and as [Mrs A] has said, at the time I thought she would pass away within an hour given her clinical symptoms, the medical history and my experience with these cases. I regret that I was not called back to [Mrs A] earlier than I was. I would have expected to have been called back after one hour.
>
> At approximately 1030 hours I was contacted by [the Neonatal Nurse Practitioner] advising me that [Baby A] was still alive. I immediately went from the Outpatient clinic, where I was consulting, to Delivery Suite to reassess [Baby A].
>
> My assessment confirmed that [Baby A] was alive with a steady heart rate. I was most surprised to find [Baby A] still alive and I expressed this to Mrs A. I recommended

transfer to the Newborn Unit where she could be kept warm, provided with some intravenous fluids, and receive some supplemental oxygen via nasal CPAP prongs.

Upon admission to the Newborn Unit, [Baby A] had an axillary temperature of 30.0°C, heart rate 116/minute, respiratory rate 44/minute and an oxygen saturation of 74% in air. The initial arterial blood gas (1119 hours) showed a pH 6.45, pCO2 37, pO2 69, BE -39.6 and blood glucose, < 1.1 mmol/L.

I spoke with both parents at approximately 1300 hours on 10th July 2002 informing them of the situation and that I still considered [Baby A's] prognosis very guarded.

I spoke with [Mrs A] at 1830 hours on 10th July 2002 to appraise her of progress and long-term concerns.

I regularly updated [Mrs A] regarding [Baby A's] progress throughout her hospital stay.

The metabolic acidosis and hypoglycaemia were corrected over the ensuing five hours. [Baby A's] condition continued to improve and at 1700 hours a cerebral ultrasound examination showed no evidence of intracerebral bleeding, therefore arterial and central venous lines were placed and full intensive care initiated.

[Baby A's] subsequent progress was complicated by hypotension, pulmonary haemorrhage, patent ductus arteriosus and chronic lung disease (all common complications in extremely premature infants). She did not sustain a cerebral haemorrhage or develop periventricular leukomalacia.

Conclusion

Given [Baby A's] clinical symptoms, the medical history and my own experience (and that of the public hospital) with infants as significantly premature as [Baby A] was, I had no doubt at the time that she was dying and that she would pass away within an hour. At all times my actions and recommendations were entirely consistent with what I believed to be in the best interests of [Baby A], her parents and the family. My recommendations were made to [Mrs A] entirely in good faith in this regard. I have never had another case like it and I very much regret the upset this experience has caused [Mrs A] and the family. I have already apologised to them about this. I expect you will be passing a copy of this reply to [Mrs A] and I again take this opportunity of apologising to her for what has happened."

Discharge

Mrs A was discharged from the public hospital at 7.30pm on 16 July 2002. Baby A was nursed in the Newborn Unit until 6 October 2002 when she was transferred from the Unit to a nursery. It was planned to discharge [Baby A] from the public hospital on 29 October 2002.

Mrs A advised me that [Baby A] is now a "lovely little girl" who has no adverse outcome from her difficult start to life except for some scarring on her lungs, which she is likely to grow out of.

Independent advice to Commissioner

The following independent expert advice was obtained from Dr Lindsay Mildenhall, consultant neonatologist:

"**Medical / Professional advice 03/13975/WS**

I have received the following referral instructions from the Commissioner:

Purpose

To advise the Commissioner whether [Mrs A] received an appropriate standard of care from neonatal paediatrician [Dr C].

Background

[Mrs A] was pregnant with her eighth child and had been admitted on several occasions, from as early as 19 weeks' gestation, with vaginal bleeding. A scan taken at 19 weeks (18 June 2002) suggested the absence of amniotic fluid and placental abruption. The obstetric team consulted [Dr C] who suggested no active intervention.

In 6 July 2002 [Mrs A] was again admitted to [the public hospital] with vaginal bleeding. She was estimated to be 23 + 4 weeks' gestation. [Dr B], obstetric registrar, examined [Mrs A], completed her admission and prescribed steroids, to commence at 24 weeks.

On 8 July 2002 [Mrs A] had an ultrasound scan, which recorded a foetal growth appropriate to gestational age, but given the amount of amniotic fluid and bleeding 'the prognosis is extremely poor'. [Mrs A] had been aware of the prognosis for several weeks and was receiving counselling. In this instance, the fact that she had very little amniotic fluid was new information and it was thought that this heightened the poor prognosis. [Dr B] provided [Mrs A] with full and frank information so she could decide whether to continue with the pregnancy. [Dr B] said that he did not suggest terminating the pregnancy. Steroids were to be given the following day.

[Mrs A] advised the Commissioner that she could not agree to terminate the baby and that she wanted the baby resuscitated regardless of the outcome.

On 9 July [Mrs A's] vaginal bleeding increased; she had abdominal pain and a tender uterus. Although [Mrs A] was to commence steroids, she declined them deciding that

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she would rather go home. Later that afternoon [Mrs A] was transferred to the delivery suite and [Baby A] was born [the following day]. She weighed 540gm, her heart rate was normal and she was well perfused, but she was having significant respiratory difficulty. The paediatrician in attendance commenced resuscitation. [Dr C] arrived and, given [Baby A's] extreme pre-maturity and prolonged ruptured membranes, decided to cease resuscitation efforts.

[Dr C] advised that from his experience, and the prognostic features presenting, children born with this degree of pre-maturity have a very poor prognosis. He had no doubt that [Baby A] would die within the hour irrespective of resuscitation attempts.

However, about an hour and a half later [Dr C] was called because [Baby A] was still alive. [Dr C] immediately transferred her to the Newborn Unit. [Dr C] said that he was extremely surprised that [Baby A] continued to improve and ultrasound examination showed no evidence of intercerebral bleeding. Full intensive care was initiated.

Complaint

[Mrs A's] complaint is outlined in her complaint to the Commissioner but the issues investigated and about which we seek your comments are summarised as follows:

Whether [Dr C] provided [Mrs A] and [Baby A] with services of an appropriate standard. In particular:

- *the appropriateness of the decision not to resuscitate the baby against the parents' wishes*
- *the appropriateness of leaving the baby for over two hours after birth before beginning resuscitation.*

Expert Advice Required

To advise the Commissioner whether [Dr C] provided [Mrs A] and [Baby A] with an appropriate standard of neonatal care and, in addition, to answer the following questions:

1. What particular standards apply in this instance and [did] the care [Mrs A] received met those standards? Please explain.
2. What would be the possible outcome and treatment recommendations when labour threatened at 19 weeks' gestation and the CT scan revealed anhydramnious?
3. What level of medical intervention would be recommended for babies born at 24 weeks' gestation?
4. At what gestational age would steroids normally be given?
5. What delivery options should have been outlined to Mrs A?
6. Whether the clinical decisions about [Baby A's] resuscitation were appropriate in the circumstances?

Any other matter which, in your opinion, should be brought to the Commissioner's attention.

I have reviewed the following information supplied:

Supporting Information

- [Mrs A's] complaint to the Commissioner dated 3 September 2003 (pages 1-4) marked 'A'
- The Commissioner's notification letters to [Dr B] and [Dr C] dated 23 January 2004 (pages 5-7) marked 'B'
- [Dr B's] response to the Commissioner dated 25 March 2004 (pages 8-11) marked 'C'
- [Dr C's] response to the Commissioner dated 1 December 2003 (pages 12-16) marked 'D'
- The public hospital's response to the Commissioner dated 1 December 2003 (pages 17-18) marked 'E'
- [Mrs A's] medical records (pages 19-60) marked 'F'
- [Baby A's] medical records (pages 61-116) marked 'G'.

Comment

[Mrs A's] notes state and her statement confirms that the first dose of steroids was in fact given at 1110 hours on 9th July. The baby delivered 22 hours later. … [Mrs A] was transferred to Delivery Suite at 1345 on 9th July. [Baby A] was born on the 10th July at 0825 which is nearly 20 hours later.

1. What particular standards apply in this instance and whether the care [Mrs A] received met those standards? Please explain.

There are no formalised standards for the care of infants born at the limits of viability, only guidelines. Consultation with two other hospitals in the Australian and New Zealand Neonatal Network, confirm this ethical dilemma but are very consistent in what is suggested. This represents the view throughout many hospitals in Australasia but is not an adopted policy by all. Some would opt for a more conservative, i.e. a much less likely to intervene at very early gestations, approach.

The guidelines as adopted by Middlemore Hospital, National Women's Hospital and The Royal Women's Hospital, Melbourne are as follows. It should be emphasised that these guidelines would provide a framework around which to assess cases and that individual cases would warrant variations on these recommendations. A case where significant fetal compromise is expected, as in this case, would warrant a more conservative approach.

23 weeks 0 days to 23 weeks 6 days

Usual Practice	▪ No fetal monitoring and therefore no caesarean section for fetal distress. ▪ Consider referral to Tertiary Hospital. ▪ No attendance by paediatric staff at delivery.
If parents make a decision for active treatment after informed discussion with neonatal and obstetric specialists	▪ Consider steroids if delivery thought to be imminent or gestation of 23 weeks, 5 days plus. ▪ Paediatrician called for delivery. ▪ If birthweight >500g and gestation appears appropriate start resuscitation. ▪ Stop early if response poor.

≥ 24 weeks 0 days

Standard Practice	▪ Definite referral to Tertiary Hospital. ▪ Antenatal steroids. ▪ Fetal monitoring, consider caesarean section for fetal distress. ▪ Paediatrician called for delivery ▪ If birthweight < 500g discontinue resuscitation.
At parental discretion	▪ If < 25 weeks, parents may elect after discussion for no fetal monitoring, no caesarean section and no Paediatrician at delivery.

It is important to emphasise that Obstetricians and Neonatologists are responsible for conveying this information to parents and guiding their decisions. It is implied however that if the views of the parents go strongly against the medical staff, in that the parents favour active intervention, the parental views are complied with. [Dr C] himself follows this practice as he acknowledges in his letter to the Health and Disability Commissioner dated 19 February 2004. He was unfortunately not aware of [Mrs A's] wishes which,

from her letter of complaint, she conveyed to [Dr B] 1 to 2 days before delivery. In my view that is the fundamental issue in this case.

The Obstetric staff, when counselling [Mrs A], were quite correct in the poor prognosis they gave her with respect to a 19 week and then 23 week pregnancy with extremely low liquor volumes and antepartum haemorrhage. I find in [Mrs A's] medical notes two comments that Neonatal staff will directly talk to her about a plan of management for her child when it is born. These comments were written 2 days before delivery. I can see no mention of this taking place and all communication seemed to be via Obstetric staff. There seems to have been no documented communication between Obstetric and Neonatal staff regarding [Mrs A's] resuscitation wishes for her baby in the 24-48 hours before delivery. This would have been eliminated if Neonatal staff had been updated on her wishes by Obstetric staff or if Neonatal staff had directly communicated with [Mrs A].

2. What would be the possible outcome and treatment recommendations when labour threatened at 19 weeks' gestation and the CT scan revealed anhydramnious?

In the notes provided I can see no antenatal CT scan reports, only obstetric ultrasound reports. Ultrasound would have been however, a perfectly adequate medium to assess this pregnancy. I assume 'CT' is an error in the question.

It is quite clear that a sufficient liquor volume greatly contributes to the development of the fetal lung. Those conditions in which liquor volume is low or absent, especially renal agenesis, are associated with pulmonary hypoplasia and certain demise even when delivered at advanced gestations. A woman presenting at 19 weeks with threatened labour and evidence of no liquor would have to be deemed an extremely high risk pregnancy. Treatment options at this stage are only in the realm of Obstetric management because a fetus of 19 weeks, assuming the gestation is correct, is non-viable. Obstetric options would be to allow the labour to continue and thus deliver a non viable fetus or suppress labour in an attempt to prolong the pregnancy until a viable gestation is reached. The latter course may provide time for more liquor to accumulate and assessment of the fetus to ascertain possible reasons for the lack of liquor. Some labours however are impossible to suppress. Either option would be acceptable practice, assuming the family were involved in the decision making process.

3. What level of medical intervention would be recommended for babies born at 24 weeks' gestation?

The level of medical intervention for babies born at 24 weeks' gestation in the Western world is a topic of huge debate and angst. Practice varies from country to country and indeed between centres within countries. The Netherlands, for example, has adopted a philosophy that no baby < 26 weeks is to be resuscitated[1]. The driver for this mixture of practice is the uniformly low survival and high degree of handicap amongst babies born

at this gestation. A considerable literature is being amassed regarding these outcomes. Even with the benefit of neonatal advances over the last 5-10 years the survival outcomes at 23 and 24 weeks are not impressive and the long term morbidity in survivors high[2]. Both [Dr C's] and [Dr B's] statements allude to the outcome figures at these gestations.

Essentially this question has been answered in Question 1 above. Guidelines exist but at 24 weeks, case by case evaluation is needed. If the parents, after suitable counselling request active resuscitation at 24 weeks, that request would be complied with. The baby would then be reassessed after a period of time to ascertain how successful, or otherwise, the response to resuscitation had been. This would dictate whether resuscitation should be discontinued or ongoing Intensive Care management recommended. If a 24 week baby was clearly dead or dying after resuscitation, and the parent still insisted on resuscitation continuing, acceptable practice would be for the Medical staff to go against parental wishes in this scenario.

4. At what gestational age would steroids normally be given?

Units around the world emphasize that any guidelines are loose, giving a degree of flexibility between patients and clinicians. That being said it **would not** be normal practice to offer antenatal steroids to a mother presenting in preterm labour at 23 weeks. The exception to this would be if, despite appropriate counselling with respect to survival and morbidity data, the family absolutely insisted on steroid administration. Any decisions made to not give steroids at 23 weeks are usually reviewed once a pregnancy reaches 24 weeks, assuming there is still risk of preterm delivery. Many clinicians would still support a decision for no active input into a baby delivering at this gestation if that was what the families wished. If the family requested active management at 24 weeks most clinicians would support this as well and begin steroids. The decision to start steroids is also often made when the 23 and 6 day mark is reached anticipating a 24 week delivery.

5. What delivery options should have been outlined to [Mrs A]?

Had this pregnancy been normal up until her presentation at 23 weeks other modes of delivery could have been discussed, ie Caesarean section versus vaginal delivery. Monitoring the baby during labour, with the assumption of intervening with Caesarean section if fetal distress evolved could also potentially be discussed. While these are Obstetric issues, in my opinion the monitoring of this labour and performing a Caesarean would have been inappropriate for the following reasons.

(i) This was an extremely high risk pregnancy and the chances of pre-labour fetal compromise were very high.

(ii) There is no firm evidence that Caesarean section in extremely preterm infants has any benefit over vaginal delivery[3].

(iii) Caesarean section at 24 weeks requires a classical procedure to be performed i.e. a vertical uterine incision often including the fundus. This has major implications for future pregnancies with a higher subsequent incidence of pre labour uterine rupture and precludes future vaginal delivery.

Due to (ii) and (iii) even normal pregnancies up to 23/24 weeks, likely to deliver would need close analysis to justify Caesarean section.

6. Whether the clinical decisions about [Baby A's] resuscitation were appropriate in the circumstances?

Retrospective reviews have confirmed that fetal compromise at the limits of viability make any survival statistics much worse[4].

In my opinion, [Dr C's] antenatal recommendation of no active intervention was correct.

The description of [Baby A] shortly after delivery as being cyanosed with grunting respiratory distress was consistent with a baby born with underdeveloped lungs secondary to oligohydramnios but also of any 24 week delivery. The baby after initial resuscitation was described by Junior Neonatal staff as 'pinking up' which, if a true clinical description would be surprising if the lungs were severely underdeveloped. [Dr C's] review shortly after however found a baby with 'significant respiratory difficulty'. With the antenatal history, this clinical sign, [Dr C's] past experience of similar cases (which any Neonatal Paediatrician would describe as bleak) and his assumption of the parental wishes his decision to not actively manage this baby would be acceptable practice.

Opinion:

[Dr C] provided an appropriate standard of care for this labour and delivery based on justifiable expectations for an extremely at risk fetus and on his understanding of [Mrs A's] wishes for the resuscitation of [Baby A]. That this latter factor was incorrect and guidelines for reassessing the infant, once born, were not in place reflects a communication issue between departments and needs addressing.

Process recommendations:

1. Antenatal counselling needs to involve Neonatal Unit staff directly or failing that regular updating of Neonatal staff from the high risk Obstetric service.
2. Delivery and resuscitation plans need to be clearly documented in the mother's notes.
3. Delivery and resuscitation plans need to be reassessed as a pregnancy progresses to more viable gestations.
4. Verbalised changes in parental wishes for delivery and immediate management of an at risk neonate require ALL relevant parties to be reinvolved in discussion.

5. If a baby is born alive and a decision not to resuscitate is made, regular reassessments by Neonatal staff (either Senior or experienced Junior staff) should be undertaken. Failing this, guidelines should be set, either clinical features or time deadlines, for Delivery Suite staff to request neonatal reassessment.

References:

1. Sheldon T, 'Dutch doctors change policy on treating preterm babies', BMJ, Jun 2001; 322: 1383.
2. Doyle LW. Victorian Infant Collaborative Study Group, 'Outcome at 5 years of age of children 23 to 27 weeks' gestation: refining the prognosis'. Pediatrics. Jul 2001; 108(1):134-41.
3. MacDonald H, 'Perinatal Care at the Threshold of Viability', Pediatrics, Nov 2002; 110: 1024-1027.
4. Batton DG. DeWitte DB. Espinosa R. Swails TL, 'The impact of fetal compromise on outcome at the border of viability', American Journal of Obstetrics & Gynecology. May 1998; 178(5):909-15."

Response to provisional opinion

The public hospital provided the following response to the Commissioner's provisional opinion:

"Thank you for your provisional report of 27 August 2004. [The public hospital] accepts the findings and recommendations in your report and will be complying with them.

Child Health and Womens Health Services (the Services) are reviewing their practices and procedures in light of the comments and recommendations of your expert advisor, Dr Lindsay Mildenhall, Consultant Neonatologist. Staff from the Services held a meeting on 9 September 2004 to discuss these matters. The following attended: […] and [Dr C].

They noted that Ms A case was an extremely difficult clinical situation and that there is possibly none more demanding in perinatal care. They accepted that processes/systems need to be improved as a consequence of your investigation.

Comments were made in relation to the following matters:

1. **Re guidelines around decision making**
   There has been a well-developed understanding over the years between obstetricians and paediatricians at [the public hospital]. However, it is clear in light of your report

that there is a need for this understanding to be written down and the newborn unit staff will be addressing this.

The guidelines referred to by Dr Mildenhall are not accepted nationally by other neonatologists in New Zealand.

2. **Re documentation of delivery and resuscitation plans**
There is an obvious need for better delivery and resuscitation plans and they need to be highlighted and recorded in the body of the clinical notes. Given that they will always alter over time with advancing maturity and changes in parental attitude/wishes, the newborn unit will keep in contact with mothers who are undelivered and in similar situations to [Mrs A] in order to amend and make changes to the plans, if necessary.

3. **In-service education**
This case will be useful for in-service education in the Services particularly in relation to regular review and discussion of delivery and resuscitation plans and documentation of the outcome.

4. **Resuscitation guidelines / protocols**
In cases like this neonatal staff are called to the delivery. In [Ms A's] case the decision was made not to resuscitate. There are guidelines or protocols for calling paediatric staff to Delivery Suite, the most up to date revision being in April 2004. The guidelines are being reviewed to see if there is any clarification needed to cover situations like [Ms A].

Any doctor or midwife in Delivery Suite has the right and responsibility to call paediatric staff for assistance when needed.

5. **Summary of discussions re Dr Mildenhall's recommendations**
It was agreed that:
- resuscitation plans need to be more clearly documented
- plans need to be reviewed and reassessed as pregnancy progresses
- verbalised changes in management need to be documented although it is noted that it is difficult for all parties to be involved in discussions simultaneously
- regular assessment should be made of newborn babies if the clinical situation warrants it.

Please find attached an apology letter for [Mrs A] from [the public hospital]."

Code of Health and Disability Services Consumers' Rights

The following Rights in the Code of Health and Disability Services Consumers' Rights (the Code) 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.

…

5) Every consumer has the right to co-operation among providers to ensure quality and continuity of services.

RIGHT 5
Right to Effective Communication

…

2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly, and effectively.

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 unreasonably infringed.

Opinion: No breach – Dr C

Under Right 4(1) of the Code Mrs A and Baby A had the right to have services provided with reasonable care and skill.

Medical intervention
Mrs A complained that Dr C did not continue to resuscitate Baby A when she was born at 24 weeks' gestation, despite her understanding from a discussion with Dr B that Baby A would be resuscitated in the event that she was born alive.

Several days before Baby A's birth the obstetric team at A public hospital consulted Dr C for advice on the likely outcome for a baby born at 23 weeks with oligohydramnios from 19

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

weeks and recurrent antepartum haemorrhages. He advised the obstetricians that the situation was "hopeless" and no active intervention should be attempted in such circumstances.

On 10 July 2002 Dr C received a second call about Mrs A, who was in labour. By this time she was 24 weeks' gestation. Dr C could not personally attend, but asked two neonatal nurse practitioners to assess the infant and advise him accordingly. Dr C arrived shortly after Baby A was born. He found her in significant respiratory distress, and reaffirmed his earlier advice that no active intervention be undertaken because of the baby's very poor prognosis. He explained this to Mrs A and recommended that resuscitation not be initiated, as he was sure the baby was dying and would pass away within the hour. Dr C assured me that it is his usual practice to follow the parents' wishes in such circumstances and he thought Mrs A was in agreement with his recommendation.

According to my advisor, the question whether very premature babies (less than 24 weeks) should be resuscitated, and to what degree, is an ethical dilemma faced in specialist units throughout Australasia. Some opt for a conservative approach with no active medical intervention. Most neonatal units would make the decision on the degree of medical intervention to offer after assessing the baby at birth. Intervention at 24 weeks is the subject of "high debate and angst". Guidelines suggest antenatal steroids, foetal monitoring during labour, and a paediatrician present at the delivery. If the baby weighs less than 500gm at birth resuscitation would be discontinued. However, at 24 weeks case-by-case evaluation is required and cases where significant foetal compromise is expected warrant a more conservative approach. My advisor also said that at 24 weeks, if the parents, after suitable counselling request active resuscitation, that request would be complied with. The baby would then be assessed to ascertain how successful or otherwise the response to resuscitation had been and whether continued resuscitation or ongoing intensive care management was recommended.

In Mrs A's case, significant foetal compromise was anticipated. As well as the risks associated with extreme prematurity, Baby A was at risk from a lack of amniotic fluid and repeated antepartum haemorrhage.

Dr Mildenhall confirmed that, as a paediatric neonatologist, Dr C 's role was to advise the obstetric team managing Mrs A's overall care about the probable outcomes and long-term effects for Baby A, if she was born under such circumstances. I accept Dr Mildenhall's advice that Dr C's antenatal recommendation of no active intervention was appropriate; that he provided an appropriate standard of care when assessing Baby A after she was born; and that the decision not to resuscitate Baby A (based on Mrs A's antenatal history, the baby's clinical condition at birth and very poor prognosis, and Dr C's belief that Mrs A had agreed with his recommendation not to resuscitate the baby) was within accepted standards.

Accordingly, in my opinion, Dr C provided services with reasonable care and skill and he did not breach Right 4(1) of the Code.

Delayed resuscitation
Baby A was not reassessed when she did not die within a short period, and resuscitation was not commenced for over two hours. The situation was extremely distressing for Mrs A and her family.

Dr C expected Baby A to die soon after she was born and thought the kindest thing would be to leave her with her family to die peacefully. He was not informed that Baby A remained alive until two hours later. On learning of her progress, he immediately began resuscitation and arranged her transfer to the Neonatal Intensive Care Unit. He said that with the benefit of hindsight he would have expected to be told Baby A was still alive after one hour not two – although he did not ask to be kept informed of her condition.

As soon as Dr C was informed that Baby A was still alive he acted promptly and full resuscitation measures were commenced. I am satisfied that in the circumstances, when Dr C was unaware that Baby A was still alive, he did not breach Right 4(1) of the Code.

Opinion: No further action – Dr B

Communication
Under Right 5(2) of the Code Mrs A had the right to an environment enabling open, honest and effective communication. Mrs A complained that on 8 July Dr B gave her information about her baby's poor prognosis and the possibility of terminating her pregnancy with friends and family present.

Dr B was asked by nursing staff to see Mrs A because she was upset about her scan results and needed further information. He understood that Mrs A's friends and whanau, who were comforting her when he arrived, were there to support her during the discussion and decision-making process. The right to support is recognised in Right 8 of the Code. While it would have been wise for Dr B to clarify with Mrs A who she wanted present for the discussion, I am satisfied that his actions were understandable in the circumstances. Accordingly, I do not intend to take any further action on this aspect of Mrs A's complaint.

Painful examination
Mrs A complained that when Dr B examined her on 6 July 2002 he was rough and it was painful, although she did not tell him at the time that he was hurting her.

Dr B advised me how he performs vaginal examinations and explained why, as the pregnancy advances, they can sometimes take longer. The examination was necessary because he needed to isolate the cause of Mrs A's bleeding, if possible. He was unaware that he had hurt her and would have apologised at the time if he had known.

I appreciate that some examinations, although clinically necessary, are uncomfortable, and that Dr B would have apologised had he appreciated the pain Mrs A suffered. As this matter has now been brought to Dr B's attention, I do not intend to take any further action on this aspect of Mrs A's complaint.

Administering steroids
Mrs A complained that she asked Dr B to give her a steroid injection at 23 weeks and 6 days' gestation but he refused.

The evidence does not support Mrs A's allegation. According to her antenatal records, as documented on 18 June and 29 June, the plan was always to administer steroids at 24 weeks' gestation. On 8 July Dr B recorded: "Steroids from tomorrow." Dr B discussed steroids with Mrs A on 9 July but according to the records, she declined them. After discussion with another doctor, Mrs A had her first dose of steroids administered at 11.10am on 9 July.

Twenty-four weeks was considered by Mrs A's doctors the appropriate stage at which to use steroids and it was planned to administer them at that stage. Accordingly, this aspect of Mrs A's complaint is not supported by the evidence and I do not intend to take any further action on this aspect of Mrs A's complaint.

Resuscitation
Under Right 4(5), every consumer has the right to co-operation among providers to ensure quality and continuity of services. Dr B spoke to Mrs A on 8 July about the implications of her scan results and options for labour, delivery, and resuscitation of her baby. Mrs A said that she asked him whether they would resuscitate Baby A if she showed any sign of life at birth. She understood from his response that Baby A would be supported if she was attempting to breathe on her own. However, Dr B did not record this in the clinical records – but did record that he had requested that a staff member from the Special Care Baby Unit come and speak to Mrs A, to assist her to make an informed choice about management options. This did not occur as staff were too busy that evening.

Dr B saw Mrs A the following morning and recorded "situation fully explained to patient. Pt declines steroids at present (steroids offered)". He did not record anything about Mrs A's wishes for management of the labour and delivery or resuscitation if the baby was born alive.

Dr B did not see Mrs A again until she was about to deliver Baby A nearly 24 hours later. Mrs A was seen in this period by other medical staff.

After Baby A's birth, resuscitation was commenced but was discontinued following Dr C's recommendation. Dr B had no role in this decision.

It is not clear exactly what Mrs A told Dr B about her desire for resuscitation of her baby. The last documentation of resuscitation issues was recorded by another doctor the day

before she delivered. The documentation stated that an assessment of the baby's condition would be made at birth and decisions made based on the baby's condition. There is no indication this was discussed with Mrs A. The decision to stop resuscitation, as far as Dr B was aware, was made with Mrs A's consent.

A delivery and resuscitation plan, including Mrs A's wishes about resuscitation, should have been clearly recorded and made known to all involved in her care, but the failure to do so was a systemic one not attributable to Dr B alone. Dr B made reasonable efforts to advise Mrs A of the options and to obtain further specialised advice to assist her with decision-making. In all the circumstances, no further action will be taken on this aspect of Mrs A's complaint in relation to Dr B.

Opinion: Breach – The public hospital

Resuscitation at birth
My expert advisor said that for infants born at the limits of viability there are guidelines that can provide a framework to assist with decision-making about the care of such infants, but that cases must be considered individually. Cases where significant foetal compromise is expected, as in this case, warrant a more conservative approach.

It is the role of obstetricians and neonatologists to convey this information to parents in Mrs A's situation so that they can make informed decisions about delivery and resuscitation. Delivery and resuscitation plans that make clear the parents' wishes should be developed, documented, and communicated to those involved in the woman's care.

Mrs A was counselled by Dr B and other obstetric staff at 19 weeks and 23 weeks about the poor prognosis for her baby because of the low liquor volumes and antepartum haemorrhage. When Mrs A was admitted to hospital towards the end of week 23, the obstetric staff consulted with the neonatal staff about the baby's prognosis if born around 24 weeks. Dr C confirmed a very poor prognosis. Obstetric staff discussed this with Mrs A in the days leading up to the baby's birth. Several discussions with her about the baby's poor prognosis and options for the management of the labour, delivery and resuscitation are documented between 8-9 July, but there is no documented delivery and resuscitation plan that made clear Mrs A's wishes.

Obstetric staff also requested on several occasions on 8 and 9 July that neonatal staff speak to Mrs A so that she could make as informed a decision as possible about resuscitation of her baby, if born alive. Neonatal staff could not speak to Mrs A directly on 8 July because they were busy and a further request was made on 9 July. There is no documented communication between obstetric and neonatal staff regarding Mrs A's resuscitation wishes for her baby before delivery. It appears to have been decided between obstetric and neonatal staff, once Mrs A was admitted to delivery suite, that in view of the baby's very poor

prognosis, decisions would be made on the basis of an assessment of the baby at birth by neonatal staff and a discussion with Mrs A at that time.

Nobody took responsibility for clearly obtaining Mrs A's wishes, documenting a delivery and resuscitation plan based on those wishes, or communicating Mrs A's wishes to the staff who would be involved in the labour and delivery. Obstetric staff appeared to be waiting for neonatal input to assist Mrs A with decision-making but the neonatal staff did not consider it as essential to see Mrs A before she went into labour. The omission doubtless reflected the competing demands on their time.

This was a systems failure. In my opinion, by not having a clear process in place to ensure that Mrs A's wishes regarding delivery and resuscitation were ascertained and clearly documented as part of a delivery and resuscitation plan and conveyed to all those involved in her labour and delivery, the public hospital breached Right 4(5) of the Code.

Reassessment
Baby A was expected to die very soon after birth. She did not, and over the two hours following her birth appeared not to deteriorate. Her condition was not regularly reassessed by neonatal staff and there were no guidelines in place to clarify the situation in which delivery suite staff should request neonatal reassessment. As a result, Baby A's continued survival and clinical condition was not conveyed to Dr C for two hours after her birth when a member of the Neonatal Unit came to see how Mrs A was.

In my opinion, 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, the public hospital breached Right 4(1) of the Code.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists.

- A copy of this report, with details identifying the parties removed, will be sent to the Paediatric Society of New Zealand and all District Health Boards, and will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.