Midwife – Ms B

General Practitioner – Dr C

Practice Nurse – Ms D

Medical Practice

A Report by the

Health and Disability Commissioner

(Case 03/06196)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Parties involved

Ms A	Consumer
Dr C	Provider/General Practitioner (specialist in obstetrics)
Ms B	Provider/Midwife
Ms D	Provider/Practice Nurse
Dr F	General Practitioner (specialist in obstetrics)
Dr E	General Practitioner (specialist in obstetrics)
Dr G	Obstetrician

Complaint

On 28 April 2003 the Commissioner received a complaint from Ms A about services provided to her by Ms B, Dr C and Ms D during her pregnancy. Ms A's complaint was summarised as follows:

Ms B
On 30 September and 7 October 2002, Mrs Ms B did not provide services with reasonable care and skill to Ms A, in that she:

- *did not adequately investigate Ms A's symptoms, which included severe itching and vomiting;*
- *did not refer Ms A for investigation of her symptoms.*

Dr C
On 25 September 2002, Dr C did not provide services with reasonable care and skill to Ms A, in that he did not adequately investigate the cause of Ms A's itching.

Ms D
On 10 October 2002, Ms D did not provide services of an appropriate standard to Ms A, in that she did not respond appropriately to Ms A's request to see a doctor urgently.

An investigation was commenced on 18 July 2003.

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

Information reviewed

- Information from Ms A
- Information from the Practice Manager of Medical Practice, including:
  – Ms A's medical records
- Information from Dr C, including:
  – Ms A's obstetric records
- Information from Ms B, including:
  – clinical notes relating to Ms A
- Information from Ms D
- Medical records from the DHB
- Information from Dr E
- Information from the Practice Nurse at another Medical Practice.
- Information from the consumer's mother.

Independent expert advice was obtained from Dr William Ferguson, general practitioner, Ms Joyce Cowen, midwife, and Ms Rosemary Minto, practice nurse.

Information gathered during investigation

Consultation with Dr C
On 25 September 2002 Ms A consulted Dr C at the surgery of the Medical Practice. Ms A was 32½ weeks pregnant with twins. It was her first pregnancy. Dr C was Ms A's Lead Maternity Carer (LMC), and shared her care with Ms B, midwife. Ms A, who had a history of vomiting during her pregnancy, complained at the consultation of itching and vomiting. This was the first occasion during her pregnancy that itching was mentioned as a problem to Dr C. According to Ms A, she told Dr C that her itching was severe; in particular, that her hands and feet were itching badly at night. She also claims to have been suffering from mild swelling of the legs. Dr C disputes these claims:

> "She had no significant oedema [swelling] … I have to say that at that consultation the vomiting had not been severe and neither was the itching being complained of severe. I thought the itching was more likely to be pruritus of pregnancy but obviously, if she had come back with worse symptoms of itching or vomiting, I would have investigated this in a different manner."

His notes relating to this consultation read:

> "vomiting – [one word illegible] slight itch".

Dr C considered that the symptoms were not atypical for a woman carrying twins. Consequently, he did not conduct further investigations into Ms A's condition.

Dr C told Ms A during their consultation that he would be absent from his practice for two weeks. According to Dr C, he had made "robust arrangements" for his absence and had told Ms A about them. His colleague, Dr F, general practitioner, was covering his maternity patients from 30 September to 4 October. From 5 October to 13 October, Dr C's maternity patients were to be attended by Dr E, general practitioner, at another Medical Centre. According to the practice manager of the Medical Practice, Dr G's obstetrician, had agreed to provide specialist care if required. In response to my provisional opinion, Ms A clarified that she had been informed by Dr C of his absence and that his patients would be attended by Dr F. However, she did not recall being informed of the latter arrangements he made concerning Dr E.

Worsening symptoms

Following her consultation with Dr C, the frequency of Ms A's vomiting increased. On 27 September Ms A attended a public hospital for a regular ultrasound scan. The scan was interrupted on three occasions because of nausea. The ultrasonographer became concerned with her condition and recommended that she be reviewed. Ms A replied that she would discuss her condition with Dr C at their next routine appointment, scheduled for 16 October 2002. The ultrasonographer advised Ms A not to wait until this appointment as she might have liver trouble. Ms A indicated that she would bring up the matter with her midwife on 30 September.

On 30 September Ms A met her midwife, Ms B, at the public hospital. The purpose of the meeting was to familiarise Ms A with the delivery suite. Ms A stated that a midwifery assessment was scheduled on this day, but was postponed because of its proximity to her consultation with Dr C. Ms A further stated that she told Ms B she was feeling generally unwell, but did not mention her itching. Nor did she mention her discussion with the ultrasonographer.

Ms B disputes Ms A's version of events; she states that the meeting was not a midwifery assessment but a tour of the delivery suite. The next midwifery assessment, according to Ms B, was scheduled for 7 October.

Midwifery assessment by Ms B

On 7 October 2002 Ms B attended Ms A at her home. Ms B conducted a midwifery assessment that included measuring girth and clinical gestation. Ms B recorded Ms A's blood pressure as 110/70; no protein in her urine; that the foetal hearts were heard; and that foetal movements were satisfactory. In response to my provisional opinion, Ms A stated that Ms B did not test her urine during their consultation, or take a urine sample. Ms B did not perform a glucose test. Ms B's clinical notes of her consultation with Ms A read:

> "Oedema – ankle + feet [one word illegible]
> vomiting + having trouble eating – discussed diet
> Suggested taking oral Maxolon."

Ms A stated that, during the assessment, she complained of vomiting and itching resulting in sleeplessness. In particular, she claimed to have been suffering from severe itching all over her body, especially in her feet, and of vomiting bile five to six times at 12-hourly intervals.[1] Ms B disputes these assertions. According to Ms B, the itching complained of was not severe or localised to Ms A's feet, and Ms A did not tell her about vomiting bile.

Ms B examined Ms A and found no evidence of a rash, or the type of abrasions that would be caused by scratching. Ms B stated:

> "I have had clients with severe itching and in every case there has been either a rash or signs of abrasions caused by rubbing or scratching. Also in every case the client with severe itching would be rubbing or scratching themselves in my presence. In my opinion and experience Ms A was not suffering from severe itching."

In response to my provisional opinion, Ms A noted:

> "[I] tried my best to convey the severity and unbearable nature of my itching. I did show Ms B my hands and feet and the comb I used to rake my skin at night. My feet did show at this point evidence of vigorous scratching. I was also itching on my back at this time but not raking my skin to the [same] extent as my limbs. Ms B concluded that as no scratch marks were visible on my body, the itching was therefore a non-issue. I completely disagree with Ms B that I failed to mention the itching on my feet.
> …
> I cannot emphasise enough that just because Ms B did not see any of the symptoms I described (in this one hour) [did not mean] that they were of little or no consequence, or being over-dramatised by me."

Ms B offered Ms A sleeping pills to help her sleeplessness; the offer was declined. Although Ms B was concerned about Ms A's vomiting, it had been continuous throughout the pregnancy. Ms A observed that she was "very puffy all over [her] body" during her consultation with Ms B. I note that Ms B recorded oedema (puffiness) around Ms A's ankles and feet.

Ms B discussed fluid management with Ms A and suggested taking oral Maxolon, which she had previously been prescribed. Ms B told Ms A to seek assistance from her or Dr C if her vomiting worsened. The remainder of Ms B's visit was dedicated to discussing birth, labour and the twins. According to Ms B, Ms A was not visibly scratching during the discussion.

[1] These details are contained in a chronology that accompanied Ms A's letter of complaint.

Telephone call to Ms D
Following her appointment with Ms B, Ms A continued to experience nausea and itching. On 9 October she consulted a book on twin pregnancy and observed chronic itching to be a symptom of cholestasis and decided to contact Dr C's locum, Dr F.

On 10 October Ms A attempted to contact Dr F at approximately 11.00am, but he was unavailable. She was then put through to the practice nurse at the medical practice, Ms D. Ms D informed Ms A that neither Dr C nor Dr F was available to assess her, and that she should consult Ms B. Ms A then requested a consultation with a general practitioner. Ms D replied that none of the other medical practitioners at the medical practice specialised in obstetrics. Ms A persisted in her request to be seen by a general practitioner. She described her conversation with Ms D (in her letter to Dr C dated 22 November 2002) as follows:

> "[Ms D] informed me that there was no-one else who could see me, that I should speak with [Ms B] [the midwife]. When I explained that I had and was not confident with her consult and that I wanted a second opinion from a doctor, [Ms D] made her diagnosis and opinions (of me) very clear. I was told I was sounding like a 'neurotic pregnant woman' and there was nothing wrong with me. She asked if I had a rash, I explained no, it was not PUPPS [PUPPP: pruritic urticarial papules and plaques of pregnancy] but a problem with my liver (I did not think my telling [Ms D] about the book would be well received at this point). … She went on to say that there was nothing wrong. I should just get on with it. She [then] went on to say that [Ms B] was an experienced professional, if [Ms B] said nothing was wrong then that was that."

Ms D had a different recollection of the conversation:

> "[Ms A] was not very happy with [Ms B]. At no stage in the conversation did [Ms A] indicate that the appointment was urgent or that she was extremely concerned about herself … I asked her what was wrong and she said she was itching all over and it had become worse since she had last seen the doctor or midwife, and that she had vomited a few times. I had made appointments for [Ms A] for vomiting in the past, so as far as I was aware the vomiting was not a new problem … I did say that perhaps the itching was hormonal, but that [Ms B] was far more experienced with pregnancy related issues and I strongly suggested she call her … [Ms A] then said quote 'I am sorry I am probably being a neurotic pregnant woman'. I replied quote 'that is possible, but I will try to get you an appointment as soon as I can, and we can find out for sure.'"

Ms D offered to contact the surgery of another general practitioner, Dr E, to arrange an appointment for Ms A.

Subsequent telephone calls
Ms D telephoned the other Medical Centre at 11.45am and was told by the receptionist that Dr E would not be available until 1.30pm and that his afternoon was fully booked with consultations. Ms D discussed Ms A's condition with the practice nurse at Dr E's surgery.

Ms D recalled:

> "I gave her [the practice nurse] all of [Ms A's] details: address, phone number and the details of what was wrong; that she was 34 weeks pregnant with twins, itchy all over and vomiting."

According to Ms D, the practice nurse responded by assuring her that Dr E would be informed of Ms A's situation on his arrival, and that an appointment would be arranged. The practice nurse could not recall her conversation with Ms D, and did not document its substance. However, she documented the following details as part of a telephone audit she was conducting:

> "10/02 [Ms D] – [The practice nurse at the medical centre] (direct) 11:45 Referral to [Dr A] of pregnant Pt. from their clinic – we are covering for [Dr C]."

Dr E was also unable to recall the substance of the message given to him, but advised that there seemed to be no acute urgency in the request.

While awaiting Ms D's response to her request, Ms A made a number of telephone enquiries regarding her condition. She contacted the public hospital in order to consult Dr G, the obstetrician who had agreed to provide specialist care if required. He was unavailable. Ms A then attempted to contact his locum at another hospital. She was also unavailable. However, Ms A was supplied with the contact details of a nurse who worked with the locum.

Ms A contacted the nurse and described her condition. The nurse enquired whether Ms A had had any blood tests. Ms A replied that she had not. The nurse then arranged for Ms A to be reviewed immediately at an Assessment Unit at the public hospital. As Ms A was departing to undergo this assessment, Ms D called to notify her of the arrangements that had been made at Dr E's surgery.

Admission to the Public Hospital

Ms A decided to have her condition reviewed at the Assessment Unit rather than wait for Dr E to become available. After three hours at the Assessment Unit, Ms A was admitted to the public hospital with suspected cholestasis of pregnancy.

Ms A's medical records from the public hospital read:

> "10/10/02
> …
> Present Hx [history] – Has had nausea and vomiting
> on occasion for past 3/52 [three weeks].
> Itchiness abdomen, palms + feet
> gradually getting worse and now
> generalising over most of body."

A second entry reads:

"10/10
15.30
…
Since last six weeks → vomiting + itching
getting worse in last 2 weeks.
vomiting every 2nd day – colour ranges fr. [from]
clear yellow to green
…
Itching all over body, worse @ night?
…
O/E [on examination] comfortable.
bilat [bilateral] ankle oedema.
Scratchy marks all over body
Ø [not] jaundiced Ø [not] dehydrated."

At 7.00pm Dr E contacted Ms A. He was apparently very surprised to learn that she had been admitted to hospital.

Ms A's twins were delivered by Caesarean shortly before noon on 11 October 2002.

Response to Provisional Opinion

In relation to her consultation with Dr C on 25 September 2002, Ms A clarified that the itching she mentioned was uncomfortable but not so severe as to be unbearable. However, she stated that her condition when she consulted Ms B, on 7 October, should have led Ms B to exercise caution or conclude that further exploration of her condition was required. Ms A noted that at the time she was oedematous, 34 weeks pregnant with twins, and experiencing her first pregnancy. In respect of her itching, Ms A stated that she tried to convey the severity of her itching to Ms B. She clarified that Ms B was informed about her feet itching, and that signs of vigorous scratching were evident on her feet when she consulted Ms B.

Ms A noted that an emergency Caesarean section was performed only four days after her consultation with Ms B. Further, her mother had observed that she was unwell in the week preceding that consultation, and had seen her vomiting bile. However, Ms A clarified that she had not vomited the day she was seen at the Assessment Unit of the public hospital, although she had vomited four to five times the previous morning. According to her, vomiting was generally only a problem in the morning and itching at night. Commenting on the fact that she was not dehydrated on admission to the public hospital, Ms A observed:

> "When not vomiting, I tried to drink water. I can offer no other explanation for [the] lack of dehydration and can assure you that my claims of vomiting are not overstated."

Of her conversation with Ms D, Ms A made the following comments:

> "[Ms D's] recollection of the conversation was both interesting and disappointing. I felt I was extremely insistent about needing to see a Dr on this day [10 October 2002] and repeatedly mentioned that my liver was the cause.
> …
> I did say that 'I was probably sounding like a neurotic pregnant woman', I was trying to deflect an argument but was genuinely surprised when [Ms D] agreed and repeated 'yes, you are sounding like a neurotic pregnant woman.'
> …
> Ms D contends, 'At no stage in the conversation did [Ms A] indicate the appointment was urgent or that she was extremely concerned about herself.' I remember saying to [Ms D] that I needed to see a doctor on this day, and that any other would be too late. I am amazed that [Ms D's] response contained the above statement … [Ms D's] account of our conversation was much more measured and polite than was, in fact, the reality.
>
> Again, that I was well advanced in my first (and a twin pregnancy), with escalating symptoms consistent with the majority of my pregnancy should have caused concern, even without knowledge of cholestasis.
> …
> That I was distressed during the phonecall regardless should have cautioned [Ms D] to have been more supportive in her tone and my request to see any Dr on this day, not the next.
>
> Unfortunately, unless both parties can agree (retrospectively) on the content and tone of a conversation, I agree it is difficult for a third party to reach a satisfactory conclusion."

Independent advice to Commissioner

Midwifery advice
The following independent expert advice was obtained from Ms Joyce Cowan, midwife:

> "My name is Joyce Cowan. I registered as a midwife in 1972 and have practised as an independent midwife since 1989. Prior to that I was employed at a base hospital Obstetric Unit. I currently work part time as a midwifery lecturer as well as having a caseload of midwifery clients.

I have read and agree to follow the Health and Disability Commissioner Guidelines (September 2003).

I have been asked to comment on the care given by [Ms B], midwife, to [Ms A] on October 7th 2002.

I understand that the complaint from [Ms A] is that:
[Ms B] *did not provide services with reasonable care and skill to* [Ms A], *in that she*:
– *did not adequately investigate* [Ms A's] *symptoms, which included severe itching and vomiting;*
– *did not refer* [Ms A] *for investigation of her symptoms.*

My instructions from the Commissioner are to comment on the following: -

Expert advice required

Did [Ms B] adequately investigate [Ms A's] symptoms? In particular, given [Ms A's] presentation, could [Ms B] reasonably have been expected to:
(a) Consider HELLP syndrome;
(b) Consider cholestasis;
(c) Refer [Ms A] to her LMC or other provider; and
(d) Conduct further tests to examine [Ms A's] condition?

Are there any aspects of the care provided by [Ms B] which you consider warrants either:
– Further exploration by an investigation officer?
– Additional comment?

In order to put these questions into context I will include a summary of the information I have gained from reading the following sources supplied to me: -

[Ms A's] email complaint to the HDC
[Ms A's] pregnancy notes
[Ms A's] letter of complaint to [Dr C] dated 22 November 2002
A transcribed version of [Dr C] letter of response dated 6 December 2002
Letter of notification to [Ms A] dated 18 July 2003
Summary of telephone conversation clarifying the complaint dated 9 June 2003
Letter from [Ms A] amending summary dated 25 July 2003
Letter of response from Practice Manager of [the Medical Practice] dated 25 August 2003
Letter of response from [Dr C] including medical records dated 25 August 2003
Letter of response from [Ms B] including clinical notes dated 8 August 2003
Nurse record summary for [Ms B] received 7 August 2003
Letter of response from [Ms D] dated 10 June 2003
Nurse record summary for [Ms D] received 10 September 2003

Medical records from [the District Health Board] received 4 August 2003

Summary of events

[Ms A] was receiving shared maternity care during her first pregnancy, from her GP [Dr C] and a midwife [Ms B]. [Dr C] was her lead maternity caregiver (LMC). On 7 October 2002 [Ms B] visited [Ms A] at home to perform an antenatal assessment.

Gestation at this visit was 34 weeks and 2 days and it was a twin pregnancy. Foetal growth and wellbeing had been satisfactory to date.

[Ms A] had been experiencing itching all over her body and this had been particularly intense on her feet and worse at night. Consequently it had been difficult for [Ms A] to sleep. She had also been suffering from vomiting during the pregnancy and at the time of the visit was vomiting 5-6 times each 12 hours or so and finding it difficult to eat much food.

[Ms B] examined [Ms A] and recorded her blood pressure as 110/70, no protein in the urine, foetal hearts heard and foetal movements satisfactory. Oedema (swelling) of the ankles and feet was noted.

Following this visit, on 10 October [Ms A] was admitted to hospital after becoming very concerned about worsening itchiness and increasing vomiting and was delivered by emergency Caesarean section on 11 October after a diagnosis of cholestasis. There was also concern over possible development of a severe form of preeclampsia, HELLP syndrome, but this was not confirmed according to hospital records.

Conflicting reports

The evidence provided by [Ms A] is different in several respects to the evidence provided by [Ms B]. I will summarize the main points concerning the antenatal assessment as recalled by both parties as follows: -

[Ms A's] account

- The itching was severe and all over her body, although mainly on her feet. It was much worse at night, making sleep impossible. Some relief was obtained by dipping feet in a bucket of cold water at half hourly intervals.
- Vomiting (all bile) was occurring every 12 hours or so and 5-6 times on each occasion.
- Unable to eat or drink much.
- Very puffy all over body.
- Dark circles under eyes.
- Mother staying as too weak to get out of bed.

- Midwife did not have proper monitoring equipment and unable to take blood pressure.
- Midwife said itching was normal as there was no rash.
- Midwife not concerned about the swelling or vomiting.

[Ms B's] account

- Carried out a full antenatal check including blood pressure. Blood pressure recorded.
- [Ms A] did not mention that the soles of her feet were itchy but did mention the other areas of her body that were itchy.
- On inspection [Ms A] had no rash.
- No rubbing or scratching observed during visit over one hour.
- Was concerned about the vomiting but was not told about [Ms A] vomiting bile. Discussed diet and fluid management and suggested oral Maxolon which had been previously prescribed by the GP.
- Asked [Ms A] to contact herself or GP if vomiting got any worse.
- Spent time discussing baby care, clothing and the nursery.
- [Ms A] accompanied her to the gate to secure the latch.

Expert advice required

Did [Ms B] *adequately investigate* [Ms A's] *symptoms? In particular, given* [Ms A's] *presentation, could* [Ms B] *reasonably have been expected to:*

(a) Consider HELLP syndrome

From the clinical symptoms on 7 October the only sign that may have pointed to a possibility of HELLP syndrome was the vomiting. HELLP syndrome is a very severe form of pre-eclampsia, and involves blood changes and impaired liver function. HELLP is an acronym for **H**aemolysis, **El**evated liver enzymes and **L**owered **P**latelets. The condition often presents suddenly and deteriorates rapidly.

The fact that [Ms A] had been vomiting over several weeks would have probably made the diagnosis of HELLP syndrome on 7 October much less likely than if the vomiting had had a relatively sudden onset. It is usual for the blood pressure to be elevated if pre-eclampsia is developing although a normal blood pressure does not rule it out. Certainly oedema may be a symptom of pre-eclampsia but is also very common in normal pregnancy, especially with twins. [Ms A] has said that she was puffy all over but [Ms B] recorded oedema of the ankles and feet only (although there is an illegible entry following this on the antenatal record (p73), which may be '+ fingers'. Had [Ms A] been clearly puffy all over I would have expected the midwife to be concerned enough to investigate further.

It is significant that after hospitalization and investigation, although there was a clear indication for a high index of suspicion that severe preeclampsia *could* develop, because of the liver and renal impairment, the indication for Caesarean section written on the surgical report (p103) was twin pregnancy and hepatorenal impairment. There was clearly evidence of elevated liver enzymes but I have found no report to indicate that there was any haemolysis (breaking down of red blood cells).

There is some ambiguity in the clinical record about whether or not the platelet level was consistently low. I refer to the comment on the haematology report for blood samples taken several times on 10 October (p139). The normal platelet level is 150-500 x 10 ^9/L. The comment on the form is 'automated platelet count of 127 x 10 ^9/L will be inaccurate due to the presence of large platelets. The platelet count estimated from the film is approx 232 x 10^9/L' which is clearly within normal parameters. On page 142 the platelet readings over several days are charted and the levels recorded are the lower levels presumably taken from the automated count rather than the blood film. On every lab report with one exception the automated count has been qualified by a comment concerning a normal estimate taken from the film.

Therefore I have assumed that because of the liver changes and some question over a decrease in the level of platelets, every effort was made to ensure that preeclampsia or HELLP syndrome would be picked up early and treated appropriately but in fact it seems the conditions did not develop.

In my opinion it was *reasonable* for [Ms B] not to consider HELLP syndrome given the clinical picture that she had on October 7, even though the possibility of this condition was definitely raised once the diagnosis of renal and liver impairment had been made after [Ms A's] admission to hospital. (HELLP syndrome is a severe form of preeclampsia and preeclampsia often involves renal impairment.)

(b) Consider cholestasis

Cholestasis is a poorly understood condition and may be difficult to diagnose. The symptoms often present in the third trimester and the itching is typically over the palms of the hands and the soles of the feet, thought to be due to collection of bile acids and histamine release in these areas (Morgan, 2003). There are risks to the foetus including hypoxia, foetal distress, stillbirth and preterm delivery (Chin, 2003).

The question of whether [Ms B] should have considered the diagnosis of cholestasis depends on the information that she was given by [Ms A] during the visit on 7 October. There are significant inconsistencies between the reports from the midwife and her client. I will comment on the reasonableness of the care given in regard to each recollection of events.

1. [Ms A's] statement

[Ms A] stated that she told her midwife that the itching was all over her body but mainly on her feet and so severe that she needed to immerse her feet in a bucket of water every half hour during the night. There was no rash visible.

These symptoms are very suggestive of cholestasis and based on this statement [Ms B] *should* have considered the diagnosis or at least referred her client to an obstetrician for an opinion.

2. [Ms B's] statement

[Ms B] stated that her client did not mention that fact that the soles of her feet were itchy. She did inspect other areas of [Ms A's] body, which she had been told were itchy and saw no rash at all. Seeing no rash in a case where the woman is complaining of severe itching may lead the midwife to suspect liver disease. However in reality itchiness without a rash is not uncommon in pregnancy and the fact that [Ms B] witnessed no scratching or rubbing over the hour of the appointment would have suggested to her that the symptoms were not too severe. Severe itchiness should definitely not be dismissed as normal in pregnancy but from [Ms B's] account of the assessment the symptoms did not seem to be severe during the time she observed [Ms A].

From the account of events given by [Ms B], I consider that it was reasonable for her *not to* consider cholestasis on 7 October.

(c) Refer [Ms A] *to her LMC or other provider*

Again, my opinion on this matter depends on whether I base my opinion on the statement made by [Ms B] or by [Ms A].

I will comment on the reasonableness of the care depending on the individual recollection of events.

[Ms A's] statement

The account of [Ms A's] condition on October 7 contained in her report to the HDC (p3) certainly suggests a condition needing prompt referral to a specialist obstetrician. The symptoms of cholestasis (severe generalized itching in the absence of a rash, and more severe on the feet), and the worsening vomiting to the point where [Ms A] was bedridden would have been cause for concern.

If my opinion was based on [Ms A's] statement I consider that [Ms B] should have at least contacted the doctor standing in for the LMC, Dr [C], to discuss the situation. It would have then been appropriate for the LMC to refer [Ms A] to an obstetrician for review.

Ms B's statement

There are many inconsistencies between the two statements. The two areas of concern are (i) the itching and (ii) the vomiting. I will discuss them separately: -

(i) According to [Ms B] the itching experienced by [Ms A] did not appear to be severe. It did not seem to cause her any obvious discomfort during the time of the antenatal visit. No mention was made of itchiness on the soles of the feet and the need to put the feet in cold water every half-hour during the night.

(ii) [Ms B] stated that she was not told [Ms A] was vomiting bile and she suggested oral Maxolon to control the nausea. As [Ms A] had previously been prescribed this medication and had stopped taking it, it seemed a reasonable suggestion to try it again. She discussed food and fluid management and asked [Ms A] to contact her or the GP if the vomiting got any worse.

[Ms A] stated that she was too weak to get out of bed. [Ms B] stated that she spent time discussing care of babies, the baby clothes and inspecting the nursery with [Ms A]. At the conclusion of the visit [Ms A] walked to the gate with [Ms B] to make sure the latch was closed, as she was concerned her dog may escape if the gate was not properly shut. It does not sound that [Ms A] was too weak to get out of bed on 7 October. However I know that a woman's condition can deteriorate rapidly and question whether it was after the midwife's visit that her condition deteriorated. As [Ms A] was delivered urgently on 11 October it is clear that by then she was very unwell indeed. However, it must be noted that on admission to hospital on 10 October it was noted by the admitting doctor that [Ms A] was not dehydrated indicating that she must have been able to manage her fluid balance reasonably well over the previous few days since seeing [Ms B].

My opinion is that, given the 7 October events described by [Ms B] it was reasonable to give dietary and fluid management advice, suggest trying the oral Maxolon again and ask Ms [A] to contact either the midwife or GP if the vomiting became more severe.

(d) Conduct further tests to examine [Ms A's] *condition?*

According to [Ms A's] account of her condition – *reasonable midwifery care should have* included a urine test for ketones (to test for dehydration) and a blood test for liver function.

According to [Ms B's] account the above tests *could have* been done. However it was *not unreasonable* to provide the care and advice stated with the instructions to call if concerned that symptoms were becoming worse.
Are there any aspects of the care provided by [Ms B] *which you consider warrants either:*

– *Further exploration by an investigation officer?*

No

– *Additional comment?*

It is possible that problems in communication between midwife and client here could have been heightened by the fact that care was fragmented between the LMC GP and midwife and no one practitioner was providing a 'continuity of carer' service. When one practitioner sees the woman regularly it is easier for them to see progressive changes, particularly when a relationship is established over many visits.

References

Morgan, G.MIDIRS *Midwifery Digest*, Vol. 13, No 3, Sep 2003, pp 321-324

Chin, GY. *Journal of Paediatrics, Obstetrics and Gynaecology*, Mar/Apr 2003, pp 22-27"

Additional midwifery advice
Ms Cowan advised that, whereas a standard midwifery assessment requires a protein test, testing a pregnant woman's urine for glucose is not standard practice for all practitioners. She clarified that not all practitioners considered these glucose tests useful because it can be normal for excess glucose to be released in the urine.

General practice obstetrics advice
The following independent expert advice was obtained from Dr William Ferguson, general practitioner specialising in obstetrics:

"I have been asked to provide an opinion to The Commissioner on Case No. 03/06196, and I confirm that I have read and agree to follow The Commissioner's guidelines for independent advisors. I am a Fellow of The Royal New Zealand College of General Practitioners, hold a Diploma in Obstetrics and am currently an Examiner in The Diploma of Obstetrics and Medical Gynaecology at National Women's Hospital, and function in the department as a part time Senior Lecturer. I have had 20 years of GP Obstetric experience.

Expert advice required

What are the typical symptoms of:
HELLP syndrome; and Cholestasis?

When do these symptoms typically appear during pregnancy?

How common are these conditions in:

Pregnant women; and
Pregnant women expecting twins?
Given [Ms A's] *presentation, were* [Dr C's] *services of a reasonable standard. Please include comment on whether* [Dr C] *could reasonably have been expected to:*
Consider HELLP syndrome;
Consider Cholestasis;
Refer [Ms A] *for specialist assessment and treatment; and*
Conduct further tests to examine [Ms A's] *condition?*

Did [Dr C], *as* [Ms A's] *Lead Maternity Carer, take appropriate actions to ensure adequate care in his absence?*

Are there any aspects of the care provided by [Dr C] *which you consider warrants either:*
Further exploration by an investigation officer?
Additional comment?

In compiling this report I have read all of the documents relevant to the case forwarded by The Commissioner's office and reviewed the information on Intra-hepatic Cholestasis of Pregnancy and HELLP Syndrome in all the major current obstetric textbooks (see references below for specific sources).

[Ms A] presented to [Dr C] for a consultation on 25th September, immediately prior to his departure for two weeks holiday. At that point she was just under 33 weeks, in her first pregnancy, with twins. In the consultation she complained of vomiting and itching. [Dr C] did not regard these symptoms as significantly unusual. [Dr C] had arranged for continuing care through her midwife, [Ms B] and a locum was arranged for his obstetric practice, [Dr F]. [Dr G], Specialist Obstetrician, had seen [Ms A] earlier in the pregnancy as recommended in the Maternity referral Guidelines, and was available to provide any specialist care or consultation if it was required.

Over the ensuing 15 days [Ms A's] itching, nausea and vomiting became progressively worse. In the last 4 days she became increasingly unwell and oedematous. On 10th October she attempted to obtain an urgent appointment with one of the doctors as she had no confidence in the midwife, who had reassured her 3 days previously that all of her symptoms and unwellness were normal. The urgency of her situation was not recognised over the telephone by the practice nurse [Ms D]. The locum General Practitioner Obstetrician [Dr F] was now also away, and another General Practitioner Obstetrician, [Dr E], who worked in another practice across the town was standing in for both [Dr C] and [Dr F]. The urgency of the situation was not communicated to [Dr E], who was not available to see her until 7.30 that evening. The Specialist Obstetrician, [Dr G], was also away, and his locum was unavailable.
Fortunately [Ms A] had the wisdom and fortitude to persevere with this sequence of unhelpful events and in the end she was admitted to hospital on 10th October. On admission it was soon recognised she was suffering from Intra-hepatic Cholestasis of

Pregnancy. She was fully assessed, her condition stabilised and a caesarean section was performed the next day. Immediately post operatively she became even more oedematous, and her platelet count dropped transiently. There was obviously concern at this stage that she may have also been suffering from HELLP Syndrome. There seems to be some confusion around this because the clinical presentation at this point certainly raised the possibility of HELLP Syndrome however there was no mention of this diagnosis either in the hospital notes or in the final discharge letter. Fortunately [Ms A] made a full recovery and her babies have done well.

Expert Advice Required.

1 *What are the typical symptoms of HELLP Syndrome and Cholestasis and when do these symptoms typically appear during pregnancy?*

HELLP SYNDROME

HELLP Syndrome is an acronym that represents a particular constellation of clinical findings diagnostic of the condition. It includes Haemolytic Anaemia, Elevated Liver transaminases, and Low Platelet count. This is an enigmatic condition, first described as being a specific entity in the early 1980's. Most commonly it is seen in the context of pre-eclampsia or 'toxaemia' of pregnancy, and is said to complicate between 2 and 12% of women suffering from this condition. The normal hallmarks of pre-eclampsia, such as raised blood pressure or protein in the urine, may however be completely absent.

It occurs typically in women in their first pregnancies in the third trimester, becoming progressively more severe with the passage of time. It usually presents with non-specific symptoms of unwellness, often belying the seriousness of the underlying condition at that stage. There may also be symptoms of abdominal pain, nausea, vomiting and headache. The haemolytic anaemia results in a drop in the haemoglobin as the red blood cells are damaged and ruptured. This is typically associated with disseminated intra-vascular coagulation, in which there is complete disorder of the normal blood clotting mechanism. This results in a mixture of both excessive intra-vascular clotting and simultaneously a propensity to bleeding as a result of the consumption of platelets as part of the clotting process. Haemorrhage may then occur as a result of inadequate platelets. Laboratory tests would normally show abnormal red blood cell fragments in the blood film, disorder in the various components of blood clotting and a platelet count which in this condition usually drops below 100 b/l. Liver enzymes are elevated in a non-specific pattern. HELLP Syndrome is very dangerous to both mother and baby with significant perinatal and maternal mortality. The non-specific nature of the onset of the condition and the absence of any distinctive symptoms or signs without laboratory testing means that a delay in the diagnosis and inappropriate management secondary to initial misdiagnosis is an all too common feature of the condition.

CHOLESTASIS

Cholestasis, or more accurately Intra-hepatic Cholestasis of Pregnancy, is also a condition involving the liver that typically presents in the third trimester, becoming more severe as the pregnancy progresses. It presents with widespread itchiness, or pruritus, typically occurring more severely in the extremities such as the palms and soles. When more severe the condition is commonly associated with a progression of anorexia, malaise and epigastric discomfort. The severity of the itching is such that commonly there will be superficial excoriation of the skin. Severe cases will progress after 1 or 2 weeks to develop mild jaundice of an obstructive pattern that will be associated with pale stools and dark urine.

The condition is considered to be caused by an adverse effect on the liver of high oestrogen levels towards the end of pregnancy. This heightened sensitivity of the liver to oestrogen seems to have a significant genetic or familial component, which probably explains the marked variation in the incidence of this condition around the world. The itching is caused by a build up of bile acids in the blood as the liver is unable to excrete them normally. It is commonly associated with minor alterations of the liver enzymes in a specific 'cholestatic' pattern.

It is now considered that milder presentations of this condition account for Pruritis Gravidarum, a benign form of the condition that is not associated with any overt abnormalities of liver function. In the rarer cases that progress to jaundice there is a significantly increased risk of both fetal distress and stillbirth, especially towards term. As a consequence of this the condition is usually managed by induction at around 37 weeks gestation.

Both HELLP Syndrome and Intra-hepatic Cholestasis are associated with progressive worsening of non-specific symptoms in the third trimester of pregnancy, including general unwellness, nausea, vomiting and possibly epigastric discomfort. Both are associated with abnormalities of the liver function tests. The hallmark of Intra-hepatic Cholestasis is pruritis. There is no known association between these two conditions, although they could occur together coincidentally.

How common are these conditions in pregnant women, and pregnant women expecting twins?

In most countries Intra-hepatic Cholestasis in pregnancy occurs rarely, with a prevalence of between 1/1,000 and 1/10,000 pregnancies (ref. Haines and Taylor Obstetrical and Gynaecological Pathology). There is however an up to 10 to 20 fold greater prevalence in Scandinavian and some South American countries. This fact, and other specific research confirms the genetic nature of the intolerance of the liver to oestrogen. The syndrome is more frequent in multiple pregnancies, but even in the context of multiple pregnancies the condition remains rare in the New Zealand setting.

HELLP Syndrome is said to occur in between 2 and 12% of women suffering from pre-eclampsia or 'toxaemia' of pregnancy. This condition is notably more common in women having their first babies and 3 to 4 times more common in twin or multiple pregnancies. HELLP Syndrome is more common however in multiparous women and is not more common in twin pregnancies.

Given [Ms A's] *presentation were* [Dr C's] *services of a reasonable standard? Please include comments on whether* [Dr C] *could reasonably have been expected to:*

(a) Consider HELLP syndrome;
(b) Consider Cholestasis;
(c) Refer [Ms A] *for specialist assessment and treatment; and*
(d) Conduct further tests to examine [Ms A's] *condition.*

CONSIDER HELLP SYNDROME

(a) In answering this question I would rather address the issue as 'Consider an atypical presentation of pre-eclampsia' rather than specifically HELLP Syndrome as I believe the diagnosis of HELLP Syndrome was not proven. I will comment further on this issue below. In saying this it certainly does not detract from the seriousness of the condition with which [Ms A] presented.

Women who are primagravid and women who have multiple pregnancies all require close monitoring from late in the second trimester onwards, particularly for fetal growth disorders and the hypertensive disorders of pregnancy such as pre-eclampsia. For a woman who is both having her first pregnancy and twins this is particularly so.

Reviewing [Dr C's] notes I see that [Ms A] was appropriately and closely monitored, particularly from 23 weeks gestation onwards. She had a specialist referral and was enrolled in a system of regular scanning to ensure normal fetal growth (usually a very sensitive indicator of an emerging abnormality in a twin pregnancy). [Dr C] saw her at just under 24 weeks, 27 ½ weeks, 28 ½ weeks, 29 ½ weeks and 32 ½ weeks. In addition to these visits she was seen by the midwife at 26 and 31 weeks. At the time of the last consultation on 25th September a growth scan had been done 2 weeks previously that was normal, and an appointment was made for a follow up scan 2 days after the appointment which also was reassuring. Her blood pressure was unchanged and had remained normal and she had no proteinuria. I cannot see, from the record, when her last lot of routine ante-natal bloods were done. Ideally routine blood tests should have been done somewhere around 28-30 weeks gestation. It is not standard practice however to routinely look for markers of pre-eclampsia in the absence of any clinical signs at this stage. Therefore I consider that at the time of the consultation of 25th September [Dr C] had adequately excluded the presence of that underlying group of conditions, and was providing antenatal management of reasonable care and skill.

CONSIDER INTRA-HEPATIC CHOLESTASIS OF PREGNANCY

(b) On 25th September [Dr C's] notes mention vomiting and slight itch. It seems that problems with nausea and vomiting in early pregnancy had been quite severe and it is sometimes considered that these problems are worse in twin pregnancy. It is not uncommon for the symptoms to continue through the pregnancy and for problems associated with reflux to supervene towards the end of the pregnancy. Discomforts of various sorts are customary in the third trimester. General wellbeing is known to decline considerably in the third trimester and this is particularly evident between the 31st and 35th gestational week. The question in this case is whether [Ms A's] symptoms were sufficiently severe or abnormal to require further investigation or assessment at that stage. In addressing this question I have received some guidance from a research paper specifically addressing the issue of upper gastro-intestinal symptoms in the third trimester of the normal pregnancy (ref. 3). It is generally accepted that some 50% to 70% of pregnancies are troubled with significant nausea and vomiting in the first trimester. This research showed that 17% of women had persisting nausea, and 8% of women had persistent vomiting that continued unchanged through the third trimester. Heartburn continued unchanged through the third trimester in 60% of women. I consider that at the date of this consultation the mention of the vomiting would reasonably have been interpreted as a continuation of existing symptoms and not drawn any undue attention.

At this consultation [Ms A] mentioned itching for the first time. I believe at this presentation her symptoms were likely to have been mild, and definitely not associated with any extensive skin excoriations. I conclude this because the condition is known to come on slowly, and progressively increase in severity towards term. The medical history obtained from the hospital record states 'vomiting and itch getting worse in last 2 weeks' and 'itchiness abdomen, palms and feet gradually getting worse'. On examination at this time there were 'scratching marks all over body'. ([The DHB] Record admission notes).

It is not uncommon for women to mention itchy skin in pregnancy. Minor degrees of itchiness, unassociated with any rash, are found in pregnancy because stretching of skin and vasodilatation, both pervasive features of the second to third trimester of pregnancy can cause itching. What is distinctive in Cholestasis is the progression and the escalating severity. [Dr C] unfortunately was never in a position to observe that progression.

To put the rarity of this condition in a New Zealand context in reviewing this case I was first struck by the realisation that in nearly 20 years of active GP Obstetrics I have never myself encountered a case, and was only vaguely aware of the condition. It seems that most General Practitioner Obstetricians in New Zealand would have a fairly low level of awareness of the condition. To investigate this impression further I scanned all of the commonly used Obstetric text books, and past and present course notes from the National Womens' Hospital Diploma of Obstetrics and Medical Gynaecology and recent course notes from the Otago Diploma of

Obstetrics. There was no mention of Intra-hepatic Cholestasis or even its more common and mild manifestation as 'Pruritis Gravidarum' in any of the commonly used obstetric texts. Information was only available in the two text books I have quoted and used, one a specialist textbook of maternal-fetal medicine and the second a textbook of obstetric pathology, neither of which is either widely available or referred to by primary care practitioners.

Although the course notes for the Diploma of Obstetrics go into detail on many facets of the medical complications of pregnancy there is no mention at all of liver disease in pregnancy. Although this seems like an omission it is necessary to bear in mind that 'primary diseases of the liver remain rare in pregnancy, only 50 cases were recorded in 56,000 pregnancies (less than 0.1%) in one centre' (ref. 4). By way of introduction to the chapter on liver disease in Creasy's textbook it is stated 'the lifetime experience of the individual Obstetrician, Internist, and hepatologist in managing disorders of the liver, pancreas and biliary system in pregnancy is likely to be limited … these limitations can lead to delays in diagnosis and appropriate management'. Unfortunately the symptom of itching is never, certainly in a New Zealand context, going to ring an alarm bell even in a conscientious practitioner in the same way that a slight rise in blood pressure, a small trace of protein in the urine, or unexplained headache would cause alarm and prompt further investigation in a woman in her first pregnancy with twins.

I conclude from all of this that [Dr C] could not have been expected to consider Intra-hepatic Cholestasis of Pregnancy at the time that itching in pregnancy was first mentioned unless he had previous experience of the condition, which I consider to be highly unlikely. I therefore also conclude that it was not necessary for him at that point to have referred her for specialist assessment, or to have conducted further tests to examine her condition in order to provide services of reasonable care and skill.

Did [Dr C]*, as* [Ms A's] *lead maternity carer, take appropriate actions to ensure adequate care in his absence?*

[Ms A] was to have ongoing care with her midwife, with backup if required from another experienced General Practitioner Obstetrician, [Dr F]. An arrangement with [Dr G], Specialist Obstetrician, was already in place if any problems arose. I believe [Dr C] had done everything within his power to ensure that there was ongoing and appropriate care arrangements in place during his absence. Most women in New Zealand currently do not in pregnancy have the option of having a General Practitioner involved in their care, and normal care would be midwifery only with specialist backup when required. It was not within [Dr C's] control that [Dr F] also required cover, and had made a further arrangement with another experienced General Practitioner Obstetrician. Nor was he to have any idea that the specialist would be unavailable and that there would be a problem with his backup arrangements.

Finding appropriate backup arrangements for General Practitioner Obstetricians has been a major feature of the crisis that has afflicted the sub-speciality over the last few years. The workforce has diminished from providing care for 60% of pregnant women in New Zealand prior to July 1996 to the current situation in which there are apparently only 20 General Practitioners left providing intra-partum Obstetric care throughout the country. I am aware that in many areas, particularly rural areas, the last remaining GP Obstetricians have been forced to give up when it was no longer possible to have reliable backup arrangements with colleagues as they gave up their obstetric practices. To a lesser extent there has also been a marked reduction in specialist involvement in obstetric care with, as I understand it, only 17% of Obstetricians and Gynaecologists in New Zealand still providing intra-partum care. Thus whilst I see that the backup arrangements both from the GP and the specialist perspective were unsatisfactory this is a natural consequence of the maternity system that has been in place in New Zealand over the last few years, and the practitioners involved cannot be blamed in any way for it.

Are there any aspects of the care provided by [Dr C] *which you consider warrants either further exploration by an Investigation Officer or additional comment?*

<u>THE DIAGNOSIS OF HELLP SYNDROME</u>.

1 As mentioned earlier in the report the diagnosis of HELLP Syndrome was not confirmed in the hospital discharge letter, and I presume there may be some ongoing confusion about this. It was most probably a part of the differential diagnosis, and may have been discussed at some length immediately after the delivery when [Ms A] was particularly unwell. Her blood film and her blood clotting tests never showed any of the abnormalities associated with either haemolytic anaemia or disseminated intra-vascular coagulation. Her elevated liver enzymes were consistent with the abnormalities associated with Intra-hepatic Cholestasis, and required no further explanation. She had a drop in her platelet count transiently just after delivery, although this did not reach the threshold of less than 100,000 per mm^3 which several of my sources identify as a diagnostic criteria for this condition.

In reviewing the hospital notes I believe however that in addition to Intra-hepatic Cholestasis, [Ms A] had an atypical presentation of pre-eclampsia that contributed to her unwellness in the days immediately prior to delivery. Even though her blood pressure was unchanged and she had no protein in her urine (the most familiar identifiable criteria of the condition) her progressive unwellness in the days prior to admission and increasing oedema raised the question of such an underlying process. Certainly being in her first pregnancy and having twins made her at high risk. By the time of her admission her blood pressure had in fact risen slightly from about 110/70 for most of her ante-natal visits to 120/86. Although she had no protein in her urine importantly there was evidence biochemically of significant renal impairment with elevated uric acid and creatinine. The decline in her platelet count immediately after delivery recovering over the ensuing few days is a well known feature of this multi

system disorder. Considering all of these clinical features I believe she also suffered from pre-eclampsia and I believe her obstetric record should be amended to record this.

2 The difficulty she had in being seen at the [medical] practice on 10.10.02. Whilst it is not in my brief to make a comment on the role of the practice nurse or the midwife in this case I would like to make a general comment about the difficulty [Ms A] had in being seen on the day of her admission to hospital. It has been an unfortunate side effect of the LMC system and the rigid funding mechanism that goes with it that GP's who are not involved as LMC's have become almost actively avoident of women presenting either ante-natally or post-natally with any problem perceived to be related to pregnancy. I contend that had [Ms A] presented either herself, or for arguments sake her child, with any other conceivable medical problem to the practice nurse on that day she would have been fitted in urgently as patients invariably are every day in General Practice in New Zealand. I therefore see the practice nurse's role in this as being heavily influenced by the unseen politics of maternity care. It could be argued that the other doctors in the practice had limited experience in maternity care but it seems ironic that a woman who was clearly both quite physically unwell and very distressed would be effectively discriminated against by virtue of being pregnant by the machinations of a funding system that is supposed to enhance continuity of care. [Ms A] showed remarkable persistence, and in taking matters into her own hands almost certainly averted a more serious outcome.

3 This case does illustrate a fundamental point about ante-natal care. There are a number of symptoms that occur in a plethora of different conditions both related and unrelated to pregnancy that may be the harbinger of serious underlying obstetric illness. For example headache, nausea, indigestion and general malaise are very common symptoms in primary care generally and also in normal pregnancy. However every one of these symptoms requires careful consideration in a pregnant woman and must be positively diagnosed. Any persisting undiagnosed symptoms in pregnancy especially when associated with an unremitting and progressive timecourse should be considered serious until proved otherwise."

Practice nurse advice

The following independent expert advice was obtained by Ms Rosemary Minto, practice nurse:

"I, Rosemary Minto, have read and agreed to follow the Guidelines for Independent Advisors as described in the documentation I have received from the Office of the Health and Disability Commissioner.

I am a Registered General Obstetric nurse, having graduated from Tauranga Hospital School of Nursing in 1983. I received a Post-Graduate Certificate in Advanced Nursing Practice – Practice Nursing in 2002 and have been a full time practice nurse since 1997 with accreditation from New Zealand Nursing Organisation in 2000. My experience

covers caring for families across the life span and I have worked alongside midwives as they practice in a general practice setting.

My instructions from the Commissioner are to comment on the questions below after examining all the written evidence provided for me. My opinions are based on the assumption that the practice nurse in question has eight and a half years experience as a practice nurse and as such, should be aware of the New Zealand College of Practice Nurses, NZNO (NZCPN, NZNO) Standards of Practice available to her from her professional organisation (NZNO 2001) and also the Health and Disability [Commissioner's] Code for Consumers. With her years of experience I would expect a practice nurse to be competent in her telephone triage abilities and to practice safely and effectively with the limitations inherent in telephone triage.

I have examined the following list of information:

- Complaint, including:
  - [Ms A's] e-mail complaint to the HDC, dated 28 April 2003. (p1-2)
  - [Ms A's] pregnancy notes. (p3-5)
  - [Ms A's] letter of complaint to [Dr C], dated 22 November 2002. (p6-8)
  - A transcribed version of [Dr C's] letter of response, dated 6 December 2002. (p9)
- Letter of notification to [Ms A], dated 18 July 2003. (p10-11)
- Summary of a telephone conversation clarifying the complaint, dated 9 June 2003. (p12-14)
- Letter of response from [the] practice manager of [the medical practice], dated 25 August 2003. Including: (p15-22)
  - A log of 10 October 2002 from [Ms D's] daily message book (p20-22)
- Letter of response from [Ms D], dated 10 June 2003. (p23-24)
- Nurse record summary for [Ms D], received 10 September 2003. (p25)
- Medical records from [the District Health Board], received 4 August 2003. (p26-73)
- Request for information, to [Dr E], dated 10 November 2003. (p74)
- Response to request for information, from [Dr E], dated 3 December 2003. (p75-77)
- Request for information, to the practice nurse, dated 11 December 2003. (p77).
- Response to request for information, from the practice nurse, dated 18 December 2003. (p78).
- Further request for information, to the practice nurse, dated 21 January 2004. (p79).
- Response to request for information, from the practice nurse, dated 23 January 2004. (p80). Including:
  - A telephone audit dating from 8 October 2002 to 10 October 2002. (p81).

In addition to this I requested a copy of the patient's notes [to determine] if the practice nurse had documented the conversation as recommended by NZCPN, NZNO Standards of Practice (Pg 5,1.1.2).

The factual summary I supply is taken from the information supplied to me:

[Ms A], the patient, had seen her maternity carers on the 25th September, 30th September and 7th October prior to contacting the [the medical practice] and speaking with the practice nurse [Ms D]. Both carers were aware of her ongoing symptoms but had not done any further investigations other than routine assessments of blood pressure, urine check and foetal heart rate, which were within normal limits. There is documentation of oedema on the 7th October by the midwife. The patient decided on the 9th Oct to seek an opinion the following day.

The patient spoke to [Ms D], the practice nurse, at approx 11.00 am on the 10th Oct. [Ms D] informed her that the two obstetric GPs were unavailable and recommended she should see her midwife. When the patient declined and insisted to be seen by a GP [Ms D] inquired about her symptoms.

1. The factual account from the patient then differs as she states that [Ms D] suggested that she was sounding like a 'neurotic pregnant woman' and that there was nothing wrong with her and that [Ms D] 'begrudgingly' agreed to contact the locum to make an appointment. She also said in her statement that [Ms D] did not contact her again that day.

2. [Ms D], in her written account, states that the patient said 'I am probably sounding like a neurotic pregnant woman' and that [Ms D] had replied that it 'is possible' and offered to get her an appointment 'as soon as she can'.

[Ms D's] account then states that she rang the locum's rooms as soon as she hung up from speaking to the patient and spoke to the practice nurse, describing the symptoms. The practice nurse at the locum's office stated she would make an appointment and confirmed to [Ms D] she would call the patient to inform her of the time. [Ms D] then states she called the patient back to inform her of this and the patient did not at any time suggest this appointment was unsatisfactory.

My opinion on these two accounts:

1. It is very unlikely that a professional practice nurse of [Ms D's] experience [would] suggest to any patient that they were 'neurotic'. It is more likely that the patient had suggested it and that [Ms D] made the comment she did.

2. It is standard practice to re-contact the patient and inform her that her request had been actioned and what the patient should expect from this action as [Ms D] stated she had done so I am more inclined to accept [Ms D's] reported scenario on this account.

3. The patient then states that [Ms D] asked if she had a rash and suggested that the itch was a normal side-effect of the hormones in pregnancy and that 'there was nothing wrong' and suggested that if the midwife did not think there was anything wrong then there wasn't.

[Ms D's] account of this part of the conversation states that she suggested the itching may be hormonal and that the midwife was far more experienced with pregnancy related issues and that the patient should call her.

My opinion on this issue

3. [My opinion] – of the itching – is that in my experience it is a recognised symptom of pregnancy, particularly in twin pregnancies, and usually presents at around 30 weeks. It would not be a symptom that would cause any perception of urgency by a nurse. On questioning a midwife of considerable experience this is the opinion she gave too.

Expert Advice Required

On the evidence provided, did [Ms D] *provide services of an appropriate standard to* [Ms A] *on 10 October 2002? In particular, please comment on:*

– *whether* [Ms D] *responded appropriately to* [Ms A's] *request to see a doctor urgently;*

– *whether* [Ms D] *notified* [Ms A] *about the outcome of her enquiries in a timely manner;*

As seen in the factual account above, [Ms D] did contact the locum's office to gain an appointment for the patient as soon as she had completed the telephone call with the patient and did notify the patient that this had been done. The question of urgency is problematical as [Ms D] states the patient:
a) did not inform her that she was in urgent need of an appointment and
b) did not complain when she was informed of the action of [Ms D] in passing the information on to the locum's nurse.

In my opinion [Ms D] responded appropriately in calling the locum's rooms as she did given the information she had received from the patient, and in notifying [Ms A] when she did.

– *whether* [Ms D] *advised* [Ms A] *appropriately about:*

(a) consulting her midwife;

[Ms D], in her statement indicated she had suggested that the patient should see the midwife twice during the conversation. This is the normal procedure. Due to current funding legislation in most cases the patient has only the lead maternity carer (LMC) – the midwife – and whoever that midwife chooses for a locum back-up as her choice and in my experience practice nurses are expected by the LMC to refer the patient to them with any problems in the first instance. In this case the patient was more fortunate in having shared care and a choice of a locum. This appears to have clearly been explained to her by her lead carers and so it was appropriate that [Ms D] advise the patient to see her midwife.

(b the probable cause of her itching;
Itching in pregnancy occurs due to hormonal changes, particularly after 30 weeks and is a fairly common symptom. As [Ms D] was only informed of this symptom alone and not of the patient's concerns regarding cholestasis, it is reasonable that [Ms D] commented as she did as to the possible cause of her itching.

It is also reasonable that [Ms D], as a nurse, felt confident in the fact that the patient had seen both her midwife and her LMC recently with these symptoms and that they had not indicated there were any problems.

Triage may be limited if the triaging nurse does not have immediate access to patients' records in order to understand the progress of a condition and possible problems. I did not have any information as to whether [Ms D] did in fact have access to [Ms A] medical notes at the time of the telephone conversation.

whether the information left at [Dr E's] *surgery, by* [Ms D]*, was adequate in the circumstances;*

The documentation from the locum's office – [the other] Medical Centre – is deficient of enough information to allow me to give an informed opinion regarding the information they had received from [Ms D]. [Ms D] states that she had informed the nurse of the symptoms but not of the urgency as she was unaware of the patient's feeling of urgency.

The description of symptoms given by [Ms D] to [Dr E's] surgery appear to be as described to her by the patient.

whether [Ms D] *could reasonably have been expected to identify the symptoms of cholestasis.*

Nurses are neither trained nor expected to diagnose medical conditions although practising within their scope of practice they are expected to 'identify changes in client health status and intervene appropriately (NZCPN 2001)'.

Telephone triage has its limitations and as the patient is not visible to the nurse the assessment is reliant on what information the patient gives to the nurse or that the nurse is able to extract from the patient. The patient states that she did not inform [Ms D] of her concerns regarding possible cholestasis which in turn would make it very difficult for [Ms D] to make an informed assessment regarding the possible urgency.

So I do not believe it would be reasonable to expect [Ms D] to identify the symptoms of cholestasis.

Further Comments

[Ms D] did not appear to have asked the patient if she was happy with her assessment at any time nor confirm with the patient that what she had done was acceptable, rather she stated that the patient did not comment regarding her opinion of the arrangements made. To ensure that her nursing practice was appropriate and acceptable to the patient (NZCPN, NZNO 2001, PG 7) this should have been done. In my opinion this would be a minor failure on [Ms D's] part to meet Standards of Practice.

I would further comment that although, in my opinion, [Ms D] appears to have acted within the Code of Consumers Rights and within the Standards of Practice (NZCPN, NZNO 2001) it is impossible to judge as to the appropriateness of the tone of the discussion between the patient and [Ms D] which limits my ability to form an accurate opinion as to the appropriateness of [Ms D's] attitude and level of respect evident towards the patient.

Documentation is an essential part of a health provider's care and in this case does not appear to have been kept to an acceptable standard by the nurses involved. I have requested any notes that were added to [Ms A's] medical file by [Ms D] regarding the incident but have not received any at the time of writing this report. This does not affect the outcome of my opinion in the treatment given to the patient by the nurse, but is essential to an accurate picture of the case.

References:

New Zealand College of Practice Nurses, NZNO (2001). Standards of Practice for Practice Nurses. Wellington: NZNO."

Additional practice nurse advice
In a subsequent telephone conversation with my staff, Ms Minto was informed that [Ms A's] medical records, dated from 10 October to 12 October 2002, contain no reference to her conversation with [Ms D]. In response to an enquiry, Ms Minto indicated that this omission in documentation by [Ms D] would constitute a minor breach of the College of Practice Nurses' Standards of Practice.

Code of Health and Disability Services Consumers' Rights

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

RIGHT 4

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.*

Relevant Standards

New Zealand College of Practice Nurses, *Standards of Practice for Practice Nurses* (2001)

Standard One

Clinical

1.1.2 Practice Nurses accurately monitor, assess, and document clinical situations during telephone triage and face-to-face client contacts.

Standard Two

Outcomes

– *Nursing practice is appropriate and acceptable to identified client needs.*

Opinion: Ms B – No breach

HELLP syndrome
Right 4 of the Code affirms a patient's right to receive services of an appropriate standard. Ms A complained about the services provided to her by Ms B because she considered that Ms B failed, among other things, to diagnose HELLP syndrome.

According to Ms Cowan, my midwifery advisor, the only symptom typically associated with HELLP exhibited by Ms A on 7 October 2002 was vomiting. The lengthy duration of her vomiting additionally reduced the likelihood that HELLP could reasonably be considered a potential diagnosis. A diagnosis of HELLP syndrome was not confirmed by hospital records. Accordingly, I accept that it was reasonable for Ms B not to consider HELLP syndrome as a potential diagnosis on 7 October.

Cholestasis
Whether Ms B should have considered cholestasis depends on what Ms A told her on 7 October. There are a number of significant inconsistencies between the accounts of Ms A and Ms B of their consultation, particularly in relation to symptoms of itching and vomiting which, if severe, should have been of concern.

Ms A stated that on 7 October she was suffering from severe itching, primarily localised to her feet, and that her symptoms were communicated to Ms B. Ms A also claimed that signs of vigorous scratching were evident on her feet at her consultation with Ms B. According to Ms B, an examination revealed no abrasions of the type caused by scratching and she did not observe Ms A scratching during their consultation. Ms B also denied being informed of itching localised to Ms A's feet. Ms B's clinical notes of their consultation contain no reference to itching or abrasions. The medical records received from the public hospital, dated 10 October 2002, read: "Scratchy marks all over body". However, an earlier observation from the same day reads: "Itchiness abdomen, palms + feet gradually getting worse". On the evidence available, I am not able to determine the severity or localisation of Ms A's itching, nor the extent to which this information was communicated to Ms B.

A chronology that accompanied Ms A's letter of complaint alleged that she was vomiting bile, five to six times, at 12-hourly intervals when she consulted Ms B. According to Ms B, she was not told Ms A was vomiting bile. Ms B's clinical notes simply read "vomiting". The hospital records three days later note that Ms A was vomiting every second day, and that she was not dehydrated on admission. My midwifery advisor commented:

> "[O]n 10 October it was noted by the admitting doctor that [Ms A] was not dehydrated indicating that she must have been able to manage her fluid balance reasonably well over the previous few days since seeing [Ms B]."

The records also indicate that Ms A's condition gradually worsened, rather than fluctuated. In relation to the observations made of her condition, on admission to the public hospital, Ms A stated:

> "When not vomiting, I tried to drink water. I can offer no other explanation for [the] lack of dehydration and can assure you that my claims of vomiting are not overstated."

However, Ms A also stated that vomiting was generally only a problem in the morning, and that she had not vomited on the day of her admission. Given these statements, coupled with Ms A's successful management of her fluid balance and the fact that her condition gradually worsened, I find it difficult to accept that she vomited with quite the frequency suggested by her chronology. Accordingly, I am not satisfied that Ms B should have considered cholestasis as a potential diagnosis at her consultation with Ms A.

Midwifery examination and referral
At the 7 October assessment, Ms B recorded Ms A's blood pressure as 110/70 and noted the absence of protein in Ms A's urine; that the foetal hearts were heard; and foetal movements were satisfactory. Ms Cowan advised that testing a pregnant woman's urine for glucose is not standard practice for all practitioners, since it can be normal for excess glucose to be released in the urine.

On the evidence available, I consider that Ms B's investigation of Ms A's symptoms was adequate. Further, I consider that Ms B's decision not to refer Ms A for further investigation of her symptoms was reasonable. Accordingly, Ms B did not breach Right 4 of the Code in her midwifery care on 7 October 2002.

Opinion: Dr C – No breach

HELLP syndrome
In the view of my general practitioner advisor, Dr Ferguson, a diagnosis of HELLP syndrome was not proven. It is likely that Ms A suffered from an atypical presentation of pre-eclampsia prior to her delivery. Dr C monitored Ms A closely, particularly after she had reached 23 weeks' gestation. The result of such close monitoring, according to Dr Ferguson, was that the markers of pre-eclampsia had been adequately excluded by Dr C when he saw Ms A on 25 September 2002. Therefore, I consider that it was reasonable for Dr C not to have considered HELLP syndrome or pre-eclampsia as potential diagnoses on 25 September.

Cholestasis
Ms A states that during her consultation with Dr C, on 25 September 2002, she complained of vomiting and itching that was uncomfortable but not so severe as to be unbearable. Dr C's contemporaneous clinical notes record vomiting, and a "slight itch". Medical records received from the public hospital, dated 10 October 2002, indicate that Ms A's itching had gradually worsened in the preceding two weeks. I note Dr Ferguson's comments that itching and vomiting are not uncommon symptoms during pregnancy, and that the significance of these symptoms is determined by their severity. Cholestasis is known to

develop progressively, gradually escalating in severity. Ms A had suffered from intermittent nausea and vomiting throughout her pregnancy. Consequently, Dr C construed these symptoms as a continuation of her pre-existing condition. According to Dr Ferguson, this was reasonable in the circumstances. With regard to Ms A's itching, Dr Ferguson provided the following comments:

> "Unfortunately the symptom of itching is never, certainly in a New Zealand context, going to ring an alarm bell even in a conscientious practitioner in the same way that a slight rise in blood pressure, a small trace of protein in the urine, or unexplained headache would cause alarm and prompt further investigation in a woman in her first pregnancy with twins."

The typical incidence of intra-hepatic cholestasis of pregnancy in New Zealand is between 0.01% and 0.1%. I consider that diagnosing a condition of this rarity would take extraordinary vigilance on the part of any general practitioner. Given the incidence of cholestasis, Dr C's contemporaneous clinical notes, and the comments of my advisor, I consider that it was reasonable for Dr C not to have considered cholestasis of pregnancy as a diagnosis on 25 September.

In these circumstances, Dr C's decision not to refer Ms A for further assessment of her symptoms was also reasonable.

Cover arrangements

Dr C arranged for his colleague, Dr F, to attend his maternity patients between 30 September and 4 October, and for another GP, Dr E, to provide cover between 5 and 13 October. Dr G, obstetrician, agreed to provide specialist care if required. Unfortunately, when Ms A required assistance on 10 October, Dr F, Dr E, and Dr G were unavailable. Clearly these absences were unfortunate. However, as noted by Dr Ferguson:

> "I believe Dr C had done everything within his power to ensure that there was ongoing and appropriate care arrangements in place during his absence."

Dr Ferguson acknowledged the fortitude shown by Ms A in trying circumstances, and that her actions almost certainly prevented a serious outcome.

Obviously, Dr C's cover arrangements, although thorough, were not as "robust" as he claimed. However, I am satisfied that Dr C met the standard of care expected of a responsible GP practising obstetrics, and did not breach Right 4 of the Code.

Opinion: Ms D – No breach

Referral to GP
The exact content of the conversation that took place between Ms A and Ms D is uncertain. Accounts differ and I do not consider that further investigation into this matter will clarify the minutiae of the conversation. In particular, I have been unable to clarify the level of urgency conveyed by Ms A, or the tone of their discussion. However, the outcome was that Ms D promptly contacted the surgery of Dr E and requested an appointment for Ms A.

Ms D's conversation with the practice nurse at the other Medical Centre, was recorded in an audit entry written by the practice nurse. The entry reads:

> "10/02 [Ms D] – [Medical Practice] nurse (direct) 11:45 Referral to [Dr A] of pregnant Pt. from their clinic – we are covering for [Dr C]."

The practice nurse could not recall the specifics of her conversation with Ms D, but stated that she took a message for Ms D that was later relayed to Dr E. He also could not recall the details of this message, but claimed that there was no acute urgency conveyed in Ms D's request. Ms D recalled:

> "I gave her [the practice nurse] all of [Ms A's] details: address, phone number and the details of what was wrong; that she was 34 weeks pregnant with twins, itchy all over and vomiting."

In these circumstances I am satisfied that Ms D made an appropriate referral.

Advice to contact midwife
In response to the concerns raised by Ms A on 10 October, Ms D told her to consult her midwife. She did so because Ms A's lead maternity carer, Dr C, was absent, as was his locum Dr F. In these circumstances, Ms D followed normal procedure and provided appropriate advice to Ms A.

Ms D also provided advice to Ms A about her symptoms and explained that the cause of Ms A's itching might have been hormonal. In my opinion, this was a reasonable comment in these circumstances and, in my view, was not intended as a diagnosis.

Cholestasis
My practice nurse advisor commented that Ms D could not reasonably be expected to have identified the symptoms of cholestasis on 10 October 2002. Practice nurses are not expected to diagnose medical conditions, let alone rare ones.

In my opinion Ms D provided services of an appropriate standard to Ms A when she responded to the telephone call on 10 October, and she did not breach Right 4 of the Code.

Vicarious liability

Section 72 of the Health and Disability Commissioner Act 1994 states that employing authorities may be held vicariously liable for breaches of the Code. Since Dr C and Ms D did not breach the Code, no question of vicarious liability arises in relation to [the medical practice].

Other comments

Appropriateness and acceptability of nursing practice
My practice nurse advisor commented that Ms D did not appear to have enquired whether Ms A was content with the assessment she received. This should have been done to ensure that her nursing practice was appropriate and acceptable to her patient, as required by Standard Two of the New Zealand College of Practice Nurses' *Standards of Practice*.

Standards of Practice
Section 1.1.2 of the Standards of Practice requires practice nurses to document clinical situations during telephone triage. Given the symptoms Ms A described, Ms D should have made a record of the conversation.

Vigilant patient
Ms A suffered from a rare, yet very serious, condition with a prevalence of between 1/1,000 to 10,000 pregnancies. In response to her worsening symptoms, she sought medical attention. Her Lead Maternity Carer was absent. His locum was absent. She was referred to another GP, Dr E, who was also temporarily unavailable. She attempted to call obstetrician Dr G, but could not reach him. She tried to contact his locum but she was also unavailable. Ms A's perseverance in such trying circumstances averted a potential tragedy.

Follow-up actions

- A copy of my final report will be sent to the Medical Council, the Midwifery Council, and the Nursing Council.

- A copy of my final report, with details identifying the parties removed, will be sent to the Royal New Zealand College of General Practitioners, the New Zealand College of Practice Nurses, and the Maternity Services Consumer Council, and 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.