Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

The importance of fetal growth assessment with pre-eclampsia diagnosis
20HDC00035

A consultant obstetrician and gynaecologist at Palmerston North Hospital (MidCentral District Health Board (MCDHB) now Te Whatu Ora Te Pae Hauora o Ruahine o Tararua MidCentral) has breached the Code of Health and Disability Services Consumers' Rights.

Rose Wall, Deputy Commissioner found the clinician in breach of Right 4(1) of the Code for not providing services with reasonable care and skill.

This case involves a woman who was hospitalised with pre-eclampsia at 32 weeks gestation. No fetal growth assessment was undertaken when the pre-eclampsia was diagnosed, despite this being the expected standard of care. The woman was monitored on the maternity ward with regular CTGs and was briefly transferred to the delivery suite when an abnormal CTG was detected, but she returned to the maternity ward once this normalised.

During the woman's admission a scheduled ultrasound with a private provider was cancelled. The baby, born via emergency caesarean section following an unsuccessful induction of labour, was subsequently diagnosed with a severe brain injury and passed away 11 days later. Severe placental compromise indicated that one or more in utero events likely led to the baby's death.

"Given that no fetal growth assessment was completed at the time the pre-eclampsia was diagnosed and, as there appears to be a general lack of information given to the woman about the risks of induction and labour for the baby (in the context of her recent history of CTG abnormalities), I consider the doctor did not provide services with reasonable care and skill," said Ms Wall.

Ms Wall expressed concerns about the doctor's communication with the patient. The obstetrician did not adequately explain why the woman's ultrasound was cancelled, and she did not receive sufficient information about the potential risk of induction and labour to her baby.

Te Whatu Ora Te Pae Hauora o Ruahine o Tararua MidCentral was also found in breach of Right 5(2) of the Code, which gives consumers the right to an environment that enables honest and effective communication between the consumer and provider. Ms Wall also noted Te Whatu Ora's guideline around fetal monitoring was not in line with national guidance.

In response to the breach, Ms Wall made a number of recommendations for Te Whatu Ora Te Pae Hauora o Ruahine o Tararua MidCentral, including using an

anonymised version of this report as a case study to encourage reflection and discussion during obstetric and maternity education sessions, particularly around the importance of good communication with the patient.

Ms Wall recommended that the obstetrician provide a written apology to the patient and ensure that when decisions are made to change a planned procedure or investigation, the decision is discussed with the patient and an explanation provided. She also recommended that the Medical Council of New Zealand consider whether a review of the doctor's competence is warranted.

In response to the breach, Te Whatu Ora Te Pae Hauora o Ruahine o Tararua MidCentral has updated their guidelines to align with the Manatū Hauora Ministry of Health guidelines. This includes a recommendation to order an ultrasound scan and Dopplers at diagnosis of pre-eclampsia.

The doctor now incorporates growth assessment and Doppler velocimetry into the assessment of women with pre-eclampsia.

24 April 2023

Editor's notes

The full report of this case will be available on HDC's website. Names have been removed from the report to protect privacy of the individuals involved in this case.

The Commissioner will usually name providers and public hospitals found in breach of the Code, unless it would not be in the public interest, or would unfairly compromise the privacy interests of an individual provider or a consumer.

More information for the media, including HDC's naming policy and why we don't comment on complaints, can be found on our website here.

HDC promotes and protects the rights of people using health and disability services as set out in the Code of Health and Disability Services Consumers' Rights (the Code).

In 2021/22 HDC made 402 recommendations for quality improvement and providers complied with 98% of those recommendation.

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