Health Practitioners Disciplinary Tribunal: Professional Misconduct – Not Established (Med08/107D)

Charge

The Director of Proceedings charged that Dr Enrique Jose Tomeu (the Doctor) was guilty of professional misconduct.

The particulars of the charge were:

1. The Doctor, as the consultant obstetrician on call, on being advised by the registrar that ventouse delivery had been unsuccessful, attempted a further ventouse delivery.

2. The Doctor failed to give the Patient adequate information upon which she could consent to a further attempt at ventouse delivery. In particular he did not tell her that:
   - Her labour was obstructed; and/or
   - A further attempt at ventouse was not appropriate; and/or
   - The appropriate option was to proceed to delivery by caesarean section.

3. In the course of attempting the delivery, the Doctor treated the Patient disrespectfully, raising his voice and telling her to shut her mouth and push.

4. Having delivered the baby’s head by ventouse delivery, the Doctor handed the delivery over to the Midwife.

5. When the Midwife discovered a nuchal cord and while she was preparing the clamp and scissors, before she could cut the cord the Doctor manually moved the cord over the baby’s head and/or used excessive force in doing so.

Finding

The Tribunal found the Doctor not guilty of professional misconduct.

Background

The Doctor was an obstetrician and gynaecologist at Southland DHB from August 2005 until September 2006.

The Patient was 29 years old and had had an uneventful pregnancy. Her estimated due date was 2 June 2006. On 7 June 2006 her Midwife visited her at home. The Patient was experiencing considerable hip pain. Induction was discussed because of the pain and so a referral was made for an assessment by an obstetrician at Southland Hospital.
The Patient was seen on 9 June 2006 and an induction of labour was scheduled to take place the next day.

On 10 June 2006 the Midwife induced labour at 0920 hours with 1mg of prostaglandin E2. A CTG was taken for an hour, and it was normal before and after the prostaglandin was inserted.

The Patient was told she could return home. She and her partner returned to Southland Hospital at about 1500 hours. A further dose of 2 mg of prostaglandin E2 was given at 1515 hours. A CTG recording at that time showed that the Patient was contracting 5-6 times each 10 minutes.

The Patient said she was in constant pain. At 17.30 hours the Patient was given pethidine and maxalon. The Tribunal found that the Patient’s pain continued unabated.

The Tribunal considered that there should not have been any provision of a second prostaglandin. The Tribunal accepted this was a precipitous labour as it was over stimulated by the administration of the second prostaglandin. The situation was exacerbated with the absence of pain relief.

The Tribunal found the Patient was obviously in significant pain and discomfort and she was encouraged to push without pain relief.

At 1825 hours, the senior house officer (SHO) was called. Upon arrival the SHO encouraged the Patient to bear down; she noted the baby’s head was coming down, but still remained at station plus two. She informed the Patient she would try and help her deliver the baby using a vacuum cup (ventouse). The baby was not delivered during the ventouse attempts by the SHO.

The SHO left the room to call the Doctor so he could assess the Patient for a caesarean section (CS). She said that she told the Patient, prior to the ventouse attempts, that if the baby did not deliver easily, then it might be necessary to resort to a CS. The Patient agreed.

The SHO explained to the Doctor on the telephone that the Patient had been fully dilated for one hour, that she had attempted delivery by ventouse but had failed to deliver the baby, and that she wanted him to assess the Patient. He told her immediately to prepare for a CS. The Doctor anticipated an obstructed labour.

After reading the notes at the nurses’ station, the Doctor entered the delivery room. He was then told by the SHO that the Midwife was not happy with the prospect of a CS.

While the Doctor was being telephoned, the Patient left the bed, and continued to push from a standing position. When the Doctor arrived and examined the Patient, the fetal head was distending the introitus, and moved down when he applied fundal pressure.

The Doctor then undertook a pelvic examination and found the head was at the level of the introitus, in the left occipito anterior position, and that the cervix was fully dilated. The head was already oedematous from previous attempts to deliver by ventouse prior to his arrival. Although he had originally considered that delivery by
CS would be necessary, he now considered in light of the examination that a further attempt at vacuum extraction should be undertaken.

The Patient was making noise with each contraction. The Doctor gave her an instruction which was the subject of differing recollections. The Patient’s recollection of the words used was “you’ve got to stop using your words and use your energy to push the baby out”. The Doctor denied that he told the Patient to “shut her mouth and push”.

There was also an issue as to the extent of discussion of options between the Doctor and the Patient at this point. The Doctor says he did discuss the alternatives of CS and a further attempt at a vacuum extraction. He said he could recall explaining that the baby’s head was already oedematous from the previous attempts to vacuum prior to his arrival, and there was a danger of injuring the baby by using instruments again; but there was also a risk of injuring either or both of them while performing a caesarean with the baby deep in the maternal pelvis. The Patient said there was no discussion as to the possibility of her having a CS, when he came into the room. Had she been made aware of that option she would have consented. She would not have placed her baby at risk, and would have taken the option of a CS had those things been explained.

The Doctor then applied the vacuum extractor, and pulled with one contraction, easily delivering the fetal head. Following delivery of the head, the Doctor invited the Midwife to complete the delivery.

The Midwife discovered the umbilical cord was positioned loosely around the back of the baby’s neck, and that it ran down either side of her body. In order to deliver the baby in that position, she said she needed to remove the cord from where it was. She said when she tried to move the cord she discovered she could not lift it over the baby’s head; and that she then put her hand out so the Doctor could pass her the required instruments.

The Doctor’s recollection was that there were no clamps or scissors immediately available. He moved in and put his hand on the baby’s head but as he touched it the Patient pushed, so that the baby was delivered and the cord avulsed.

Following the baby’s delivery, it became clear that the attachment of the umbilical cord to her abdomen had been torn, and that there was bleeding from the torn area. This was clamped and sutured in order that the bleeding could be controlled. The Patient suffered a large vaginal tear which the Doctor repaired in theatre under general anaesthetic.

The delivery of the baby was completed about 10 minutes after the Doctor’s arrival at the hospital. The baby was in fair condition with apgar scores of six at one minute, and seven at 5 minutes. She weighed 3480 grams.

Approximately 30 minutes after birth, the baby stopped breathing. She was intubated and ventilated. At about 2100 hours the possibility of a subgaleal hematoma was raised by paediatric staff. The baby’s condition subsequently deteriorated despite blood transfusion. She was transferred to Dunedin by helicopter at about 0500 hours on 11 June 2006. The baby died on 12 June 2006.
Reason for Finding

The Tribunal accepted that there were three possible modes of delivery which needed consideration, at the time the Doctor undertook his clinical assessment of the Patient. These were:

- An instrumental delivery, whether by vacuum extractor cup or the use of forceps.
- Caesarean section—a normal step after a failed attempt at a vaginal delivery.
- To allow the labour to continue naturally without further intervention, if need be on a wait and see basis.

The Tribunal found, given the highly charged atmosphere the Doctor found, and the need to effect a prompt delivery, it was appropriate for him to act as he did. The Tribunal does not consider that the Doctor’s clinical judgment, which he exercised appropriately, was affected by the difficulties in professional relationships which existed between himself and the Midwife. Accordingly, the first particular was not established.

In the joint note which was prepared by the Doctor and the Midwife after the delivery, it was stated that informed consent had been obtained. The obtaining of informed consent would have been difficult, given the administration of pethidine an hour and a quarter prior to the Doctor’s involvement. There was also significant maternal distress. The Patient was not in a good position to give consent.

Particular 2 was not established in any respect. The Tribunal was of the view that the labour was not obstructed. Consequently the first subparticular was not established. The Tribunal reached the conclusion that a further attempt at ventouse was appropriate and therefore the second subparticular was not established. The Tribunal did not accept that it was appropriate to proceed to delivery by caesarean section, and therefore the third subparticular was not established.

The Doctor stated that he could not recall telling the Patient to “shut her mouth”, and that he would not use terminology of that type in such a situation. He agreed with what the Patient had said in her evidence, that he had told her she had to stop using her words and instead use her energy to push the baby out.

The Tribunal concluded:

- The words used were as recalled by the Patient (“you’ve got to stop using your words and use your energy to push the baby out”), who was unshaken in her account of them.
- The words contained in the particular were not used, that the Doctor was not intending to be disrespectful to the Patient, and that particular 3 was not established.

It was established that the Doctor did “hand the delivery over” to the Midwife—although it was also noted that he remained close by, and was able to be involved in subsequent events. The Tribunal concluded that to “hand delivery over” to the Midwife was a common and acceptable practice.
The Midwife was examining for the cord, and found it was positioned loosely around the back of the baby’s neck, and that it ran down either side of her body. In order to deliver the baby in that position she needed to remove the cord from where it was. When she tried to remove the cord she discovered she could not lift it over the baby’s head. She put her hand out, so the Doctor could pass her the instruments required as she could not access them.

The Doctor thought the equipment that was needed was unavailable, so he stepped in, because the baby was in the course of delivery. The Tribunal did not consider his actions unreasonable. The delivery was progressing very rapidly, and action was required.

The first limb of particular 5 alleged that the Doctor manually moved the cord over the baby’s head. There was no evidence that this occurred.

The Tribunal accepted the Doctor’s evidence that at the moment he touched the cord, there was a sudden push with the cord then avulsing, this providing a plausible explanation for the “snapping” of the cord. There was a plausible natural explanation for what occurred, albeit an unusual occurrence. Therefore, the assertion raised by the second limb of particular 5, relating to the use of excessive force, was not established.

**Conclusion**

As none of the particulars were established, the charge was dismissed.

The full decisions relating to the case can be found on the Tribunal web site at [www.hpdt.org.nz](http://www.hpdt.org.nz)
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