
Obstetrician, Dr C / Crown Health Enterprises / Midwife, Ms D

Opinion - Case 98HDC17933

Complaint

Complainants, Mr A and Mrs B, complained to the Commissioner concerning the treatment provided to Mrs B by her obstetrician, Dr C. The complaint is that:

- *In 1997 Dr C did not provide Mrs B with maternity services of an appropriate standard, in particular:*
 - *that on 1, 2 and 3 October 1997 Dr C did not take timely, reasonable and appropriate action to monitor the health of Mrs B's baby.*
 - *that Dr C misinterpreted the clinical indications and CTG tracings and did not take action to deliver the baby in a time and manner that minimised potential harm.*
- *Further to this, the complaint is that Dr C did not communicate effectively with Mrs B during her pregnancy and on occasions intentionally banged Mrs B's abdomen with the scan probe.*

On 21 May 1999 the investigation was expanded on the Commissioner's initiative into the care provided by Ms D, midwife. The complaint concerning Ms D was that:

- *On 2 October 1998 Ms D, midwife, failed to communicate her concerns about the health of Mrs B and her unborn child to Dr C, obstetrician.*
-

Obstetrician, Dr C / Crown Health Enterprises / Midwife, Ms D

Opinion - Case 98HDC17933, continued

Investigation Process	The complaint was received by the Commissioner on 17 September 1998. An investigation was undertaken and information obtained from:		
	Mr A and Mrs B	Complainants	
	Dr C	Obstetrician / Provider	
	Ms D	Midwife / Provider	
	Dr E	Pathologist, Crown Health Enterprises	
	Dr F	Lecturer in Obstetrics	
	Ms G	Hospital Services Manager, Crown Health Enterprises	
	Mr H	Chief Executive Officer, Crown Health Enterprises	

The Commissioner obtained and reviewed documentation relating to the treatment of Mrs B including medical records, the post-mortem report and a report from an independent inquiry by two obstetricians and gynaecologists commissioned by Crown Health Enterprises. The Commissioner sought advice from an independent obstetrician/gynaecologist.

Information Gathered During Investigation Complainant, Mrs B, was referred to the obstetrician, Dr C, on 30 August 1997, during the 31st week of her pregnancy. She was referred to Dr C by her general practitioner because of concern that she was carrying too much fluid.

At this visit Dr C measured Mrs B and described her size as being near full term. He conducted a scan and found no foetal abnormalities. Dr C stated that he believed Mrs B would require a caesarean section as she had broken her pelvis a year earlier and had scoliosis (her backbone had a sideways deviation). Dr C told Mrs B to stop work immediately to help reduce the excess fluid and provided a foetal kick chart.

Continued on next page

**Obstetrician, Dr C / Crown Health Enterprises /
Midwife, Ms D**

Opinion – Case 98HDC17933, continued

**Information
Gathered
During
Investigation
*continued***

Mr A, Mrs B's husband, stated to the Commissioner that his wife found Dr C's manner intimidating. He reported that Dr C was vague in his explanations unless pressed and brusque to the point of rudeness. He further stated that Dr C would routinely bang on Mrs B's stomach with the scanner probe quite hard and without warning.

On 10 September 1997 Mrs B visited Dr C again. Dr C examined Mrs B and stated that he was pleased that the fluid seemed to have reduced.

On 30 September 1997 Mrs B noted that the foetal movements were not as strong as usual. For the previous five weeks she had been recording 10 foetal movements by mid to late afternoon each day. On this particular day the tenth movement was not reached until 9pm.

Mrs B did not feel any movements during the night of 30 September 1999 and at 10.00am on 1 October 1997 she rang her midwife, Ms I, who suggested they go to the hospital to be monitored. At 11.30am Mrs B was put on the foetal monitor by Ms I who then contacted Dr C.

Mrs B felt three faint kicks during the monitor run. Dr C arrived and told Ms I to admit Mrs B. No further movements were felt during the day.

In the evening Ms D, hospital midwife, put Mrs B on the cardiotocograph monitor (CTG) to measure foetal heart-rate and rhythm. On completion Ms D advised Mrs B not to eat dinner, as she believed that Dr C would want to perform a caesarean section. Dr C was informed that Mrs B had not felt any foetal movements and he viewed the monitor run. Dr C decided not to intervene and Mrs B was told to have dinner.

Mrs B did not experience any foetal movements overnight. On the morning of 2 October 1997 an additional monitor run was conducted. Dr C also requested blood tests and an cardiotocograph (CTG) to record the electrical activity of the foetal heart. He also ran a scan. Mr A reported to the Commissioner that Dr C banged on his wife's stomach with the scanner probe and said that he saw the baby move, although Mrs B felt no movement.

Continued on next page

Obstetrician, Dr C / Crown Health Enterprises / Midwife, Ms D

Opinion – Case 98HDC17933, continued

**Information
Gathered
During
Investigation
*continued***

Mrs B stated to the Commissioner that her husband, who is a farmer, had concerns about Mrs B contracting campylobacter (a type of bacterial infection) from livestock as he was aware this can cause birthing difficulties in sheep. Dr C stated to the Commissioner that he sought the advice of a microbiologist in the city by phone on the possibility of a campylobacter infection. He also phoned Dr F, Senior Lecturer in Obstetrics at a public hospital, for further assistance. Dr F stated to the Commissioner that in this phone conversation Dr C discussed the possible impact of campylobacter and briefly discussed concerns about the foetal heart-rate but did not discuss that foetal-heart tracings.

After the evening monitor run Ms D expressed concern and again advised Mrs B not to eat dinner as she felt Dr C would wish to conduct a caesarean section. Mr A stated to the Commissioner that when Dr C decided to continue with observation Ms D strongly advised them to seek a second opinion. Mr A rang Ms I who stated that she trusted Dr C's ability.

An independent inquiry by two obstetricians and gynaecologists commissioned by Crown Health Enterprises after a complaint by Mr A and Mrs B noted that the midwives involved in the care of Mrs B "*discussed [the differences in CTG interpretation] openly amongst themselves and with Mrs B, but at no point directly communicated their concerns to Dr C*". Ms D stated to the Commissioner that she passed her concerns onto Dr C and the clinical notes indicate Dr C was notified of the CTG tracing results.

Mr A stated to the Commissioner that he asked a midwife to contact Dr C and requested that he come in to answer some questions. Mr A and Mrs B stated that when Dr C arrived they expressed concern at the monitor runs and their fears for the baby. They stated Dr C advised that there was something wrong with the baby but that he was not sure what it was. He further advised that the safest place for the baby was where it was. Mr A asked about having a caesarean and was advised that this could be done if they wished but that there were risks involved for the baby.

Continued on next page

Obstetrician, Dr C / Crown Health Enterprises / Midwife, Ms D

Opinion – Case 98HDC17933, continued

**Information
Gathered
During
Investigation
*continued***

During the morning of 3 October 1997 Mrs B felt three kicks at 4.00am and another at 8.00am. A further monitor run was conducted that morning with a nurse in attendance. Mr A stated to the Commissioner that the nurse stated to Mrs B that she felt some movement, although Mrs B could not feel this.

At 3.00pm a further monitor run was conducted by Ms D who could find no heartbeat.

Dr C arrived and took a scan shortly after 3.00pm. Mr A reported to the Commissioner that Dr C pointed out the baby's head, arms and legs and then said "*you're absolutely right, there is no heartbeat*". Dr C continued to scan. Mr A asked if Dr C was saying that their baby had died. Mr A reported that Dr C replied "*Well, yes, I'm sorry*". Mr A advised the Commissioner that Dr C told he and his wife to "*go home*" and did not offer them any support beyond stating he would deliver the baby in a few days time.

The baby was delivered stillborn on 6 October 1997 at a public women's hospital.

Crown Health Enterprises' independent inquiry reported as follows in relation to Dr C's ability to communicate:

"All people interviewed acknowledged that [Dr C] had problems communicating to some people, patients and staff alike. The general consensus was that he was often direct to the point of bluntness, abrupt, used few words and had poor 'bedside manner'. This was most often interpreted as being rude. This appears to be common knowledge around the town and we understand that many practitioners forewarn their patients about this prior to a consultation with [Dr C]. It was acknowledged that several complaints about this issue had been addressed to the CHE in the past. When confronted with these comments, [Dr C] acknowledged that he was aware of problems in this area and had tried to address them."

Continued on next page

Obstetrician, Dr C / Crown Health Enterprises / Midwife, Ms D

Opinion – Case 98HDC17933, continued

**Information
Gathered
During
Investigation
continued**

In relation to Dr C's failure to perform a caesarean section it is stated that:

"[Dr C] did not perform a caesarean section because he misinterpreted the CTGs. He failed to recognise that the foetal heart rate changes represented severe chronic foetal hypoxia [chronic lack of oxygen to the foetus] which required immediate delivery. [Mrs B's] clear history of significantly decreased foetal movements should have alerted him to the possibility of foetal hypoxia. [Dr C] openly acknowledged his error to us during the interview and has expressed deep remorse for his failures. He also acknowledged that the number of deliveries in [the town] meant that his exposure to serious antenatal CTG abnormalities was limited. He has since arranged to visit the High Risk Antenatal Clinic in [the city] 4 to 5 times a year to update his skills."

In relation to the system for obstetric responsibilities the inquiry report stated:

"The structure of the Obstetrician on-call responsibilities may also have contributed to the loss of [the baby]. In the current system the responsibility for care of any particular woman remains with the Obstetrician who initially saw her, even though she may be an in-patient."

In the conclusion of this report it is stated:

"The death of [the baby] was directly related to a misinterpretation of the clinical picture and the CTG tracings by [Dr C]."

Continued on next page

Obstetrician, Dr C / Crown Health Enterprises / Midwife, Ms D

Opinion – Case 98HDC17933, continued

**Information
Gathered
During
Investigation
*continued***

The inquiry report contained the following recommendations:

- Dr C should receive professional advice and help in order to significantly rectify his communication deficiencies. This problem should be reviewed regularly and his progress monitored. For example, a Patient Satisfaction Survey, as available from the RNZCOG, should be administered every 3 years.
- Dr C must update his CTG interpretation skills. This could be achieved by attending a CTG course and regular visits to the High Risk Clinic in the city. The entire unit would benefit from a CTG update programme.
- A closer relationship with the public unit should be encouraged. This should include early recourse to second opinion in difficult cases, and the faxing of all relevant clinical information, including CTGs, where appropriate.
- Dr C should update his ultrasound scanning techniques and applications. This should involve attendance at a formal course designed for this purpose. He should also regularly subject his scanning techniques to peer review.
- A formal pathway to enable patients and staff to seek a second obstetric opinion should be developed and put in place.
- The inter-personal problems and lack of trust within the Obstetric Unit need to be addressed. We believe this will need to be an independent review by someone outside the Obstetric Unit. It is vital that working relationships be re-established so the Unit can function safely.
- The on-call structure for the obstetricians should be changed to a strict 1 in 2 roster with the obstetrician on call for the day being responsible for all secondary obstetric patients within the Unit.
- The CHE should establish a system of back-up for either of the obstetricians, for times of significant physical or emotional stress (e.g. a short-term locum via the public unit). This would allow the obstetrician concerned to address the health issue, without undue stress being placed on his remaining colleague.

Continued on next page

Obstetrician, Dr C / Crown Health Enterprises / Midwife, Ms D

Opinion – Case 98HDC17933, continued

**Information
Gathered
During
Investigation
*continued***

- The CHE should review how it responds to a traumatic obstetric event. Any debriefing meeting should also consider how best to help the family affected. This will usually involve personal contact from the CHE, an offer to meet with them, and an apology if an error has been made.
- We feel that a meeting between Mrs B and Mr A, and Dr C may provide a platform for beginning the process of resolution for both parties.

Crown Health Enterprises confirmed to the Commissioner that these recommendations have been implemented.

**Independent
Advice to
Commissioner**

During the course of this investigation the advice of an independent obstetrician/gynaecologist was sought. My advisor stated that:

“At the outset I should say that this case has of course been widely canvassed in the [town] by formal investigation at the request of [Crown Health Enterprises] by [Dr J] and [Dr K]. The main finding of their inquiry was that ‘the death of [the baby] was directly related to the misinterpretation of the clinical picture and CTG tracings by [Dr C]. Following perusal of this file I would certainly concur with this opinion. However, [Dr J] and [Dr K] were certainly much better placed to make a perusal of this situation, as their investigation was on site and they interviewed most of the participants and were therefore very well aware of the whole background of the case. They have made significant recommendations with regard to management within the Maternity Unit of Crown Health Enterprises. While many of these had a bearing on the case, and [Dr C’s] management, others were more general on their application. However, it is apposite that I should make comments directly with regard to the issues notes within the summary.

Continued on next page

**Obstetrician, Dr C / Crown Health Enterprises /
Midwife, Ms D**

Opinion – Case 98HDC17933, continued

**Independent
Advice to
Commissioner
continued**

Did [Dr C] treat [Mrs B] appropriately?

I assume from this comment 'treat' means medical treatment as opposed to his general professional approach to [Mrs B]. It would be difficult to comment on the latter as there is certainly no comment in the file from [Dr C] himself concerning [Mrs B's] complaints of communication, nor in fact about the medical management. His own opinion can only be gleaned secondhand from the independent investigators' report. In general terms this question is already answered by my previous comments.

Should [Dr C] have requested more tests to monitor the condition of the [complainants, Mr A and Mrs B's] baby?

a) Early third trimester

[Mrs B] was referred to [Dr C] early in the third trimester because of the polyhydramnios [presence of an abnormally large amount of fluid surrounding the foetus] and he scanned her at the time noting that the stomach was visible and that it was unlikely there was any abnormality of swallowing. At this stage he might have considered referral to a tertiary centre for a more detailed ultrasound to exclude abnormality. In the event it is likely that this would have been negative as no significant abnormality was found at post-mortem which might have given rise to the polyhydramnios.

Continued on next page

**Obstetrician, Dr C / Crown Health Enterprises /
Midwife, Ms D**

Opinion – Case 98HDC17933, continued

**Independent
Advice to
Commissioner
*continued***

While [Mrs B] was ultimately delivered vaginally, there were two factors in her past history which suggested that Caesarean of itself might have been considered as the primary mode of delivery. Her scoliosis is alluded to and this may have significantly altered the spino-pelvic relationships. There was also the matter of her fractured pelvis and there is no detail concerning this as a possible distorter of pelvic capacity. In the event the babe was only 2.5kg and stillborn and vaginal delivery was facilitated by both of these. Delivery at term however, might have been more difficult as a result of these two factors. Likewise, their presence might have been considered with regard to the management at the time of her admission. Both of these factors were noted by [Dr C] in his early letter to the general practitioner.

Continued on next page

**Obstetrician, Dr C / Crown Health Enterprises /
Midwife, Ms D**

Opinion – Case 98HDC17933, continued

**Independent
Advice to
Commissioner
*continued***

*b) At the time of admission
There was clearly considerable midwifery concern about the state of the cardiocograph tracings [electronic measure of foetal heart-rate and rhythm] at the time of [Mrs B's] admission and this was certainly not without justification. However, [Mr A] was clearly not concerned by these but, given the midwifery concern, he might have considered further obstetric advice with regard to the state of the tracings. Facsimile communication, as suggested by [Mrs B], is certainly undertaken widely now days in the interpretation of traces within the region and had a trace been faxed to the duty staff at [the public women's hospital] then a second opinion could have been obtained forthwith. There is little doubt that such an opinion would have confirmed that the baby was significantly distressed at the time of admission and that delivery should have been considered at that stage. Had any of the traces which were submitted been forwarded to [the city], then they would have all been considered abnormal and justify immediate delivery by Caesarean Section on those grounds alone, quite apart from any other background secondary indications which might have existed. Clearly at that stage [Dr C] did not have a great concern about the babe, but transfer to a tertiary centre might have been considered where Specialist ultrasound assessment of foetal blood flows would have been available. However, it was clear that these investigations were not required to diagnose that the babe was already in significant distress following admission.*

In his letter [Mr A] indicates that [Dr E] 'found nothing wrong with [the baby] and described her death as preventable'. While this might well be so it is important to note that even at the time of admission, had delivery been undertaken at that stage, the baby might not necessarily have been normal and, with the background polyhydramnios, normality was already somewhat in question.

Continued on next page

**Obstetrician, Dr C / Crown Health Enterprises /
Midwife, Ms D**

Opinion – Case 98HDC17933, continued

**Independent
Advice to
Commissioner
continued**

Scanning technique

While I am not an expert Scanner, it does seem that Scanners do frequently try and jolt the baby into action by vigorous movements of the scanning probe and it is therefore not inappropriate.

Further comments

Appropriate Treatment

Your first dot point in the issues asks whether [Dr C] treated [Mrs B] appropriately. While in my initial summary I assumed that this meant medically, I suspect what it really meant was did he give her the respect and consideration which was appropriate in a doctor/patient relationship. Within the file as presented the only evidence for this of course lies within [Dr K] and [Dr J's] inquiry and they had the benefit of discussing these difficulties with [Dr C], [Mr A] and [Mrs B] and the other staff members involved.

There is nothing, apart from [Mr A] and [Mrs B's] letter, which would allow me to come to any other decision beside that expressed by the review. I am not presented with any response with regard to the [complainants, Mr A and Mrs B's] complaints from [Dr C], nor is there any indication that he has been approached and declined to comment on the personal or medical matters. It would seem to be a matter of natural justice that [Dr C] should be invited to comment.

Continued on next page

**Obstetrician, Dr C / Crown Health Enterprises /
Midwife, Ms D**

Opinion – Case 98HDC17933, continued

**Independent
Advice to
Commissioner
*continued***

Second Opinions

There is within the review document comment that [Dr C] consulted a Microbiologist in [the city] and [Dr F], Senior Lecturer in Obstetrics and Gynaecology, with regard to the problem. There is no medical comment within the file which indicates that such consultation took place, nor is there any report from [Dr F] or the Microbiologist concerning their advice. I would be surprised that, if [Dr F] was asked about interpretation of traces, he did not request it to be faxed as within the Unit in [hospital] we frequently receive faxed cardiocograph tracings for comment. It may be, therefore, that [Dr C] was inadvertently reassured by such consultations as, had the trace been forwarded, the course of action would have been clear. While telephone consultations are very valuable, they do not allow a full appreciation of the clinical picture.

Conclusion

In summary, therefore, it is clear that the major factor leading up to the intrauterine death of [the baby] was the misinterpretation of the cardiocograph tracings. Had these been acted on at a significantly earlier stage during [Mrs B's] admission, then [the baby] would surely have been born alive. However, this is not to say, necessarily, that she would have in fact been normal or even survived as we do not have a good understanding of the background to the cause of death and the post-mortem report is not helpful in this regard.

I cannot offer any comment other than that within the review with regard to the personal and professional manner of [Dr C's] management and you will need to rely upon the review to assess whether or not you feel there were deficiencies.”

Obstetrician, Dr C / Crown Health Enterprises / Midwife, Ms D

Opinion – Case 98HDC17933, continued

**Response to
Provisional
Opinion**

In response to my provisional opinion Dr C stated:

“4.1 *Your expert has stated ‘There is within the review document comment that [Dr C] consulted a Microbiologist in [the city] and [Dr F], Senior Lecturer in Obstetrics and Gynaecology, with regard to the problem. There is no medical comment within the file which indicates that such consultation took place, nor is there any report from [Dr F] or the Microbiologist concerning their advice. I would be surprised that, if [Dr F] was asked about interpretation of traces, he did not request it to be faxed’*

4.1 *The basis for your expert making this quite strong claim is not disclosed. However, this part of the opinion appears to have been pivotal in your making a finding against [Dr C].*

4.2 *You will now have received a copy of a letter from the Hospital enclosing a copy of [Dr F’s] letter. We hope that this matter is now put to rest. For the avoidance of doubt, it is reaffirmed that:*

4.2.1 *[Dr F] did not ask for a fax of the tracing,*

4.2.2 *[Dr C] was not aware that this facility was available,*

4.2.3 *This facility is actively used now.”*

Continued on next page

Obstetrician, Dr C / Crown Health Enterprises / Midwife, Ms D

Opinion – Case 98HDC17933, continued

**Response to
Provisional
Opinion
*continued***

Mr H, Chief Executive Officer of Crown Health Enterprises, supplied a copy of a letter from Dr F dated 17 April 1998 which stated that, during Mrs B's admission to the public hospital:

"[Dr C] consulted with me ([Dr F]) about the Campylobacter and we decided that this was probably not a significant issue, in particular there was no evidence of any intrauterine infection at that stage. However he did comment that the fetal heart rate was a little bit fast. My comment to him at that time was that she should have an ultrasound scan as this may give a better idea of fetal wellbeing. I did not see the fetal heart rate tracings, which had been performed."

Mr H stated to the Commissioner that:

"Interpretation of tracings, - there is no medical comment within the file which indicated that such a consultation took place, nor is there any report from [Dr F] concerning their advice"

You will note that the bottom page of the letter from [Dr F] confirms that [Dr C] consulted [Dr F], and that [Dr F] was aware of the fetal heart rate tracings, although he did not see them. We would like you to further consider this finding. We consider that although in hindsight it would have been preferable for [Dr C] to have faxed these tracings, [Dr F] did not request that these were faxed to him and advised [Dr C] to proceed with an ultrasound scan. The scan was then completed and as it demonstrated fetal movements the pregnancy proceeded.

Concern about the babe. Although we understand how the statement that [Dr C] was not concerned about the babe was reached, we do not believe that the conclusion is correct. If [Dr F] had advised [Dr C] that a transfer to a tertiary centre was appropriate, this would have occurred.

Continued on next page

Obstetrician, Dr C / Crown Health Enterprises / Midwife, Ms D

Opinion – Case 98HDC17933, continued

**Response to
Provisional
Opinion
continued**

We accept the concern about [Dr C's] communication style. While we appreciate that there are people who find his style difficult, those who know him well reach different impressions. People who work closely with him find that he is a very caring man, who goes a long way to ensure that the best of care is provided to patients. We do not agree with the finding that he did not care.

...

In considering the opinion that [Dr C's] obstetric services were not provided with reasonable care and skill and that his conduct did not comply with professional standards we believe that information in the letter from [Dr F] casts a different light on the situation. We consider that the situation is considerably less clear cut than the Health and Disability Commissioner's conclusion and provisional report tend to indicate.

...

It is also important to note that at the time that this incident occurred the two [town] Obstetricians were practicing mainly in private. This meant that they were providing services to their patients on a seven day a week basis. Since October 1999 they have become employees of [Crown Health Enterprises]. This has enabled a rostered call system to be implemented. In January 2000 a third obstetrician joined the team which provided further improvement for call and peer review opportunities.

Obstetrician, Dr C / Crown Health Enterprises / Midwife, Ms D

Opinion – Case 98HDC17933, continued

Further advice to the Commissioner After reviewing the responses to my provisional opinion I sought further advice from my obstetrician and gynaecologist advisor. My advisor stated that:

“Thank you very much for asking me to further review [Mrs B’s] file following the appearance of [Dr F’s] letter to the Manager of the Women’s and New Born Service at [the public hospital] in response to their request for information for their local inquiry.

It would seem from [Dr F’s] letter that the discussion centred around whether or not Campylobacter infection might be responsible for the foetal tachycardia which was noted. [Dr F] indicated that he did not think this was likely and, by the situation as described, that there was any significant maternal infection. It would seem that the matter of the foetal heart rate was only touched on in passing and the advice was that ultrasound should be carried out to try and assess more effectively the state of the foetal wellbeing.

The ultrasound was carried out and this showed that the babe was somewhat under the 50th centile in size, but apparently the liquor was satisfactory. Foetal movements were apparently seen during the scanning. However, it should be noted that at no stage during the admission was it recorded that foetal movements were felt by [Mrs B].

However reassuring that the ultrasound might have been, the cardiograph tracings remained significantly abnormal without satisfactory explanation and continued to indicate foetal compromise. The CTG tracing on the morning of 2 October was particularly flat and unreactive and had a shallow deceleration in response to a small contraction although was not strictly tachycardic. Nevertheless, this trace indicated that immediate delivery should have been contemplated.

Continued on next page

**Obstetrician, Dr C / Crown Health Enterprises /
Midwife, Ms D**

Opinion – Case 98HDC17933, continued

**Further advice
to the
Commissioner
continued**

The trace on the afternoon of 2 October had marginally more beat to beat variation and perhaps a brief degree of reactivity, albeit during a period where a slight deceleration might have been considered. Nevertheless this trace was still significantly abnormal and not reassuring.

A further trace on the morning of 3 October again showed no beat to beat variation and demonstrated a shallow deceleration in response to a small contraction. While foetal movements were said to have occurred on the latter stages of this trace, there was absolutely no foetal response in relationship to these supposed movements and the trace itself was virtually flat.

Therefore, while the ultrasound findings have been reassuring on the afternoon of 2 October, the cardiocographic tracings on the morning of 2 October and the morning of 3 October indicated that the foetus needed immediate delivery and the trace on the afternoon of 2 October was not reassuring.

It is therefore clear that the situation was discussed with [Dr F] on 2 October, it would seem that the consultation centred mainly around the cause of the tachycardia rather than the state of the tracing itself. The possibility that this might have been infective in nature was considered and thought to be unlikely. The possibility that it might have been related to Campylobacter infection was certainly exceptionally unlikely. It seems that the detail of the trace was not clearly communicated to [Dr F], which led to the advice that ultrasound should be undertaken. In the event this was falsely reassuring and not in keeping with the general state given the lack of maternal appreciation of movement and the state of the cardiotocographic tracings.

Therefore, while [Dr C] may have been reassured by discussions with [Dr F] and the subsequent scan, the indications were nevertheless there for immediate delivery on the morning of 2 October.

Continued on next page

**Obstetrician, Dr C / Crown Health Enterprises /
Midwife, Ms D**

Opinion – Case 98HDC17933, continued

**Further advice
to the
Commissioner
continued**

I would therefore not resile from my original advice in this regard.”

**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.*

...

- 4) *Every consumer has the right to have services provided in a manner that minimises the potential harm to, and optimises the quality of life of, that consumer.*
- 5) *Every consumer has the right to co-operation among providers to ensure quality and continuity of services.*

RIGHT 5

Right to Effective Communication

- 1) *Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. ...*
-

**Obstetrician, Dr C / Crown Health Enterprises /
Midwife, Ms D**

Opinion – Case 98HDC17933, continued

Opinion: In my opinion midwife, Ms D, did not breach Right 4(5) as she took reasonable actions to communicate her concerns about the tracings to the
No Breach obstetrician, Dr C. Ms D further advised Ms I, her Unit Manager, and
Midwife, Ms D complainants, Mr A and Mrs B, of these concerns.

Opinion: In my opinion Dr C did not breach Right 4(1) by banging Mrs B with a
No Breach scanner probe. I am informed that scanners work by provoking vigorous
Dr C movement and Dr C's use of this probe was therefore appropriate.

Opinion: In my opinion the obstetrician, Dr C, breached Rights 4(1), 4(2), 4(4), 4(5)
Breach and 5(1).
Obstetrician,

Dr C **Rights 4(1) and 4(2)**

Crown Health Enterprises' inquiry report noted that Dr C failed to interpret the cardiocograph tracings correctly and therefore did not perform a caesarean section. In particular, Dr C failed to recognise that the foetal heart rate changes indicated severe chronic foetal hypoxia. The Commissioner's expert concurred with these findings. Based on Crown Health Enterprises' report and the advice provided by the independent expert, it is clear that Dr C's obstetric services were not provided with reasonable care and skill and that his conduct did not comply with professional standards. Therefore, in my opinion, Dr C breached Right 4(1) and Right 4(2).

Right 4(4)

In my opinion, Dr C did not provide obstetric services in a manner that minimised potential emotional harm to complainant, Mrs B, when he realised that her baby had died in utero. Instead, his manner was insensitive and compounded Mrs B's emotional suffering. Therefore, in my opinion, Dr C breached Right 4(4).

Continued on next page

**Obstetrician, Dr C / Crown Health Enterprises /
Midwife, Ms D**

Opinion – Case 98HDC17933, continued

Opinion: Right 4(5)

Breach

**Obstetrician,
Dr C *continued***

Dr C was obviously concerned about Mrs B's condition and called both a microbiologist and Lecturer in Obstetrics, Dr F, but he did not fax copies of the CTG tracings to Dr F and, in my opinion, did not discuss the detail of the tracings. I am advised that while telephone consultations are very valuable, they do not allow an appreciation of the full picture. In seeking the advice of Dr F, Dr C should have faxed him copies of the CTG tracings. Dr C failed to co-operate effectively with Dr F to ensure quality and continuity of obstetric services to Mrs B. Therefore, in my opinion, Dr C breached Right 4(5).

Right 5(1)

Mrs B informed the Commissioner that she found Dr C's manner "*intimidating*" and "*brusque to the point of rudeness*". Mr A reported to the Commissioner that on 3 October 1997, after conducting a scan, Dr C pointed out the baby's head, arms and legs and said "*you're absolutely right, there is no heartbeat*". Mrs B's husband, Mr A, further reported that when he asked Dr C whether he was saying that their baby had died, he replied, "*well, yes, I'm sorry*" and told them to "*go home*". I accept Mr A and Mrs B's version of events. Dr C's explanations were vague and his manner abrupt. As a first time mother Mrs B was in a vulnerable position and required clear, effective communication. In my opinion Dr C failed to communicate effectively with Mrs B and therefore breached Right 5(1) of the Code.

**Obstetrician, Dr C / Crown Health Enterprises /
Midwife, Ms D**

Opinion – Case 98HDC17933, continued

**Opinion:
No Breach
Crown Health
Enterprises**

Employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights. Under section 72(5) it is a defence for an employing authority to prove that it took such steps as were reasonably practicable to prevent the employee from doing or omitting to do the thing that breached the Code.

The obstetrician, Dr C, was an employee of Crown Health Enterprises. However, in the circumstances Crown Health Enterprises had taken such steps as was reasonably practicable to ensure obstetricians interpreted cardiocograph readings correctly, minimised potential harm to consumers, and communicated effectively with consumers. Accordingly Crown Health Enterprises is excused from vicarious liability for Dr C's breach of Rights 4(1), 4(2), 4(4) and 5(1).

**Opinion:
Breach
Crown Health
Enterprises**

Employers are vicariously liable under section 72(2) of the Health and Disability Commissioner Act 1994 for ensuring that employees comply with the Code of Health and Disability Services Consumers' Rights.

Crown Health Enterprises has advised that it did have a facility in place to enable obstetricians to fax tracings to the public hospital for a second opinion. However, the obstetrician, Dr C, was not aware of this facility and therefore did not consider faxing the tracings to Lecturer in Obstetrics, Dr F, when he consulted him by phone. Where a consultative relationship exists between providers, protocols need to be in place which clearly establish the nature of the relationship, the format of queries, the information that should be contained in them and the format and nature of responses. Such a protocol protects both the enquirer and the respondent from making assumptions based on inadequate information.

In my opinion, by failing to ensure that Dr C was aware of the facility to fax tracings to the public hospital and by failing to develop and circulate a protocol for consultation with the public hospital, Crown Health Enterprises did not facilitate co-operation amongst providers to ensure quality and continuity of services and is therefore vicariously liable for Dr C's breach of Right 4(5).

Obstetrician, Dr C / Crown Health Enterprises / Midwife, Ms D

Opinion – Case 98HDC17933, continued

Actions

I recommend that Crown Health Enterprises take the following action:

- Apologise in writing to complainants, Mr A and Mrs B, for its breach of the Code. The apology letter is to be sent to the Commissioner who will forward it to the family.

I recommend that the obstetrician, Dr C, takes the following action:

- Apologises in writing to Mr A and Mrs B for his breach of the Code. The apology letter is to be sent to the Commissioner who will forward it to the family.

In light of the confirmation from Crown Health Enterprises that each of the recommendations in the inquiry report have been implemented I have no further recommendations to make. I am satisfied that implementation of these recommendations should prevent a recurrence of the sort of tragedy that was suffered by Mr A and Mrs B.

Other Actions

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

I refer the matter of the breaches of the Code by the obstetrician, Dr C, to the Director of Proceedings for the purpose of deciding whether to institute disciplinary proceedings and/or proceedings before the Complaints Review Tribunal.
