General Practitioner, Dr B

A Report by the

Health and Disability Commissioner

(Case 03HDC10782)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Complainant/Consumer
Dr B	Provider/General Practitioner
Ms C	Provider/Midwife

Complaint

On 28 July 2003 the Commissioner received a complaint from Ms A about the services she received from Dr B in relation to the delivery of her first baby and her postnatal care in 2002. The following issues were identified for investigation:

- *The management of Ms A's labour and delivery;*
- *The leaving of a surgical swab in Ms A's vagina; and*
- *Dr B's assessment and care of Ms A after the birth of her baby including whether he diagnosed a recto-vaginal fistula in a timely manner.*

An investigation was commenced on 13 October 2003.

Information reviewed

Information from:

- Ms A
- Dr B
- Ms C
- anaesthetic registrar
- obstetrician and gynaecologist
- Public Hospital
- Accident Compensation Corporation
- Independent expert advice obtained from Dr William Ferguson, general practitioner obstetrician.

Information gathered during investigation

Background
In August 2001 Ms A was referred by her general practitioner to Dr B – a general practitioner obstetrician – for antenatal care and the delivery of her first child. Dr B at that time became Ms A's Lead Maternity Carer (LMC). Her due date was 3 April 2002.

Ms A and her partner also engaged the services of a midwife in August 2001 but subsequently transferred to another midwife, Ms C, whom they met for the first time on 19 February 2002. Ms C agreed to care for Ms A on a shared care basis, although Dr B remained LMC.

Labour and delivery
On the evening of 3 April 2002 Ms A contacted Ms C by telephone as she had been experiencing lower back pain and irregular tightenings since 31 March and had had a small show. Ms C attended Ms A at home where she assessed that Ms A was having mild, irregular contractions and was in the latent phase of labour. She gave Ms A homeopathic medications to assist in establishing labour, and returned home to await progress. Ms C spoke to Ms A by telephone at 10.00pm and again at 10.00am on 4 April. As there had been no significant change in the contractions, Ms C consulted Dr B and it was agreed that Ms A and her partner would attend the delivery suite at the Public Hospital for an assessment at 1.30pm.

Ms C met Ms A and her partner at the delivery suite at 1.55pm, and Dr B assessed Ms A at 2.00pm. Dr B performed a vaginal examination and determined that Ms A's cervix was fully dilated and that the baby was in the posterior position. He then undertook an artificial rupture of membranes, which drained clear liquor. Dr B recalled that, at this time, the baby's head was at station 0 (the degree of the descent of the baby's head in relation to the pelvis). The clinical notes record that at 2.00pm the baby's head was "well down". Dr B advised in response to the complaint that his plan was for Ms A to remain in passive second stage labour "for an hour or so" to enable the head to descend before pushing commenced.

Dr B advised in response to the complaint that having a passive second stage of labour, where the woman does not push, is not unusual or radical management. He referred to the Labour Ward Management Guidelines of Aberdeen Maternity Hospital (July 2003), which state that "there is no absolute limit or correct length for the second stage". Those protocols define a "Prolonged Second Stage Algorithm" suggesting a passive descent phase of up to two hours and an active pushing phase of one hour. If delivery is not imminent after one hour of pushing, the protocols recommend review by the registrar.

Dr B then left the Public Hospital and returned to his surgery. Ms A understood that Dr B would return in two hours, unless contacted earlier to deliver her baby.

Between 2.00pm and 3.20pm Ms A continued to have contractions. The clinical notes record that Ms A experienced back and bowel pressure, but only began pushing at 3.20pm.

This was confirmed by Ms C, who recalled that prior to 3.20pm there was no pushing, and no desire to push. Ms A disputes this and recalls that she felt the desire to push from as early as 2.30pm and pushed up until the time of delivery at 7.41pm.

A vaginal examination performed by Ms C at 4.15pm indicated that the baby had descended to station "0 – +1". At 4.30pm Ms C contacted Dr B by telephone to discuss Ms A's progress. Dr B outlined two options for Ms A: to carry on pushing or to have an epidural and Syntocinon infusion (which would augment uterine contractions and thereby speed up the labour). Ms A opted to continue pushing as she wanted a drug-free birth. During this phone call Dr B also advised Ms C to contact him in half an hour for an update.

Ms C contacted Dr B again at 5.10pm and it was agreed, in view of the lack of progress, that he would come to the delivery suite to assess Ms A. Dr B arrived at 6.00pm, having been delayed in traffic for 40 minutes.

Upon arrival Dr B ascertained that the baby was at station +2 (that is, visible on parting the labia). He decided that delivery of the baby should be expedited by Neville Barnes forceps. Accordingly, Dr B contacted the anaesthetic registrar for the purpose of administering an epidural.

The anaesthetic registrar working that evening cannot recall the exact time of the telephone call from Dr B but it was between 6.00pm and 6.30pm. He was advised that Ms A had had a prolonged labour and that she would be having a forceps-assisted delivery performed by Dr B. The anaesthetic registrar attended Ms A immediately, gained a brief history, examined her and determined that the most appropriate form of pain relief was a spinal anaesthetic (subarachnoid block), not an epidural. The anaesthetic registrar advised me that spinal anaesthesia at the Public Hospital was required to be performed in the Caesarean theatre with full monitoring facilities, and the ability to treat possible complications and proceed to general anaesthetic if required. He explained this to Ms A and Dr B.

The anaesthetic registrar recalled that Dr B was resistant to his plan, primarily because transfer to the Caesarean theatre required the involvement of the hospital obstetric medical team and theatre staff. Dr B was concerned that he would not be permitted to undertake the delivery in that theatre. After further discussion with Dr B regarding anaesthetic options (with which Dr B was not satisfied), the anaesthetic registrar contacted the on-call anaesthetic consultant. The on-call anaesthetist confirmed the appropriateness of spinal anaesthesia. When advised of this Dr B contacted the on-call obstetric consultant and was given permission to proceed to delivery in the Caesarean theatre.

In relation to the discussion with the anaesthetic registrar, Dr B stated that he had not experienced the use of the Caesarean theatre for a spinal block and thought this was an unusual request. He was also concerned that Ms A's transfer to the hospital obstetric team would affect her continuity of care. He confirmed that he had a discussion with the obstetric consultant. Dr B also stated that the conversation with the anaesthetic registrar

took about ten minutes. Ms A recalled that the discussion about where her baby should be delivered took over one hour.

Ms A was eventually transferred to the Caesarean theatre at 7.10pm. Spinal anaesthesia was sited at 7.15pm, an episiotomy was performed, and the baby was safely delivered by forceps at 7.41pm. Dr B proceeded to repair the episiotomy. There was a considerable amount of ooze from the episiotomy scar necessitating the use of swabs. As a prophylactic measure he prescribed Ms A cefaclor (an antibiotic).

Postnatal care
Ms A stayed overnight in the Public Hospital and was visited by Dr B on the morning of 5 April (although there are no notes of this visit). She was transferred that afternoon to the Maternity Unit.

On 6 April Ms A was noted at approximately 3.30pm to be suffering "terrible" diarrhoea, which was attributed to the cefaclor. Dr B was contacted by telephone, and gave verbal orders to cease the medication. Subsequent nursing notes at 7.00pm comment: "? offensive lochia [postnatal vaginal discharge] ? diarrhoea still on bed."

On 7 April at approximately 12.15pm Ms A felt some pressure, went to the toilet and found a surgical swab in her vagina. The swab was noted to be "very smelly". Ms C, who continued to provide midwifery care to Ms A, was advised by telephone and an incident form was completed. Later that evening Ms A experienced a brown, thick vaginal discharge which was thought might be the remnants of the swab. Ms A recalled that on this day, and subsequently, she complained to nursing staff about "bubbling" in her vagina and that her discharge smelt of faeces. There is no record of this in the clinical notes.

On 8 April urine samples and vaginal swabs were sent for testing. Clinical notes record that Ms A's vaginal discharge was "muddy brown in colour and offensive +++". Dr B was contacted by telephone at 11.15am and notified of the retained swab and offensive vaginal discharge. He ordered 500mg of Augmentin (an antibiotic) to be given three times per day. It is noted that there is a discrepancy between the Maternity Unit clinical notes and Ms C's midwifery notes, which record that Dr B was informed of the retained swab on 7 April.

On 9 April nursing staff documented that Ms A's lochia was brown in colour but less offensive. Additionally, the laboratory results of the vaginal swab and urine sample were received. The microbiology report in respect of the vaginal swab noted a heavy growth of mixed skin and bowel flora, and a moderate number of pus and squamous cells. These results were sent by facsimile to Dr B together with an enquiry from nursing staff regarding antibiotic treatment. The cover sheet of the facsimile noted that the vaginal discharge was still offensive but improving. A verbal order for Augmentin was received from Dr B's practice nurse.

Ms A and her baby were discharged from hospital that night.

Dr B advised that "unlike a formal surgical procedure there is no count of swabs made at the time of a delivery" and that "[u]nfortunately it has been a common problem that swabs have been left behind [after a repair of an episiotomy] in the past by virtually all practitioners, because of a lack of formal technique for this situation".

Dr B further advised that he did not assess Ms A in the Maternity Unit at the time the swab was detected because "… at no time was Ms A pyrexial [feverish] or in any way constitutionally unwell. I thus delayed seeing her until she arrived home."

On 10 April Ms A was visited by Ms C at home. Ms C ascertained that, although Ms A had a sore and red perineum, it was clean and her lochia (material passing through the vagina from the uterus after delivery) was moderately serous and a "little smelly". On the following day (11 April) Ms C assessed Ms A again at home and noted that her perineum was red, tender and gaping and that there was a purulent discharge. A swab was taken. Ms C notified Dr B of the discharge by telephone and said that a vaginal swab had been sent for testing. Dr B responded that he would undertake a home visit on 13 April. Ms A stated that on this occasion she advised Ms C that she was passing wind from her vagina. Ms C recalled that Ms A complained of a gurgling sound in her vagina but cannot recall when Ms A told her this.

On 12 April Ms A advised Ms C that her "bum" was feeling a little better but that her vaginal discharge smelled like "poo". This is recorded in Ms C's midwifery notes, together with the comment that the lochia was "scant brown". Additionally, Ms C recorded, "Seeing [Dr B] tomorrow so [Ms A] will discuss above [that vaginal discharge smells like poo] and swab being left behind etc."

At his visit to her home the following day (13 April) Dr B examined Ms A. She recalled that Dr B advised she had a small anal fissure, which would heal by itself. He did not perform a vaginal examination on this visit. He described Ms A's perineum as "tender but healing" and her lochia as unremarkable, noting it as "normal" in the clinical record. Dr B advised that, although Ms A complained of a painful perineum, this was not unusual as women who have a forceps delivery often complain of perineal pain.

Ms A stated that at this consultation she informed Dr B she had a vaginal discharge that smelt like faeces, and a bubbling and gurgling sound coming from her vagina. Dr B denies that he was informed that Ms A's vaginal discharge smelt like faeces. He recalled that Ms A described a bubbling sound in her vagina which, in his view, is not unusual as the pelvic floor muscles stretch during delivery causing air to become trapped in the vagina. He recommended that Ms A undertake pelvic floor exercises.

On 15 April Ms A was reassessed by Ms C, who recorded that Dr B had assessed Ms A and apparently informed her that she had an anal fissure. Ms C's notes further document that a review of Ms A's perineum was to be undertaken by Dr B in two weeks' time.

On 17 April the results from the perineal swab taken on 11 April became available. Those results showed a heavy growth of *Escherichia coli* (*E coli*), a bacteria ordinarily found in the rectum. Ms C's notes record that Dr B was informed of the results by telephone on 18 April. Dr B denies this, but advised that even if he had received the results he would not have been too anxious as he would have expected to see the presence of *E coli* in the vagina after birth.

Ms C assessed Ms A again on 22 April. She recorded that Ms A was well and that her perineum was feeling fine, although she continued to have a smelly vaginal discharge. Ms C discharged Ms A and her baby from her care.

Ms A saw Dr B at his surgery on 24 April. Dr B recorded that there were no abnormalities detected in the vaginal wall or perineum. He did not perform a "full" vaginal examination at this consultation. Dr B further advised that there was confusion at the consultation on 24 April whether Ms A's vaginal discharge was a faecal discharge. Dr B explained that the condition of lochia is variable in women and that it is always difficult to be sure whether it is suspicious or not.

Dr B recalled clearly advising Ms A that she should telephone if she felt there was any question regarding her vaginal discharge before the six-week check (22 May) and that she did not do so. Dr B also advised that Ms A did not specifically mention the faeces in her vagina until the six-week check and he did not consider the possibility of a recto-vaginal fistula at this point because he had not diagnosed this condition in 25 years of obstetric practice.

Ms A recalled that at the consultation with Dr B on 24 April she repeated her concern about the bubbling and gurgling sounds coming from her vagina. Ms A also "specifically" mentioned that there were faeces coming from her vagina (rather than stating that her discharge "smelt like" faeces as at the consultation on 13 April). She was still wearing sanitary pads and the smell and appearance of her vaginal discharge by this time was obvious to her. Ms A further stated that she was told by Dr B she was "healing beautifully" and was given further advice about pelvic floor exercises. Ms A was unhappy about this advice in light of the faeces coming out of her vagina. Ms A also recalled that a vaginal and anal examination was undertaken on 24 April.

On 22 May Ms A saw Dr B for the usual six-week check. Ms A recalled informing Dr B again about her vaginal symptoms and showing him her sanitary pad. Dr B examined her vagina and noted there were faeces present and suspected a recto-vaginal fistula. A recto-vaginal fistula is a defect that occurs between the rectal mucosa and the vaginal wall. A consequence of such a defect is that faecal material passes from the rectum into the vagina.

Dr B referred Ms A to a gynaecologist, who diagnosed a recto-vaginal fistula of a size that admitted the top of her index finger. The gynaecologist referred Ms A to a colorectal surgeon for treatment. She underwent surgery on 6 June for repair of the fistula. During surgery it was noted that Ms A also had an external anal sphincter rupture, which was

repaired at the time. The surgeon considered this injury to have occurred at the time of childbirth. Although Ms A is expected to make full recovery of anal and vaginal function, she was required to deliver her second child by Caesarean section, and will require this procedure for delivery of any subsequent children.

Furthermore, Ms A advised that she still experiences bubbling from her vagina, does not have complete control over her bowels despite receiving physiotherapy treatment for a year, and wears a sanitary pad every day. Ms A has also found that her fistula limits her physical activities.

ACC
In June 2002 Ms A claimed to ACC for medical misadventure. ACC received expert advice from two obstetricians.

The first ACC obstetrician expert found medical error. He advised that the length of Ms A's labour was prolonged and unacceptable and along with the retention of the swab could have contributed to the formation of her fistula. The first ACC obstetrician expert also advised that Dr B should have detected the recto-vaginal fistula earlier because of the "clear descriptions in the notes and from the patient of the symptoms".

The second ACC obstetrician expert advised that medical error occurred because (a) Dr B did not detect he had cut Ms A's external anal sphincter during the episiotomy and (b) he left the swab in her vagina.

The second ACC obstetrician expert further advised that the fistula was caused either by (a) the prolonged second stage of labour or (b) a tear of the anal sphincter during the forceps delivery or (c) cutting of the anal sphincter and rectum at the time Dr B performed the episiotomy. The second ACC obstetrician expert considered that "the cause of the recto-vaginal fistula is speculative and may be multifunctional but I suspect also constitutes medical error".

The second ACC obstetrician expert also advised that Dr B should have sought advice from a specialist much earlier in the second stage.

In his initial response to ACC Dr B stated in relation to the consultation on 24 April:

> "I do recall saying to [Ms A] though that because of a little bit of confusion as to whether there was a faecal discharge present or not that she should ring me if she felt that there was a faecal discharge from her vagina before the six week check, but in fact she did not."

In a further response to ACC Dr B disagreed with the experts' conclusions regarding the duration of the second stage of labour. He contended that in the Public Hospital the criteria for when second stage has commenced is determined by the active (pushing) stage as opposed to the latent (non-pushing) stage. In this respect Dr B considered that Ms A's

second stage commenced at 3.20pm, and that by 6pm (when he arrived at the hospital) she had therefore only been in active pushing stage for two and a half hours. He stated that he made an appropriate decision to deliver Ms A by forceps at that time, and that responsibility for subsequent delays cannot be attributed to him.

Dr B also advised ACC in his later response:

> "At that time [the consultation on 24 April] I did look for the possibility of a fistula because of the discharge that I felt to be suspicious but did not find one …"

ACC decided on 10 October 2002 that medical error had occurred. Dr B sought a review of this decision but this was declined on the grounds that his application was out of time.

Testimonials
I received a testimonial from an obstetrician and gynaecologist dated 20 June 2005. The obstetrician and gynaecologist advised that he frequently came across Dr B and his patients in the delivery suite at the Public Hospital. In the obstetrician and gynaecologist's view, Dr B provided exemplary antenatal care and his work in hospital during labour was always attentive and meticulous. He sought appropriate and timely advice from a consultant when a patient's labour was not progressing normally. Dr B's postnatal care always seemed careful and attentive and he would also seek a timely second opinion if any abnormalities occurred.

The obstetrician and gynaecologist stated that Dr B had a good reputation among his colleagues and prospective patients for his obstetric work, for example GPs in obstetric practice often requested him to speak on their behalf and he represented them at meetings of the Department of Obstetrics and Gynaecology at the Public Hospital.

I further received a testimonial from a second obstetrician and gynaecologist. The second obstetrician and gynaecologist advised that he has known Dr B in his capacity as a general practitioner obstetrician since 1986. The second obstetrician and gynaecologist considers Dr B an excellent general practitioner obstetrician with outstanding clinical acumen. His availability to his obstetric patients has often been to the detriment of his personal and family life and "obviously one makes errors but one could not fault Dr B on his commitment to practising best medical practice".

Independent advice to Commissioner

The following expert advice was obtained from Dr William Ferguson, general practitioner obstetrician.

> "Expert advice on the provision of maternity care to [Ms A], by [Dr B]

I have been asked to provide an opinion on the above case, and have read and agree to follow the Commissioner's guidelines for independent advisors. I am a General Practitioner Obstetrician of some 20 years experience, holding a Diploma of Obstetrics and Medical Gynaecology, and I am a Fellow of the Royal New Zealand College of General Practitioners. I am the spokesman for maternity issues for the Royal New Zealand College of General Practitioners, and I am an examiner in the Diploma of Obstetrics and Medical Gynaecology at National Women's Hospital.

I have reviewed all the documents and records provided by the Commissioner as detailed below and the further research material I have drawn upon has all been referenced accordingly. I found the factual record and summary of the case provided by the Commissioner was an accurate record of the events that occurred as documented in the medical record and upon reading statements provided by [Dr B] and [Ms A].

Supporting Information

Information from:

- Complainant (pages 1-27)
- Notification letter (pages 28-29)
- [Dr B] (pages 30-121)
- [obstetrician and gynaecologist] (page 122)
- [anaesthetic registrar] (pages 123-126)
- ACC (pages 127-222)
- [Public Hospital] (pages 223-294)
- [Ms C] (pages 295-316)

Labour and delivery

Did [Dr B] appropriately manage [Ms A's] labour and delivery at [the Public Hospital] on 4 April 2002?

Before responding to the specific questions raised concerning the management of [Ms A's] labour and delivery it is necessary to review aspects of the normal physiology of the second stage of labour, and how changes in the management of it have evolved over recent decades. I believe this is necessary because issues arise concerning the length of the second stage and criticisms of the management have come from the ACC Specialist Obstetric Advisors. The ideal management of a prolonged second stage of labour is somewhat contentious, and has evolved significantly over time. Thus a range of opinions on this matter are likely to be forthcoming. I will attempt therefore to summarise some of the key research over the last 30 years that has signposted changes in management before attempting to answer the questions posed by this case.

The second stage of labour begins at full dilatation of the cervix and ends with the birth of the fetus. The second stage of labour is divided into Phase one and Phase two. Phase one is from the full dilatation until the spontaneous urge to push occurs. The duration of phase one is very variable, and is physiologically no different from the first stage of labour. Encouraging a woman to push actively in this stage of labour usually only leads to maternal exhaustion, and increases the need for instrumental delivery. Phase two is the period of active pushing and this is associated with slightly increased uterine activity, decreased utero-placental perfusion and an increased risk of hypoxic stress on the fetus.

The ideal management of the second stage should allow the greatest chance of spontaneous delivery with the least risk of maternal morbidity and infant morbidity and mortality. There is however a lack of consensus regarding the optimum management of the second stage, particularly with respect to its duration. Arbitrary time limits have been (and in some instances still are) applied to the second stage leading to operative intervention (Caesarean section, forceps or ventouse delivery) in many cases, in the absence of any evidence of any maternal or fetal compromise. Traditional teaching has advocated two hours for nulliparous women (women who have not previously given birth vaginally) as the upper limit of a normal second stage. The early influential work by Friedman[1] indicates that 2 hours is on the 95th percentile for second stage duration in 'ideal' groups of labouring primagravid women. Concerns about prolonging the second stage beyond this are focussed primarily on the vulnerability of the fetus to hypoxic stress, especially with prolonged active pushing.

Maternal morbidity has been looked at much less extensively, but is focussed upon risks of haemorrhage and infection. In all of the literature I reviewed concerning the management of prolonged second stage there was no mention of a relationship between duration and risks of maternal perineal trauma or recto-vaginal fistula formation.

The advent of epidurals, the widespread use of Electronic Fetal Monitoring and the challenging of earlier assumptions with better quality research has slowly changed views on the safe duration of the second stage of labour.

Cohen[3] in 1977 followed 4403 term nulliparas, carefully monitored with CTG recordings and showed that the duration of the second stage of labour alone had no influence on either perinatal outcome or maternal postnatal morbidity. He noted an increase in haemorrhage in those women delivered with the use of mid forceps (that is a higher or mid-pelvic cavity forceps delivery, as opposed to a low pelvic or pelvic outlet delivery). There was also a higher risk of infection in those women who were delivered by Caesarean section. Cohen concluded 'as long as there is no evidence of significant fetal hypoxia, there is no fetal indication for intervention no matter how long the second stage. If descent is normal and there is no other suggestion of feto-pelvic disproportion, labour may be allowed to progress without interference.'

Obstetric practices were slowly changed by this finding, and this of course also coincided with the more wide-spread use of electronic fetal monitoring, by which it was possible to better assure the ongoing well-being of the baby, and epidural anaesthesia, which had its own direct effect in prolonging second stage but also enabled women to cope more easily with prolonged second stages. There soon followed some large observational studies (Reynolds, Yudkin[3]) that showed in an analysis of nearly 19,000 deliveries between 1981 and 1984 that there had been marked changes in the management of the second stage of labour. These changes included an increase in the length of the second stage, and associated with this was a rise in the rate of normal spontaneous delivery and a large decline in the rate of episiotomy. There was no associated change in neonatal outcomes, or in the rate of maternal post-partum complications. This more conservative approach to second stage management was well established by 1988 and the largest ever observational study of the second stage of labour was conducted by Patterson, Saunders and Wadsworth.[4] They followed over 25,000 normal labours and noted that the time required to deliver 80% of a defined group of women varied by a factor of 14 depending on their parity and the method of analgesia employed. They noted that this remarkable variation in 'normal' needed to be taken into consideration when second stage management policies are being defined. 'As the risks of maternal or fetal morbidity do not increase unduly with the duration of the second stage, the timing of intervention should be influenced by the condition of the mother and fetus, rather than the elapsed time from full dilatation of the cervix.' They noted that there was no clear cut-off point for expectation of spontaneous delivery and that women continued to give birth at a steady rate, and were followed in their study for up to 6½ hours in second stage.

A discussion paper was published in the Australian and New Zealand Journal of Obstetrics and Gynaecology in 1991[6] on the duration of the second stage. The paper reviewed the literature, and commented particularly on the National Collaborative Perinatal Project (NCPP) undertaken in the USA, which at that time was the most comprehensive analysis of the association of duration of second stage and perinatal outcome. The NCPP report concluded that when all labour and delivery variables were considered, prolonged second stage only ranked 40th out of 42 adverse associations for a significant adverse perinatal outcome. Of more importance the analysis showed that there was a far greater adverse association of failed or arrested descent and the use of difficult high or mid cavity forceps delivery. The authors concluded that prolonged duration of the second stage on its own was of little clinical significance, and warned that the injudicious use of instrumental delivery just because an arbitrary time period had passed presented a far greater hazard to the fetus.

In 1995 an influential Canadian group published a review of prolonged second stage in 6,000 nulliparous women. This study noted the second stage lasted more than three hours in 11% of nulliparous women and more than five hours in 2.7%. There was no significant relationship between second stage duration and any adverse perinatal outcome. The authors concluded 'operative intervention in the second stage is not warranted merely because some set number of hours has elapsed'.[7]

Gradually a consensus has been well established around permitting a more conservative management of prolonged second stage, such that current and influential textbooks also support this position. 'If there are no serious fetal heart rate abnormalities, if the mother is well hydrated and reasonably comfortable, and if there is some progress of descent or rotation of the fetal head, regardless of how slow, there is no need for operative delivery.'[8]

1. **Should [Dr B] have left the hospital after his initial assessment of [Ms A]?**

2. **[Dr B] advised the Commissioner that [Ms A] was fully dilated but had no desire to push and her baby's head was at station 0. He decided that [Ms A] should not push for an hour or so, wait for her baby's head to descend and then push. Was this plan appropriate? If not, what should have happened?**

In the absence of any indicators of fetal distress [Dr B's] management and advice was entirely appropriate. At the time of this assessment the baby was also in a posterior position (OP) and this provided all the more reason to withhold active pushing, and await the natural progress of rotation and descent. In a nulliparous woman it was quite appropriate to assume that this may have taken at least one hour, and as the labour was normal in all other respects it was appropriate for [Dr B] to have left the hospital. This of course pre-supposed a good working relationship between [Dr B] and the midwife who would be able to reassess the situation and advise accordingly.

3. **Should a urine analysis have been conducted? If so, when?**

A urine analysis should be done routinely at the time of the patient's admission in labour. However when a patient arrives already fully dilated it is my experience that this routine investigation would commonly be overlooked, with the expectation that delivery is imminent. The most important reason for checking the urine is to detect proteinuria, and hence evidence of underlying Toxaemia or Gestational Proteinuric Hypertension. [Ms A] did have a transient rise in her blood pressure at 35 weeks' gestation, and was referred to the antenatal day assessment unit. No evidence of the condition was found and subsequently no problems occurred, however this should have been a warning bell in a primagravid woman to ensure this assessment was done. The presence of Ketones in the urine is also checked, under the generally mistaken belief that this is a useful measure of dehydration in a labouring woman. Despite this being the teaching on the matter for several generations of Obstetricians in New Zealand, it is in fact only a measure of starvation in a labouring woman. Sometimes of course this also coincides with dehydration and hence the confusion. (This point was raised, as a criticism of management, in one of the ACC specialist opinions.)

4. **[Ms C] recorded at 4.30pm that after a telephone discussion with [Dr B] [Ms A] was given the option of continuing to push or receiving an epidural and syntocinon. Were these options appropriate? If not, why not?**

5. **If the above options were appropriate, what information should have been given to [Ms A] about these options?**

6. **Should [Dr B] have returned to the hospital and assessed [Ms A] prior to the presentation of the above options?**

By 4.30pm [Ms A] had at least one hour of active (Phase Two) second stage. The midwife had repeated the vaginal examination and although the baby's head was not visible it seemed some progress had been made, and that the station of the head had descended from station 0 to somewhere between 0 and +1. This means that some descent had occurred into the mid-pelvis. The position of the baby was not recorded at that point. Ideally I believe [Dr B] should have repeated this examination himself, as it's much easier to assess progress when the examination is repeated by the same practitioner, than if subjective impressions are recorded by two different practitioners. However the appropriateness of this decision would depend upon the degree of experience of the midwife, and the degree of the working relationship between [Dr B] and the midwife. If they were working together as a well established team then there may be no issue with this at all.

As progress clearly was slow at this stage it was perfectly appropriate to offer augmentation of the uterine contractions with a syntocinon infusion, and almost always this necessitates epidural anaesthesia. The midwife would have been perfectly capable of presenting the options of continuing to push or receiving an epidural and syntocinon, but again it would have been my preference for [Dr B] to have come in and discussed this personally. Patients can be hugely influenced by how information is presented, but it may well be that [Ms A], who was obviously showing a lot of stoicism in declining the epidural at this point, was managing adequately and indeed had made an informed decision. The advantages of an epidural would be pain relief and rest for the mother. The disadvantage is that it would inevitably further lengthen the second stage of labour and increase the risk of a forceps or ventouse delivery. There are other well-known risks of epidural anaesthesia that I will not reiterate.

Following on from this the use of syntocinon would have provided the option of reducing the risk of an eventual forceps delivery by generating more efficient uterine contractions to help with pushing the baby out and shortening the labour. Risks include over stimulation of the uterus and increased risks of fetal distress. Without knowing exactly what information was presented at this stage, and just how distressed [Ms A] was at this point in her labour, it's difficult to make any judgement on this issue.

7. **[Dr B] returned to the hospital at approximately 6.00pm and [Ms A's] baby was delivered at 7.41pm. Part of the delay appears to have been due to [Ms A's] transfer to the Caesarean theatre to receive a spinal block. Could this**

delay have been prevented if [Ms A] had received an epidural, syntocinon or other appropriate treatment at an earlier stage? If so, when?

8. **How urgent was the condition of [Ms A] and her baby when [Dr B] returned to the hospital at approximately 6.00pm?**

9. **Should [Dr B] have detected earlier that [Ms A] required a forceps delivery? If so, at what point?**

I am sure that by 6.00pm there was very considerable maternal exhaustion, but there continued to be no evidence of fetal distress, and nor was [Ms A] in any danger with the situation. In referring back to my earlier discussion of the management of a prolonged second stage, it could be seen that there was no imperative for earlier intervention based on either maternal or fetal risk and the delay had enabled steady progress in the descent of the baby's head, such that the forceps was going to be a low-risk lift-out procedure, rather than a more potentially hazardous mid-forceps delivery. However it's not possible to say from the notes just how long the baby's head had been sitting at this relatively low station, and therefore within easy reach of a simple lift-out procedure. The delays unfortunately were compounding, first [Dr B's] delay in the traffic, and then the issue with the anaesthetic registrar. This created a far from ideal situation, although I believe it had no bearing on the eventual outcome of the case. In reality a forceps delivery done significantly earlier in the afternoon at a higher station in the pelvis would have only increased the risk of trauma to mother and baby. The delay would however have been prevented by the earlier use of an epidural and syntocinon, as the syntocinon may well have brought the baby lower down in the pelvis earlier in the afternoon. The epidural would have required a simple top-up, taking at most five to ten minutes before the application of the forceps.

10. **The hospital maternal postnatal discharge form recorded the length of [Ms A's] second stage of labour was five hours and 41 minutes. Is the time recorded correct?**

11. **Was the length of time of [Ms A's] second stage of labour acceptable? If not, why not?**

12. **[Dr B] advised that 'a passive second stage is not that unusual or a radical management of a second stage of labour' and this process is used often. Please comment on this statement.**

13. **Should [Dr B] have discussed [Ms A's] condition with an obstetric consultant before his discussion with the [obstetrician and gynaecologist] (which was after 6.00pm)? If so, at what point?**

14. **Were the observations conducted during [Ms A's] labour and delivery adequate, for example fetal heart rate, temperature, blood pressure and the periods of CTG tracings?**

The duration of [Ms A's] second stage of labour was accurately recorded as 5 hours and 41 minutes. The duration of [Ms A's] second stage was excessively long but this is not a matter upon which a black and white judgement should be rushed, and not all of the factors that lead to this scenario were under [Dr B's] control. A traditional view is that the second stage should be terminated in all nulliparous women at two hours, regardless of the well-being of mother and baby. As I have explained above this is a position that cannot be supported by a steady accumulation of research over the last 30 years that all points to a more conservative approach to management, with the essential proviso that the well-being of mother and baby is closely monitored and in addition to this that progress is in fact being made. The facts in this case are that the baby was born in good condition, and that although [Ms A] had a bad outcome to her labour this was not related to the length of her second stage. [Dr B's] comments about the management of the second stage of labour in question 12 refer to the varying philosophies that continue to abound about the correct management of the second stage. Management however should be tailored to the specific circumstances of a labour and accurate information about the well-being of the mother and baby within the bounds of what is safe and accepted practice. The fully informed choice of the mother is also a key part of the decision making equation. Given that some of the reason for the delay in effecting delivery was unavoidable, much does hinge on the quality of the information that was presented to [Ms A] around 4.30pm and any ongoing discussion as time continued to tick by. If [Ms A] had agreed to an epidural and syntocinon it would probably be part of the normal […] maternity unit protocol for [Dr B] to have discussed this with the specialist on call at that point. If however [Ms A] had made an informed decision to decline intervention at that point then so long as the condition of the mother and baby was healthy, and progress was slowly being made then there was no point in obtaining a specialist assessment.

In relation to question number 14 it then became very important that the ongoing observations of maternal and fetal well-being were meticulous. From reviewing the medical records I believe that this monitoring was adequate.

My conclusions concerning the management of the second stage is that, notwithstanding the delays [Dr B] had no control over, the duration of the second stage cannot be automatically assumed to be inappropriate. Despite opinions to the contrary I am firmly of the view this did not impact on the development of the recto-vaginal fistula (see comments below). I do however view with moderate disapproval the fact that such a conservative management of the second stage was not implemented with more close continuing and personal involvement by [Dr B] to ensure the ongoing well being of both [Ms A] and her baby. In my view the responsibility for this monitoring should not have

been delegated to another practitioner much beyond 4.30pm, no matter what their level of experience.

15. **Should [Dr B] have transferred [Ms A's] care to the hospital obstetric team to conduct the delivery?**

It was appropriate for [Dr B] to have managed the forceps delivery, as it was a procedure he had adequate training and experience to perform. With the baby's head visible at the introitus there is no question that this was a delivery well within his expertise. Had [Dr B] transferred [Ms A's] care to the hospital obstetric team she may well have been delivered by an Obstetric Registrar who would be unknown to her, and who may well have had less experience than [Dr B] in such a delivery.

Management of the perineal repair and subsequent postnatal care

Before responding to the questions concerning this aspect of the case I wish to make some general comments about perineal trauma, fistula formation and postnatal care. Damage to the anal sphincter can occur in two ways. Most obviously it can occur with a perineal tear that extends into the sphincter or as an extension of an episiotomy, but it can also occur with no visible outward signs or anal sphincter damage.

In 1994 a paper was published in which for the first time techniques of anal endosonography and ano-rectal neuro-physiological testing was performed before and after delivery.[9] Alarmingly this clearly demonstrated that occult anal sphincter defects involving one or both anal sphincter muscles occurred in 35% of women having their first baby, although only a third of the women actually had any symptoms associated with this. Instrumental delivery in nulliparous women carried the highest risk of both occult sphincter damage and subsequent symptoms. It is usually not possible with clinical examination to determine if occult damage has occurred. This was borne out by the comment by the colorectal surgeon who repaired [Ms A's] fistula. 'I found that she did have a complete division of the external anal sphincter which was a surprise to me as pre-operative evaluation of the sphincter suggested it was going to be intact.'

Damage to the rectal mucosa (technically termed a fourth degree tear) can also occur in two situations. It can occur obviously as an extension of a visible third degree tear that has extended through the anal sphincters and into the rectal mucosa. In rare situations however it can also occur as a 'buttonhole' in which the sphincters may appear to be intact, along with the lower rectal mucosa, but a small defect occurs higher up. This can only be detected with a digital rectal examination performed at the time of the perineal repair.

Mention was made in the ACC specialist opinion of 'pressure necrosis on the rectum from the prolonged second stage i.e. pressure of the fetal head causing ischaemic necrosis of the rectum'. This is a condition I have never previously heard of, nor could I

find reference to it in several current obstetric textbooks.[8, 10, 11] In all the literature that reviews prolonged second stage, fistula formation was not mentioned as a possible outcome. Generally speaking this is not seen in the Western World. It is well known in Third World countries that women who labour without assistance literally for several days may suffer from the horrific circumstances of pressure necrosis. The various scenarios associated with this are well described in William's Obstetrics (21st edition)[10] with the fistula almost always forming between the vagina and the bladder, giving rise to a vesico-vaginal fistula. Various other fistulas related to prolonged labour were described in this text, but not a recto-vaginal fistula.

I have no doubt that the cause of the fistula was the rare but well described circumstance of a 'buttonhole' defect in the rectal mucosa that occurred as part of the concealed damage to her anal sphincter as a consequence of the forceps delivery. As described in the original paper by Sultan,[9] and the considerable research that has been done subsequent to this, it is a significant hazard of any instrumental delivery, regardless of the skill of the operator.

The first key management issue that arises from these findings is prevention, by avoiding unnecessary instrumental deliveries. Ironically, this includes the move to longer second stages of labour, to await spontaneous delivery when it is safe to do so. Secondly, recognition of the hazards of childbirth to the anal sphincter and rectal mucosa with early diagnosis and treatment of any damage that occurs.

16. **Should [Dr B] have detected the damage to [Ms A's] external anal sphincter? If so, when?**

17. **[Dr B] 'visited' [Ms A] on 5 April after her delivery and before she was transferred to [the Maternity Unit]. What investigations, if any, should he have conducted during this visit?**

The occult damage to the external anal sphincter probably could not have been detected at delivery (as even the colorectal surgeon was unable to find it!) however the buttonhole defect in the rectal mucosa could have been detected with a digital rectal examination prior to the repair of the episiotomy. To perform such an examination has not traditionally been part of the teaching in the Diploma of Obstetrics in New Zealand. The work of Sultan[9] and his colleagues in the last ten years will however have increasingly influenced many practitioners to be much more mindful of the possibility of significant sphincter damage particularly in high-risk situations such as primagravid women, instrumental deliveries and large babies. It is certainly not an examination that I have seen routinely done by all Obstetric Specialists. I believe many conscientious practitioners would be caught by the rare circumstances of a buttonhole tear in the rectal mucosa.

The next opportunity to make the diagnosis is in the postnatal period, as soon as the condition declares itself. [Dr B] visited [Ms A] on 5 April, the day after her delivery and before she was transferred to [the Maternity Unit]. A postnatal check the day after delivery should attend to all relevant aspects of maternal and baby well-being. With regard to the perineum after a forceps delivery and repair of an episiotomy this should have involved a check of her perineum. However no investigation would normally be done, nor would it have been appropriate to conduct any other more invasive vaginal or rectal examination. One day after the delivery all perineums will have a more-or-less equal amount of swelling and tenderness and any additional pathology such as infection or fistula formation would not yet be apparent.

Surgical swab

18. **[Dr B] advised the Commissioner that he did not use a formal technique to ensure that all the swabs were removed from [Ms A's] vagina after he repaired her episiotomy. Should [Dr B] have used a formal technique? If so, what type of technique?**

It is not customary for a formal technique to be used in counting swabs when repairing an episiotomy. Essentially this is because the field of operation is all clearly visible, and there is no cavity within which a swab may be lost. The exception to this however is when attempting to stem the flow of bleeding coming from the uterus or high in the vagina. Sometimes it is necessary to push a swab high above the field of operation to absorb blood that would be otherwise obscuring the work in hand. In these circumstances one should always use a swab with a string attached. The string dangles down into the lower vagina acting both as a reminder and a means of easy removal at the end of the procedure.

Detection of recto-vaginal fistula

19. **[Dr B] advised the Commissioner that he was informed (on 8 April) about the swab in [Ms A's] vagina and the offensive lochia during her admission to [the Maternity Unit]. [Dr B] verbally prescribed Augmentin. However, he stated that he did not assess [Ms A] in hospital because she was not pyrexial or constitutionally unwell. Should [Dr B] have physically examined [Ms A] prior to her discharge from [the Maternity Unit] on 9 April?**

    Note: Please give your advice in the alternative that [Dr B] was informed of the swab on 7 April.

20. **Should [Dr B] have assessed [Ms A] prior to 13 April?**

I believe the circumstances that arose during [Ms A's] stay at [the Maternity Unit] definitely necessitated a postnatal visit from [Dr B]. If there was any question of an

infection in her perineum, I believe it was very important for [Dr B] to assess the situation for himself, if not before starting the Augmentin, then at the earliest opportunity soon afterwards.

There is a general tendency amongst staff providing postnatal care that perineal wounds should just take care of themselves. I am quite sure that any other equivalent surgical wound in any other part of the body at any other time in a person's life, would merit far more fastidious care and attention from medical and nursing staff than do perineal repairs. It is unfortunate that this tendency also coincides with the tendency of women in the postnatal period to grossly underreport any symptomatology related to the perineal area. No doubt this is partly because of embarrassment and not knowing what to expect, but also perhaps because mothers are extremely focused upon and distracted by the baby.

Perineal pain peaks around 24 hours after delivery and then steadily declines so that most women are comfortable around four days. Four days after delivery on 08.04.02, the [Maternity Unit] records state that despite Voltaren 75mg and Panadol '[Ms A] finding it difficult getting on and off the bed'. I have concluded from the way [Ms A] managed such a prolonged second stage of labour without analgesia that she is a very stoical woman. I believe she was tolerating a very abnormal level of discomfort at this time.

There is a sense in reading the records of what transpired at [the Maternity Unit] that [Dr B] was very much conducting his postnatal care by 'remote control'. This was [Ms A's] first baby, the labour and delivery was complicated and the issue of the swab and the offensive lochia had arisen. In this context I view with mild disapproval the fact that [Dr B] relied entirely upon Midwifery care to diagnose and treat what was essentially a medical problem. In a situation where there is risk of infection I do not believe that a Doctor should wait for the patient to become pyrexial or constitutionally unwell before feeling that a visit was called for.

The swab had no bearing whatsoever on the development of the fistula or the outcome of this case. It did however act as a bit of a 'red herring' in distracting people from the seriousness of [Ms A's] symptoms. Her continuing offensive lochia, and any other symptoms that she complained of may well have been seen as being somewhat in the aftermath of the problem with the swab, rather than alerting her caregivers to the possibility of another more serious issue.

With every passing day from her discharge from [the Maternity Unit] it is of more concern to me that any symptoms [Ms A] complained of whether it be perineal pain, offensive lochia or the bubbling noises she described in her vagina were not carefully assessed and thoroughly investigated.

21. **What further investigations, if any, should [Dr B] have conducted at the consultation on 13 April in light of:**

(a) **the nursing staff at [the Maternity Unit] faxed the results of the laboratory tests of [Ms A's] urine and swab to [Dr B] on 9 April and informed him that her vaginal discharge was offensive but improving**
(b) **[Ms C] advised [Dr B] on 11 April that [Ms A's] discharge remained offensive and she had taken a swab for laboratory testing**
(c) **[Ms A] informed [Dr B] at the consultation that she had a bubbling sound in her vagina**
(d) **any other factors you consider relevant.**

By the time of the visit on 13 April I believe there was ample indication that a careful pelvic and rectal examination was required. Nine days after delivery it is not normal for the perineum to be significantly tender. I suspect that the assessment by [Dr B] that her perineum 'was tender but healing' underestimated what was really going on. It is also of concern that her lochia was described as still being offensive on 11.04.02 and I am led to wonder how carefully [Dr B] was listening to [Ms A's] concerns on the visit of 13.04.02.

Finally it is not normal under any circumstances to have a bubbling sound in the vagina in the postnatal period. This symptom alone should have sounded an unmistakable warning bell that all was not well. In the management of this case I reserve my strongest criticism of [Dr B's] management for not interpreting the clinical picture that was emerging on that visit of 13.04.02. His notion of various things being 'normal' seems to have overridden an unmistakable combination of symptoms and signs.

22. **[Ms C] recorded on 18 April that she informed [Dr B] (by telephone) of the laboratory results of the swab she had taken on 11 April from [Ms A's] vagina. If so, what action, if any, should [Dr B] have taken at the consultation on 24 April in light of these laboratory results and the other information he had received?**

I don't believe the results of the swab add anything to the clinical picture as the swab is in no way a diagnostic test for this sort of problem.

23. **[Dr B] advised the Commissioner that he advised [Ms A] to contact him if there 'was any question of a vaginal discharge before the six-week check'. Was this adequate or should [Dr B] have reviewed [Ms A's] condition prior to the consultation on 22 May?**

Whilst [Dr B] did extend the invitation to [Ms A] to contact him 'if there was any question of her vaginal discharge before the six-week check' I believe this was not adequate. From [Ms A's] perspective she had complained on numerous occasions to all of her caregivers about embarrassing symptoms that were of great concern to her, something which no doubt she found difficult to do, and nobody had really taken her seriously. Now that her perineal pain had finally subsided she had probably been fairly persuaded by everybody that what she was experiencing was 'normal'.

24. **Should [Dr B] have detected [Ms A's] fistula prior to the consultation on 22 May? If so when?**

I believe the best opportunity to make an early diagnosis was on 13.04.02. As already explained I view with mild disapproval the arms length approach to postnatal care that [Dr B] provided. However I believe to some extent this situation is aided and abetted by a Funding System that allows for comprehensive postnatal midwifery care, but really makes no provision whatsoever for a General Practitioner Obstetrician to have any useful input, as almost the entirety of the postnatal funding module is spent on midwifery care. I also concede that the presence of the swab created a bit of confusion and a smoke screen, and perhaps prevented [Dr B] from thinking of other causes of the persistent offensive lochia. However by 13.04.02 listening carefully to the patient and doing a thorough examination should have led to a diagnosis.

25. **Obstetrician and Gynaecologist […] advised ACC that there were three possible causes for [Ms A's] fistula '(1) pressure necrosis on the rectum from the prolonged second stage (that is pressure of the fetal head causing ischaemic necrosis of the rectum), (2) a tear of the anal sphincter extending into the rectum during the forceps delivery or (3) inadvertent cutting of the anal sphincter and rectum at the time of performing the episiotomy.' Please comment.**

The answer to this question is given in detail in my comments under 'Management of the perineal repair and subsequent postnatal care'.

1. I can find no reference in my obstetric literature to pressure necrosis causing a recto-vaginal fistula. The scenario of pressure necrosis from the fetal head appears to almost always cause damage anteriorly rather that posteriorly. Hence the all too familiar scenario in Third World countries of women labouring for several days, often delivering a dead baby, and subsequently developing urinary incontinence with the formation of a vesico-vaginal fistula between the bladder and the vagina.
2. In [Ms A's] case there was no tear externally into the anal sphincter, extending beyond that into the rectum. This would have been dramatically evident at the time of delivery and I'm quite certain [Dr B] would not have missed it. I refer again to the work of Sultan.[9] It is a well described phenomena that the anal sphincter can be severely damaged without any external visible laceration.
3. It is most certainly not the case that the anal sphincter and rectum was cut inadvertently at the time of the episiotomy. […] the colorectal surgeon, would have commented on the visible scar extending through the sphincter if that had been the case.

General

26. If, in answering any questions, you believe that [Dr B] did not provide an appropriate standard of care, please indicate the severity of departure from that standard.

To assist you in this last point we note that some experts approach this question by considering whether the provider's peers would view the conduct with mild, moderate, or severe disapproval.

My main concerns in this case are [Dr B's] minimal involvement in the supervision of [Ms A's] labour and his lack of involvement in her postnatal care. For the well evidenced reasons I have detailed one cannot automatically assume that the length of the second stage, in as much as it was under [Dr B's] control, was by arbitrary definition inappropriate. This is a somewhat contentious point. It was not a 'normal' second stage. Earlier intervention would have necessitated a higher forceps delivery, and the outcome of the case would not have been altered. What was inappropriate however was the fact he wasn't there to more carefully supervise progress. Similarly I feel if [Dr B] had been a bit more involved in [Ms A's] postnatal care, especially during her time at [the Maternity Unit], he may well have been in a position to make the diagnosis of the fistula at an earlier stage. Whilst viewing both the labour management and postnatal management with mild disapproval, when taken together that disapproval becomes moderate.

I also view with moderate disapproval the fact that there was no recognition on the consultation of 13.04.02 that something was wrong.

27. Are there any aspects of the care provided by [Dr B] that you consider warrants additional comment?

In [Dr B's] letter of response to the Health and Disability Commissioner (17.11.03) he comments 'I have discussed the situation with my colleagues and feel that there are no obvious changes that can be made in terms of my practice ...' I would advise the following changes:

1. To be aware of the high risk of sphincter and other damage occurring at the time of forceps or other instrumental delivery.
2. To perform a digital rectal examination prior to embarking on a perineal repair in the circumstances of an instrumental delivery or an extensive perineal laceration. One text book recommends a digital rectal examination at the end of the repair to ensure that no stitches have entered the rectum when repairing a deep perineal laceration[11] and this also is a wise practice.
3. [Dr B] should take a more active approach in seeking and checking for deviations from normal in the postnatal period.

Conclusions:

Perineal injury during childbirth can have a devastating effect on women, both psychologically and socially. It has been well noted in the literature that women tend to underreport physical and other symptoms relating to their own health in the postnatal period, and with regard to embarrassing symptoms such as vaginal discharge, perineal pain and incontinence the symptoms are grossly underreported. Thus the true magnitude of the consequences of obstetric related trauma have not generally been appreciated and the traditional teaching in this regard has been inadequate. A mind set among practitioners that is orientated toward active assessment and sensitive enquiry in these matters is essential to achieve early diagnosis. This will ensure the best outcome both surgically and psychologically.

Close attention to postnatal care is a responsibility of the LMC that cannot be delegated. It is built on the ongoing relationship of trust that develops with the mother right through the antenatal period and beyond. This relationship is the essence of Primary Obstetric care and is one of the great strengths of Family Health care when it embraces maternity care. Becoming involved only when patients are unwell or in dire straits is not part of the philosophy of General Practice Obstetric care, but reflects a more specialist-consultation orientated approach. These are complex issues that have not been easy for General Practitioners to work out in the context of a variety of different working relationships with Midwives, and the constraints of the current funding system. Nevertheless for General Practitioners who wish to continue providing obstetric care it is essential that they do not let these external contingencies change their philosophy of practice.

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Further advice
The following additional advice was obtained from Dr Ferguson:

"1. The swab left in [Ms A's] vagina did not cause her fistula or otherwise aggravate her condition.

2. [Ms A's] labour was "grossly long". However, prolonged second stages do not cause fistulas (anal/vaginal) in the Western world. The main concern is that [Dr B] was not present "carefully monitoring" the situation. Further, it was important that the baby was in an appropriate position for forceps delivery and therefore some flexibility was warranted in relation to the length of second stage of labour.

3. [Dr B] should have examined [Ms A's] anus after delivery for signs of damage which cannot be detected without looking.

4. Some latitude was appropriate regarding the delay in the detection of the fistula because the swab was an early "smokescreen". Further, [Dr B] did not "blatantly" or "callously" ignore the warning signs of a fistula. Also, the medical outcome was no different due to delay – [Ms A] would have had a wait for surgery (six weeks in [a region]) for her fistula even if detected immediately. However, the earlier the fistula is detected, the less stress for the woman."

Further advice
The following additional advice was obtained from Dr Ferguson in relation to my provisional opinion:

"Whilst I believe it is appropriate for [Dr B's] shortcomings in this case to be clearly identified, and for him to be held in breach of the relevant parts of the [Code of Health

and Disability Services Consumers' Rights], I do not believe anything further is to be gained by disciplinary proceedings against him. I do not believe [Dr B] acted in a deliberately callous or reckless fashion.

In this case I think [Dr B] had a preconceived idea that there was a perineal infection, perhaps related to the retention of the swab that would settle down by the time of the 6 week check. He had never encountered a case of recto-vaginal fistula previously, and I am sure he had no intent to cause [Ms A] any unnecessary suffering. Obstetric care is unique amongst other aspects of health care delivery in the propensity of its practitioners to apply the concept of 'normality' as if it were a roll of wallpaper, to clinical situations that may require a different response. What's required here is education, rather than punishment or other remedial process. From this tragic experience [Dr B] will have become more knowledgeable about recto-vaginal fistulas than any other primary maternity care provider in the country.

In many parts of New Zealand the waiting list for surgical repair of a recto-vaginal fistula would have easily equalled or exceeded the time taken until [Ms A] had surgery, even if it was diagnosed in the first week post partum. Thus although [Ms A] experienced a lot of unnecessary psychological distress, early diagnosis would not have greatly changed subsequent events.

Finally it must be recognised that [Dr B] works within a system that does not acknowledge that general practitioners have any role in postnatal care beyond that of midwifery, and are not funded in any way (unlike midwives) even for mileage to do postnatal visits. Whilst this is no defence in this case, it is hardly a system that engenders and supports safe practice from a general practitioner's perspective.

In summary [Dr B] is clearly in breach [of the Code], on a couple of counts. Further disciplinary proceedings, however, would in my view be a bit draconian in these circumstances …"

Response to provisional decision

Background
In his response to my provisional decision, Dr B acknowledged that his care of Ms A involved a number of minor deviations from an appropriate standard and that he was very sorry. However, his care occurred in the context of a very difficult and pressurised working environment due to the reduction of GPs performing obstetric care.

Dr B stated that towards the end of 2004 he reduced his obstetric practice significantly and has now ceased providing this type of care. He explained that his decision to cease obstetrics was partly due to the significant pressure of his obstetrics workload, which was in

addition to his general practice workload. Dr B delivered 300 babies in 2002 (when he was only one of a very small number of general practitioner obstetricians in the region). On 4 April Dr B delivered three babies including Ms A's baby.

Once his colleagues withdrew from GP obstetrics because of changes in the role of lead maternity carers, the number of referrals increased significantly. With the benefit of hindsight, he could have refused some referrals. However, Dr B very much enjoyed obstetric practice over many years and felt that it was necessary to provide this type of service, which many women wanted.

Dr B further advised that he reviewed his involvement in Ms A's care with an obstetrician colleague. The review indicated that his treatment of Ms A was not up to his usual high standards. Dr B recalled that he was very upset by this finding and it "brought into sharp focus my resolve to discontinue doing GP obstetric practice".

Management of labour and delivery
Dr B agreed with my expert advisor, Dr Ferguson, that the acceptable length of a second stage of labour has increased considerably. Nonetheless, the second stage of Ms A's labour was longer than he would have liked because of his delay in heavy traffic while coming to the hospital after 5.00pm and the delay in obtaining adequate anaesthesia. Although Dr B did not have a cell phone in his car, he had a pager that was not activated. Nonetheless, in light of the incident Dr B can now be contacted by cell phone at any time.

Dr B further advised that, in light of the review of Ms A's care with his obstetrician colleague, he should have detected that her sphincter was torn – ideally at the time of delivery and "much earlier" than the six-week check on 22 May. If he was continuing his obstetric practice, he would take into account Dr Ferguson's recommendations concerning the high risk of sphincter and other damage occurring at the time of instrumental deliveries, and the importance of digital rectal examinations.

Postnatal care
Dr B advised that in hindsight he wished he had assessed Ms A at the Maternity Unit. However, the hospital midwives did not request an assessment and he was not informed of any concerns that warranted a visit. Furthermore, his failure to assess Ms A at the Maternity Unit was also due to pressure of work. Nonetheless, he appropriately visited Ms A at home immediately after her discharge.

Dr B further responded that he could only have diagnosed Ms A's fistula during his home visit on 13 April by conducting an "intrusive examination". He was reluctant because Ms A had obvious discomfort resulting from the recent delivery of her baby. Accordingly, he decided to conduct such an examination at the six-week check on 22 May. In hindsight, Dr B acknowledged that if he was continuing his obstetric practice "I would now consider that a more intrusive examination may well be worthwhile earlier than the six-week check" notwithstanding any discomfort.

Dr B disagreed with Dr Ferguson that his suggestion (at the consultation on 24 April) that Ms A contact him if she was concerned about her vaginal discharge was inadequate in light of her abnormal symptoms. Dr B advised that this is his standard practice and takes into account the difficulties that patients, who live in the suburbs of the city, may have in travelling to his practice in the city for review. Dr B has not had problems with this arrangement in the past.

In relation to the detection of the recto-vaginal fistula, Dr B agreed with Dr Ferguson that the retention of the vaginal swab issue was a "smoke screen" and prevented him from considering other causes for Ms A's persistent offensive lochia.

However, Dr B advised that Dr Ferguson did not properly take into account that fistulas are very rare – they are extremely uncommon in New Zealand and this is the only case Dr B has experienced in over 20 years of obstetric practice. This factor delayed the diagnosis because, due to his lack of experience with fistulas, Dr B assessed that the bubbling sensation in Ms A's vagina (described to him on 13 April) was more likely to be caused by air in her vagina than air in her rectum, and he did not "seriously entertain" the prospect of a fistula. In hindsight, he now sees the bubbling sensation "quite differently".

Record-keeping
Dr B advised that his handwriting has always been a problem, and the pressure of work at the time of the incident made it worse. He no longer records information in his handwriting but by computer.

Code of Health and Disability Services Consumers' Rights

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

Right 4
Right to Services of an Appropriate Standard

(1) Every consumer has the right to have services provided with reasonable care and skill.

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

Other applicable standard

Medical Council of New Zealand
Medical Council of New Zealand 'Guidelines for the maintenance and retention of patient records' (2001)

1. Maintaining patient records

(a) Records must be legible and should contain all information that is relevant to the patient's care.

Opinion: Breach – Dr B

In my opinion, Dr B breached Right 4(1) of the Code for the reasons set out below.

Management of labour and delivery
There is some dispute between Ms A and Ms C as to the time when Ms A had the desire to push. The clinical notes indicate that at 2.00pm (when Dr B was present) Ms A had bowel pressure with each contraction. This pressure continued until 3.20pm, when it is recorded that pushing commenced. While I acknowledge Ms A's recollection that she felt the urge to push at 2.30pm, I accept Ms C's evidence and the contemporaneous clinical notes that pushing commenced at 3.20pm.

The evidence indicates that Ms A was in phase one of the second stage of labour (no pushing) for approximately 1 hour 20 minutes (2.00pm–3.20pm). She was then actively

pushing, with little progress, for a period of 2 hours 40 minutes (3.20pm–6.00pm) until Dr B arrived. Dr B claims that he advised Ms A not to push following his arrival at 6.00pm. Ms C confirms that Ms A ceased pushing at this stage as she was tired. Ms A disputes this and states that she pushed until the time of delivery at 7.41pm. The baby was delivered 1 hour 41 minutes later (6.00pm–7.41pm), making the second phase, in total, 4 hours 21 minutes long.

My expert general practice obstetrics advisor, Dr Ferguson, advised that traditional teaching was that for a nulliparous woman (a woman who has not previously given birth vaginally) two hours is the upper limit of normal for a second stage of labour. However, developments in obstetric practices, in particular more widespread use of electronic foetal monitoring and epidural anaesthesia, have permitted more conservative management of second stage including a more prolonged duration "if there are no serious foetal heart rate abnormalities, if the mother is well hydrated and reasonably comfortable, and if there is some progress of descent or rotation of the fetal head, regardless of how slow".[1] My advisor further stated that this is a well established consensus view supported by research and adopted in current and influential obstetric textbooks.

While Dr Ferguson agrees with the ACC expert advisors that the duration of Ms A's second stage was excessively long, he advised that management of labour should be tailored to the specific circumstances of a labour with reference to the well-being of the mother and baby. He is clear that if conservative management of second stage is adopted (that is, allowing second stage to exceed the traditional two hours) the fully informed choice of the mother and meticulous observation of maternal and fetal well-being are critical to management decisions. Dr Ferguson concluded that "notwithstanding the delays [Dr B] had no control over, the duration of the second stage cannot be automatically assumed to be inappropriate".

I am satisfied, in light of Dr Ferguson's advice, that there is now professional consensus permitting longer duration, and more conservative management of the second stage of labour, provided the condition of the mother and baby are healthy and that progress is being made. This opinion is supported by research outcomes from studies over 30 years. However, I note also the ACC advisors' comments regarding the need for earlier intervention or specialist input. I consider, therefore, that it is necessary to assess Dr B's actions and decisions during this period with reference to Ms A's clinical picture and the expected professional standards of care when conservatively managing a second stage of labour.

I am not critical of Dr B's decision to leave the hospital following his assessment of Ms A at 2.00pm. There were no indicators of maternal or foetal distress and I note my expert advice

[1] This was quoted by my expert from Creasey and Resnik, Maternal Fetal Medicine Principles and Practice 3rd ed, 1994.

that as the baby was in a posterior position it was appropriate to withhold active pushing and await the natural progress of rotation and descent (which was appropriately assumed to take one hour). I am also satisfied that, although he was LMC, Dr B could appropriately rely on Ms C in a shared care situation to provide midwifery services, and to keep him informed of progress. However, I am concerned that Dr B did not document his management plan in the clinical notes at this time.

Dr B was next informed of progress at 4.30pm – two and a half hours following his departure from the hospital. He was advised that Ms A had been pushing for one hour 10 minutes, and that the baby's head could not be seen. He proposed two options for Ms A – epidural and syntocinon, or to keep pushing – and requested to be advised of progress in half an hour.

Dr B's plan to offer epidural and syntocinon at this point of the labour was appropriate. However, given Dr B's decision to opt for conservative management of the second stage (which had now been in duration for two and a half hours), in my opinion Dr B was obliged to personally assess Ms A. This would have enabled him to consider relevant clinical factors (including the CTG tracing, and actual progress) so that he could be satisfied of fetal and maternal well-being, which would have informed his management plan. Additionally, his presence would have permitted direct communication with Ms A and have facilitated the informed consent process.

I note my expert advisor's comments that conservative management requires meticulous observation of maternal and fetal well-being, and his opinion that:

> "I … view with moderate disapproval the fact that such a conservative management of the second stage was not implemented with more close continuing and personal involvement by [Dr B] to ensure the well being of both [Ms A] and her baby. In my view the responsibility for this monitoring should not have been delegated to another practitioner much beyond 4.30pm no matter what their level of experience."

In the event that Dr B was unable to personally assess Ms A at this time, he should have facilitated review by a specialist obstetrician.

Dr B was next contacted at 5.10pm and decided to attend Ms A, but he did not arrive at the hospital until 6.00pm because of traffic delays. Dr B did not have a telephone in his car to advise Ms C of the delay. I note that Dr B is a practitioner of many years' experience who must have faced similar difficulties with rush-hour traffic in the past and in circumstances where time is of the essence. Although the delay due to heavy traffic was outside Dr B's control, I am surprised that he did not take a cell phone with him (although I note that he had a pager and now carries a cell phone in light of this incident).

On his arrival at 6.00pm Ms A had been in second stage labour for four hours. Dr B decided to deliver her baby by forceps and sought to arrange pain relief through the anaesthetic registrar. This was an entirely appropriate clinical decision.

Although I am unable to determine the exact timing of the various discussions with the anaesthetic registrar, it is clear that there was a difference of opinion regarding the anaesthetic registrar's plan to transfer Ms A to the Caesarean theatre. It is of course entirely acceptable for clinicians to debate management options where there is a difference in clinical opinion. However, in circumstances where time is critical, clinicians should endeavour to work as co-operatively as possible to minimise the potential harm to the patient. I acknowledge Dr B's concerns for continuity of care, but there are occasions where patient safety must take priority.

There was, in my view, a significant delay from the time of making the decision to deliver by forceps at 6.00pm and transfer to the Caesarean theatre at 7.10pm. This delay can, in part, be attributed to the discussions between Dr B and the anaesthetic registrar. However, the delay was also attributable to other factors, for example the preparation of the theatre and involvement of theatre staff. While the delay resulting from the discussion between Dr B and the anaesthetic registrar was less than ideal, they do not form the basis of my breach findings.

In conclusion, I accept the advice of my expert that Dr B should have personally assessed Ms A as soon as possible after receiving Ms C's telephone call at 4.30pm about her condition (instead of responding to Ms C's telephone call at 5.10pm). Alternatively, Dr B should have arranged a review of Ms A's condition by a specialist. This was an important point in Ms A's labour, as she had been pushing for approximately an hour without significant progress, and her second stage of labour was by then of two and a half hours' duration. The situation warranted Dr B's closer involvement, particularly if Ms A's second stage of labour was to continue without medication. In these circumstances, Dr B breached Right 4(1) of the Code.

Retention of the swab

In suturing Ms A's episiotomy Dr B inserted a swab into her vagina. This was inadvertently left behind and was subsequently discovered by Ms A on 7 April (three days later) at the Maternity Unit.

In his report to ACC, the obstetrician advised that "… there are very basic techniques available for ensuring that swabs are not retained and every person using a swab inside the vagina should use one of the recognised techniques."

My expert advisor similarly commented:

> "It is not customary for a formal technique to be used in counting swabs when repairing an episiotomy. Essentially this is because the field of operation is clearly visible, and there is no cavity within which a swab may be lost. The exception to this however, is when attempting to stem the flow of bleeding coming from the uterus or high in the vagina … In these circumstances one should always use a swab with a string attached. The string dangles down into the lower vagina acting both as a reminder and a means of easy removal at the end of the procedure."

In conclusion, I accept Dr Ferguson's advice. It is likely that Dr B was careless in checking he had removed all the swabs from Ms A's vagina after repairing the episiotomy or he failed to utilise a swab with a string. Accordingly, in my opinion, Dr B breached Right 4(1) of the Code.

Postnatal care
Dr Ferguson advised that the discovery of the swab and a possible infection in the perineum obliged Dr B to conduct a postnatal assessment of Ms A's condition at the Maternity Unit. In relation to Dr B's explanation as to why no visit occurred, Dr Ferguson stated: "In a situation [where] there is a risk of infection I do not believe that a Doctor should wait for the patient to become pyrexial or constitutionally unwell before feeling that a visit was called for." He described Dr B's postnatal care at this time as being conducted by "remote control".

In response to my provisional opinion, Dr B advised that in hindsight he wished he had assessed Ms A at the Maternity Unit. However, the hospital midwives did not request an assessment and he was not informed of any concerns that warranted a visit. Furthermore, his failure to assess Ms A at the Maternity Unit was also due to pressure of work. Nonetheless, he appropriately visited Ms A at home immediately after her discharge.

I agree with Dr Ferguson. I am concerned at Dr B's failure to assess Ms A during her stay in the Maternity Unit, particularly when informed of the swab in her vagina. Ms A was understandably concerned about the retention of the swab and the reasons for it being left behind. However, she had no contact with Dr B at all during her stay at the Maternity Unit. I consider that despite his work commitments, Dr B, as LMC, had an obligation to visit Ms A at the Maternity Unit to undertake appropriate postnatal clinical follow-up. He was also obliged to clinically assess Ms A following the discovery of the swab, in the context of concerns regarding her lochia and the risk of infection, whether or not the hospital midwives requested an assessment. Moreover, as the situation involved medical concerns arising from his own actions, it was not appropriate for Dr B to rely on midwifery care. In my view, Dr B should also have attended to explain and apologise to Ms A regarding the retention of the swab.

While I note that my expert regards Dr B's failure to follow up Ms A in the Maternity Unit with only "mild disapproval", I consider it to be more serious having regard to what the reasonable consumer would expect in this situation, particularly because this was Ms A's first baby, her symptoms were most unpleasant and distressing, and the causes were unclear.

The opinions provided by the ACC expert advisors offer a number of different explanations as to the possible causes of Ms A's fistula – that the fistula occurred at the time of the forceps delivery, at the time of the episiotomy, or developed as a combination of undue pressure on the pelvic floor tissues from a prolonged labour and aggravation of the tissues by the retained surgical swab.

Dr Ferguson advised that he has no doubt that the fistula in this case arose from damage to the rectal mucosa (lining of the rectum) at the time of forceps delivery. In his view, the damage to the rectal mucosa was a "buttonhole" injury – where a small defect appears high in the rectum as a result of instrumental delivery. The damage to the anal sphincter was also caused at the time of the forceps delivery and could probably not have been detected at that point. However, the buttonhole injury in the rectal mucosa can be detected by a digital rectal examination usually performed at the time of the perineal (episiotomy) repair and is not outwardly visible. Dr Ferguson also advised that digital rectal examination has not traditionally been part of the teaching in the Diploma of Obstetrics, nor is it routinely performed by obstetric specialists, although research in the past ten years will have increasingly influenced practitioners to be mindful of the possibility of sphincter damage, particularly in high-risk situations such as instrumental delivery.

Dr Ferguson further advised that, while it is a rare occurrence, damage to the rectal mucosa is a significant hazard of any instrumental delivery regardless of the skill of the operator. There is also a high risk of damage to the anal sphincter occurring during a forceps delivery.

In response to my provisional opinion, Dr B advised that, in light of the review of Ms A's care with his obstetrician colleague, he should have detected that her sphincter was torn – ideally at the time of delivery and "much earlier" than the six-week check on 22 May. If he was continuing his obstetric practice he would take into account Dr Ferguson's recommendations concerning the high risk of sphincter and other damage occurring at the time of instrumental deliveries and the importance of digital rectal examinations.

It is clear from Dr Ferguson's evidence that a digital rectal examination at the time of a perineal repair (immediately after delivery) is not a routine or expected standard of care. Although Dr B acknowledges (with the benefit of hindsight) that he should have detected that the sphincter was torn, I am not critical of his failure to undertake a digital rectal examination. The damage to the anal sphincter could probably not have been detected by such an examination (and in fact was only discovered during subsequent surgery).

The issue remains whether Dr B should have diagnosed the fistula earlier than he did.

Ms A is clear that at the consultation on 13 April she advised Dr B she had a vaginal discharge that smelt like faeces, and a bubbling and gurgling sound coming from her vagina. Dr B denies being advised of the faecal discharge, but does accept that he was advised of the "bubbling" in her vagina, which he did not regard as unusual. He explained that the bubbling occurred because the pelvic floor muscles stretch during delivery causing air to become trapped in the vagina. His very brief documentation of this visit describes Ms A's lochia as normal. Dr B advised that he did not undertake a "full" vaginal examination at the consultation on 13 April. It appears that that he did not conduct a rectal examination, although he examined Ms A's perineum.

Dr Ferguson's advice was that by 13 April there was ample indication that careful pelvic and rectal examinations were required. In particular, Dr Ferguson advised that it is not

normal for the perineum to be significantly tender nine days after delivery, and he was concerned that the lochia was still offensive. Furthermore, it is not normal under any circumstances to have a bubbling sound in the vagina in the postnatal period.

In respect of the "bubbling", Dr Ferguson stated:

> "This symptom alone should have sounded an unmistakable warning bell that all was not well. In the management of this case I reserve my strongest criticism of Dr B's management for not interpreting the clinical picture that was emerging on that visit on 13.04.02. His notion of various things being 'normal' seems to have overridden an **unmistakable combination of symptoms and signs** (emphasis added)."

Furthermore, Dr Ferguson advised that Dr B's instructions to Ms A at the consultation on 24 April – to contact him if she was concerned about her vaginal discharge – was not adequate.

In response to my provisional opinion, Dr B agreed with Dr Ferguson that the retention of the vaginal swab issue was a "smoke screen" and prevented him from considering other causes for Ms A's persistent offensive lochia.

However, Dr B considered that Dr Ferguson did not properly take into account that fistulas are very rare – they are extremely uncommon in New Zealand and this is the only case Dr B has experienced in over 20 years of obstetric practice. This factor delayed the diagnosis because, due to his lack of experience with fistulas, Dr B assessed that the bubbling sensation in Ms A's vagina (described to him on 13 April) was more likely to be caused by air in her vagina than air in her rectum, and he did not "seriously entertain" the prospect of a fistula. In hindsight, he now sees the bubbling sensation "quite differently".

Dr B also responded that he could only have diagnosed Ms A's fistula during his home visit on 13 April by conducting an "intrusive examination". He was reluctant because Ms A had obvious discomfort resulting from the recent delivery of her baby. Accordingly, Dr B decided to examine her at the six-week check on 22 May.

I am satisfied on the weight of the evidence that at the consultation on 13 April Ms A told Dr B that her vaginal discharge smelt like faeces (in addition to the bubbling and gurgling sound). Ms A advised me that the day before this visit she had alerted Ms C to the "poo"-like smell of her vaginal discharge. This is corroborated by Ms C's notes. Additionally, Ms C has recorded on 12 April: "Seeing Dr B tomorrow so will discuss above [that vaginal discharge smells "poo" like] and swab being left behind etc."

Furthermore, throughout her postnatal period Ms A was experiencing "offensive" lochia, and had a vaginal swab taken at the Maternity Unit that indicated a heavy growth of mixed skin and bowel flora. Dr B was informed about these matters. Additionally, two days prior to Dr B's visit on 13 April Ms A experienced a red, tender and gaping perineum associated with a purulent discharge for which a perineal swab had been taken. Dr B was also

informed of this, although he had not yet received the laboratory results. He was also aware that Ms A's perineum was painful at the time of his visit.

I am satisfied that, irrespective of Dr B's lack of experience in diagnosing recto-vaginal fistulas and taking into account that the retained swab may initially have confused Ms A's clinical picture, her presentation at the consultation on 13 April, the results of the laboratory tests requested at the Maternity Unit, and other information, should have prompted Dr B to have undertaken further investigations. In particular, Dr B should have explored more fully with Ms A her symptoms (for example, whether she was experiencing faecal discharge at the time of bowel movement), and he should have undertaken a full vaginal examination and rectal examination. I do not consider this unreasonable in light of his considerable overall obstetric experience. I also find it difficult to accept that Ms A would, in light of her distressing symptoms, have refused internal examinations despite discomfort arising from her recent delivery.

In my view Dr B should also have considered a specialist referral in light of the strong evidence that Ms A had a fistula.

I also consider it probable that Ms A advised at the consultation with Dr B on 24 April that faeces were passing out of her vagina, and she continued to have bubbling and gurgling in her vagina.

In my view, at the consultation on 24 April, irrespective of any physical examinations, Dr B should have recognised that the symptoms signified some sort of abnormality and referred Ms A to a specialist. This was particularly warranted because on 24 April the bubbling sound and the appearance of faeces in Ms A's vagina were persisting and remained unexplained. Ms C's notes also record that Dr B was informed of the results of the perineal swab, which indicated a heavy growth of *E coli*, by telephone on 18 April (although it is unclear whether he received the laboratory results). It was insufficient to advise Ms A to telephone if she felt there was any question regarding her vaginal discharge before the six-week check.

My expert advised that Dr B's failure to recognise that something was wrong at the consultation on 13 April met with his moderate disapproval.

In my view, Dr B's further failure to refer Ms A to a specialist on 24 April was a departure from the expected standard of care and skill, which delayed Ms A's diagnosis of, and treatment for, this distressing problem.

In conclusion, Dr B should have assessed Ms A's condition at the Maternity Unit, following discovery of the swab in her vagina. Dr B should also have further investigated the causes of Ms A's symptoms at the consultation on 13 April, and on 24 April referred her to a specialist, particularly in light of the faeces coming from Ms A's vagina. In my view these investigations would likely have led to an earlier diagnosis of Ms A's fistula. Accordingly, Dr B breached Right 4(1) of the Code.

In my opinion, Dr B also breached Right 4(2) of the Code for the reasons set out below.

Record-keeping
The relevant professional standard is the Medical Council of New Zealand's 'Guidelines for the maintenance and retention of patient records' (August 2001). Guideline 1 states that all records must contain "all information that is relevant to the patient's care".

Dr B's clinical notes in relation to Ms A's delivery and postnatal care are woefully inadequate. Quite aside from their brevity, they are illegible. Indeed, my investigating officer required a typewritten transcript of the notes from Dr B.

I also note that Dr B did not document his plan for Ms A's labour at the 2.00pm assessment on 4 April, and that there are no clinical notes for his visit to Ms A in hospital on 5 April.

Dr B explained that his handwriting has always been difficult to read, and the pressure of work at the time of the incident made it worse. He no longer records information in his handwriting but by computer.

I note that Dr B has taken steps since the incident to ensure that his notes are legible. The appropriate documentation of consultations, assessments and plans is important to ensure an accurate record for other health professionals involved in a patient's care, to enable continuity of care. It is an integral part of clinical practice, whatever the setting.

In my view, by failing to keep a proper record of Ms A's care Dr B breached Right 4(2) of the Code.

Actions taken

Dr B has provided a written apology to Ms A, in which he states:

> "I am writing to apologise for three aspects about your delivery in April of 2002.
>
> Firstly, I regret having left a swab inside your vagina at the time of delivery. Unfortunately this does happen from time to time, but it should not have happened. Undoubtedly this was the cause of the infection that you had shortly afterwards and also obscured the presence of the recto-vaginal fistula that you had.
>
> Secondly, I also wish to apologise for the tear to your rectal sphincter having occurred in the first place. The tear and its non-recognition was the cause of your fistula and this was something that I have never had experience of before and this in some part probably contributed to my not recognising it.

Thirdly, I wish to apologise for the delay in making the diagnosis. I simply wish I could have made the diagnosis earlier than your six week check and I feel that, had I done so, it would have aided in your recovery that much sooner.

I can understand the very significant distress that this has caused you and I can only say that I am very sorry that this has occurred."

Non-referral to Director of Proceedings

Dr B's care for Ms A was substandard. Ms A has experienced considerable stress and discomfort in part as a result of Dr B's omissions, and believes he should be disciplined. However, in my view, a significant cause of the shortcomings in his services was Dr B's heavy workload due to the dwindling number of GP obstetricians in the region. This is particularly suggested by the fact that, despite his extensive obstetric and GP experience, Dr B overlooked on more than one occasion the obvious signs that Ms A's condition after her discharge from the Maternity Unit was not normal and required further investigation. I also consider that Dr B's poor judgement at this time was influenced by the fact that he had not encountered a fistula in his practice prior to the incident. His lack of monitoring of Ms A's labour in the Public Hospital, and failure to assess her condition in the Maternity Unit, reflect the fact that Dr B was significantly over-committed.

I have also taken into account Dr Ferguson's advice that a referral to the Director of Proceedings is not warranted. Dr B has been deeply affected by his uncharacteristic lapses in this case, and has apologised to Ms A.

In all the circumstances, I have decided that there is no public interest in further proceedings, and I have not referred this matter to the Director of Proceedings.

Follow-up actions

- A copy of this report will be sent to the Medical Council of New Zealand, the Royal New Zealand College of General Practitioners, and ACC.

- A copy of this report, with details identifying the parties removed, will be sent to the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, and the Royal New Zealand College of General Practitioners, for educational purposes.

- A copy of this report, with details identifying the parties removed, will be placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

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