MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

PO Box 24463, Manners Street, Wellington • New Zealand
13th Floor, Mid City Tower • 139-143 Willis Street, Wellington
Telephone (04) 802 4830 • Fax (04) 802 4831
E-mail mpdt@mpdt.org.nz
Website www.mpdt.org.nz

DECISION NO: 248/03/104D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against P medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chair)

Mrs J Courtney, Professor W Gillett, Dr A R G Humphrey,

Dr J M McKenzie (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Rotorua on Tuesday 2 and Wednesday 3 September 2003

APPEARANCES: Ms K P McDonald QC and Ms T Baker for the Director of Proceedings

Mr H Waalkens and Ms C Garvey for Dr P.

Introduction

1. Dr P is a xx. He practises in xx. On 11 April 2003 the Director of Proceedings[1] charged Dr P with a disciplinary offence. The details of the charge are explained in paragraph 4 of this decision. The charge alleges Dr P made a number of errors when managing the pregnancy of Mrs M.

2. The facts of this case are analysed in detail later in this decision. The events leading to the charge were extremely tragic and traumatic for Mrs M and her husband. Mrs M suffered a major rupture of her uterus during the final stages of labour. Dr P performed an emergency Caesarean section but unfortunately Mrs M's baby, L, was born in a very distressed state. Baby L passed away two days after he was born.

3. The Tribunal heard the charge in Rotorua on 2 and 3 September. The Tribunal has carefully considered the evidence and submissions made by counsel for both parties. The Tribunal has determined the charge cannot be upheld. In this decision the Tribunal explains why Dr P's conduct did not constitute a disciplinary offence.

[1] The Office of Director of Proceedings is created by s15 Health and Disability Commissioner Act 1994.

The Charge

4. The charge alleges Dr P's acts and omissions constituted professional misconduct.[2] On 26 August 2003 the Director of Proceedings applied to amend the charge by deleting an allegation Dr P had not obtained Mrs M's informed consent to a "trial of labour/scar". The application to amend was not opposed. The amended charge contained two particulars namely:

> 1. *On or about 13 November 1998, or at any time after that, [Dr P] failed to adequately inform [Mrs M] of the possible consequences for her baby were her uterus to rupture during trial of labour/scar;*
>
> *and/or*
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> 2. *On 8 June 1999, between 0800 hours and 0900 hours, or thereabouts, as on-call xx for the delivery suite at xx Hospital, [Dr P] failed to:*
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> *a. adequately assess Mrs M; or*
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> *b. ensure that Mrs M was adequately assessed by a medical practitioner.*

The Director of Proceedings submitted that each particular of the charge constituted professional misconduct or alternatively, that cumulatively the particulars constituted professional misconduct.

Summary of the Director of Proceedings Case

5. Mrs M's obstetric history was explained to the Tribunal. Mrs M's first pregnancy resulted in a miscarriage. A second child, P, was a transverse lie and had to be delivered by Caesarean section in March 1997. In November 1998, when Mrs M was 12 weeks pregnant she consulted her general practitioner about a "trial of labour" for her third pregnancy. Mrs M wanted to know if she would be able to deliver her baby vaginally in view of the fact she had previously had a Caesarean section which left a scar and potential point of weakness in her uterus. The general practitioner offered to refer Mrs M to an xx. Mrs M knew of Dr P through a family connection. She decided to make contact with Dr

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[2] Section 109(1)(b) Medical Practitioners Act 1995 (the Act).

P and organised an appointment to see him to ask questions she had about a "trial of labour".

6. Mrs M met Dr P on 13 November 1998. Dr P explained that because Mrs M had had a Caesarean section when P was born there was a risk that her uterus could rupture. Mrs M was certain Dr P did not tell her about the potential consequences of a ruptured uterus for her baby. This became a crucial issue during the case. Dr P was adamant that he did explain to Mrs M the risks for her baby if Mrs M suffered a ruptured uterus. After meeting with Dr P Mrs M decided to proceed with a "trial of labour".

7. Mrs M chose two lead maternity carers (LMCs). For her pregnancy, Mrs M chose to be managed by Dr A, a general practitioner in xx who practises obstetrics. Mrs M chose a midwife to be her LMC during the delivery of her baby which was expected to be born in late May 1999. The midwife who Mrs M chose to deliver her baby was Mrs B.

8. On 20 May 1999, when Mrs M was 38½ weeks pregnant she had an ante-natal consultation with Dr A. During that appointment Dr A told Mrs M that the baby had not descended into the pelvis. Apparently Dr A recommended a referral to an xx. Dr A wrote to Dr P about Mrs M on 20 May. When Dr P gave evidence he said Dr A's letter had not been referred to him. Mrs M endeavoured to contact Dr P but could not get an appointment to see him. Mrs M told the Tribunal that she was subsequently advised by Dr A that Dr A and Dr P had discussed Mrs M's case and that Dr P had agreed to a trial of labour. The Tribunal saw a reference in Dr A's notes to her having a telephone discussion with Dr P on 27 May 1999. When Dr P gave his evidence he explained that the circumstances under which this telephone conference took place meant that Dr P would not necessarily connect this patient with previous or subsequent consultations. Moreover Dr P said he believed Dr A may not have given the patient's name during the telephone discussion.

9. Mrs M started to experience contractions on 7 June 1999 at 23.30 hours. At 00.20 hours on 8 June 1999 Mr and Mrs M went to the delivery suite at xx Hospital where they were met by Mrs B and another hospital midwife. Mrs B assessed Mrs M. Soon after the hospital midwife arranged for Mrs M to be placed in a bath. Mrs M suffered increasing

pain. At 01.30 hours Mrs M agreed to an epidural which was not administered until 03.16 hours.

10. At approximately 02.30 hours the obstetrician on call in the hospital, Dr B made an entry in Mrs M's notes. Mrs M was certain Dr B did not physically examine her.

11. At 03.30 hours Mrs B ruptured Mrs M's membranes. At 05.45 hours Mrs B recorded in the notes that Mrs M's cervix was 5-6cm dilated and that the baby's head was at station –2cm. At 07.30 hours Mrs B advised Dr B of Mrs M's progress.

12. Dr P started duty at approximately 08.00 hours. He was certain he visited Mrs M at about 08.00 hours while she was asleep. Mrs M was equally certain Dr P did not see her. There is a record of Mrs B contacting Dr P at 08.10 hours. When Dr P gave his evidence he explained that he used this telephone conversation to request a vaginal examination by Mrs B.

13. Dr A visited Mrs M at about 08.30 hours. Whilst Dr A was visiting Mrs M Mrs B performed the vaginal examination which Dr P said he had requested and noted the cervix was 5-6cm dilated and that the baby's head was still at station –2. The notes also record a telephone conversation between Mrs B and Dr P at 08.30 hours during which Dr P approved the administration of syntocinon to augment the labour process. Syntocinon was commenced at 08.52 hours.

14. Mrs B reassessed the cervix at 10.30 hours when it was noted the cervix was still 5-6cm dilated. The augmentation continued and at 13.00 hours Mrs B noted Mrs M's cervix was fully dilated. The baby's head was however still at station –2. Mrs B increased the syntocinon and topped up the epidural. At about 14.30 hours Dr A returned. A vaginal examination performed at about that time showed the baby's head was still at station –2. Soon thereafter (between 14.35 and 14.45) Dr P was told of the lack of progress and asked to attend.

15. At 14.55 hours Mrs M suffered severe abdominal pain. The foetal heart monitor recorded sudden foetal bradycardia. Dr P was summoned urgently. He promptly arrived and

expedited the Caesarean section. Dr A assisted Dr P. Baby L was delivered at 15.18 hours and was found to have an Apgar score of 0 at 1, 5 and 10 minutes. The operation records showed Mrs M had suffered a significant rupture of her uterus displacing the baby into the abdominal cavity.

16. Baby L was flown to xx Hospital on 10 June. He was unable to survive without artificial support and died on 10 June. His parents were with him when he passed away.

17. The Director of Proceedings called Dr Peter Dukes as an expert witness. Dr Dukes is one of New Zealand's most experienced and respected obstetricians and gynaecologists. He became a Fellow of the Royal College of Obstetricians and Gynaecologists in 1971 and in 1982 he became a foundation member of the Royal New Zealand College of Obstetricians and Gynaecologists (now the Royal Australia and New Zealand College of Obstetricians and Gynaecologists).

18. Dr Dukes carefully evaluated the services provided by Dr P to Mrs M. Dr Dukes was particularly concerned about the way Dr P responded to Mrs M's care after he commenced duty at approximately 08.00 hours on 8 June 1999. Dr Dukes told the Tribunal:

> *"It is perhaps surprising that Dr P did not feel constrained to see or examine the patient at this stage [08.00 hrs] given that it was likely that this was the person most at risk in the labour ward at the time with a trial of scar who had been in established labour for at least 4½ - 5 hours and in whom it was known that progress was inadequate. It would seem that no consultation took place with the lead maternity carer, Mrs B, and Mrs M and that the decision with regard to implementing augmentation was made by a subsequent phone call after Dr P had left the delivery suite."*[3]

19. Dr Dukes was critical of the fact that only a telephone consultation occurred at 08.30 hours when Dr P authorised the use of syntocinon. Dr Dukes said:

> *"A telephone consultation with the midwife at this time was not adequate. No obstetric assessment had taken place. At 08.30, 5 hours had passed since 03.30 when membranes had been ruptured. Mrs M was failing to progress in*

[3] Paragraph 30, P. Dukes.

> *labour. In my view an obstetric assessment had to take place before commencing syntocinon."*[4]

20. In summary, the Director of Proceedings case was based upon:

20.1 Mrs M's recollection of the consultation with Dr P on 13 November 1998 in relation to the issue of whether or not Dr P adequately warned Mrs M about the potential risk to her baby if a trial of labour was undertaken; and

20.2 Dr Dukes' opinion that Dr P should have personally assessed Mrs M between 08.00 and 09.00 on 8 June 1999.

Summary of Dr P's Case

21. Dr P gave evidence to the Tribunal. He explained he graduated xx from xx in xx. Dr P acquired membership of the xx in xx and xx in xx. In xx Dr P became a xx. Dr P became a xx at xx Hospital in xx. He moved to xx with his family in 1992. Dr P continues to hold a xx in the xx. He teaches xx as well as candidates for xx. Dr P was elected xx inxx. At the time of the events in issue Dr P was the xx at xx.

22. Dr P advised the Tribunal that Mrs M's appointment with him on 13 November lasted 40 minutes during which time he discussed with her the risks of uterine rupture. Dr P was confident he discussed the risk of Mrs M suffering a ruptured uterus and that he:

> *"… informed Mrs M that the literature shows that this occurs in less than 1% of women (approximately 5:1000). [He was] certain that [he] advised her there are potentially serious maternal and foetal sequelae, and that the literature indicates that the incidence of these is extremely low. [He] tells patients the risk of foetal death is approximately 1:10,000."*[5]

23. Dr P told the Tribunal he had considerable faith and confidence in the abilities of Dr A, Dr B, and Mrs B. He had worked with these professionals for a considerable period of time during which he had developed a high regard for their judgment and levels of skill. Dr P also told the Tribunal that his administrative responsibilities on 8 June did not impact on the

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[4] Paragraph 66, D. P.

[5] Paragraph 15, D. P.

decisions he took in relation to Mrs M. He acknowledged he had a full day of meetings but believed he was readily available to attend to Mrs M if required.

24. In relation to the events which occurred on 8 June Dr P told the Tribunal in his evidence in chief that he took over as the on-call xx at xx Hospital at approximately 08.00 hours from Dr B. When he was cross examined Dr P suggested he may have started work that day as early as 07.40 hours. Dr P said he conducted a ward round and examined Mrs M's notes. Dr P told the Tribunal that he did not examine Mrs M physically because she was asleep at the time. Dr P observed from the notes Dr B had assessed Mrs M at 02.30 and had recorded the intention to undertake a trial of labour. Dr P asked that Mrs B telephone him after she conducted a vaginal examination with a view to considering whether or not labour should be augmented with oxytocin (syntocinon). Dr P recalled discussing Mrs M's case with Mrs B at approximately 08.30 hours when the decision was made to commence syntocinon. Dr P anticipated Mrs M would reach full dilation at about 12.00 hours and that close foetal monitoring would be carried out from the commencement of syntocinon. Dr P said:

> *"Mrs B did not raise any concerns about any aspect of Mrs M's progress or the size of her baby, its position, the foetal heart rate pattern, or the potential for delivery by caesarean section during the course of this discussion. Accordingly [he] did not consider it necessary … to examine Mrs M at that time."*[6]

25. Dr P said that he was not contacted during the morning by anyone who raised any concerns regarding the progress of Mrs M's labour or the condition of her baby. Dr P said he made enquiries about Mrs M's progress during the course of the morning (at about 10.30 hours) and in the early afternoon. Mrs B confirmed Dr P made an enquiry at about 10.30 but denied he made contact with her in the early afternoon. Dr P was next contacted just before Mrs M was rushed to the theatre when Dr P and Dr A delivered L by caesarean section and repaired Mrs M's ruptured uterus.

26. Dr P refuted Dr Dukes' view that Mrs M should have been physically examined by Dr P soon after Dr P went on duty on 8 June. Dr P said:

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[6] Paragraph 52, D. P.

> *"Mrs M's case had not been handed over to the secondary service, that is, to my care. She had been seen by an xx namely Mrs B at 07.30 hours. None of the team members had raised concerns regarding the risks faced by Mrs M, either to [him] or recorded the same in the notes. [He] made an assessment based on the information that [he] had received. It [was his] view that the absence of a physical examination by [him] of Mrs M was reasonable on the basis of the information that [he] had available."*[7]

27. Dr P called an expert witness, namely Dr Kenneth Clark, an obstetrician and gynaecologist who practises in Palmerston North. Dr Clark is a senior and very respected member of his profession. He is the Vice President of the Royal Australia and New Zealand College of Obstetricians and Gynaecologists and Chairman of the Board of Examiners of that body. Dr Clark obtained his basic medical qualifications in 1981 and became a Fellow of the Royal Australia and New Zealand College of Obstetricians and Gynaecologists in 1989.

28. The Tribunal was particularly assisted by Dr Clark's evidence concerning Dr P's responsibilities on 8 June. Dr Clark advised the Tribunal that under the lead maternity carer module in place in 1999 it is the LMC who has professional responsibility for the care of a patient unless:

28.1 There is a formal transfer of care to another LMC or to the specialist on duty; or

28.2 An emergency arises which requires the immediate services of a specialist.

Dr Clark observed that:

> *"In this case there was no … handover [of care] as there was no request for a full handover to secondary care. It was reasonable in the circumstances to have left the patient with the LMC having advised a management plan and remained available for further consultation."*[8]

29. Dr Clark also said:

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[7] Paragraph 66, D. P.
[8] Paragraph 12, K. Clark.

> *"…it is essential that the specialist uses and can rely on the information given by lead maternity carers and other members of the clinical team in order to make decisions and to give recommendations. It is not practicable for the specialists to spend their entire time in the delivery suite. Nor is it always necessary to personally visit the suite at set intervals, especially when there are competent carers who are in attendance. The lead maternity carers have the responsibility and ability to monitor patients, make decisions and ask for advice when required. Obviously if a doctor is concerned with information that is given it would be a matter of judgment whether or not they attended without a direct request. [Dr Clark did] …not understand that to be the situation here."*[9]

30. In summary, Dr P's response to the particulars of the charge was:

30.1 He did warn Mrs M about the risk of harm to her baby if she should suffer a rupture of her uterus;

30.2 It was not necessary for Dr P to examine, or arrange an obstetric examination of Mrs M between 08.00 and 09.00 hours on 8 June because:

- Mrs M was under the care of an LMC; and
- Dr P had not been asked to take over the care of Mrs M; and
- Dr P relied on the judgment of skilled and competent professionals; and
- Dr P was available to examine Mrs M if required.

Evaluation of the Evidence

31. In assessing the evidence the Tribunal has accepted the contemporaneous notes and records made by the medical personnel caring for Mrs M and her baby.

32. When assessing the accuracy of the evidence of witnesses of fact the Tribunal is mindful that the events under scrutiny occurred in November 1998 and June 1999. It is natural that with the passage of time memories fade and recollections can become distorted.

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[9] Paragraph 21, K. Clark.

33. In assessing the credibility of witnesses of fact, and in particular their contested evidence, the Tribunal has carefully focused upon their demeanour and the way in which they have responded to careful and thorough cross examination from experienced counsel, as well as their responses to the questions put by members of the Tribunal. As is often the case when issues of credibility become important the Tribunal has concluded that not all witnesses have accurately recalled events. In those instances where the Tribunal has rejected the evidence of a witness it has done so on the basis that the witnesses recollection is inaccurate and not because the witness concerned has deliberately tried to mislead the Tribunal.

34. The Tribunal's findings in relation to the crucial questions of fact are explained by the Tribunal later in this decision when analysing the particulars of the charge. It is however convenient to summarise in general terms the Tribunal's assessment of the evidence given by the witnesses of fact.

Mrs M

35. Mrs M impressed the Tribunal. She was clearly an intelligent, objective and conscientious witness. The Tribunal believes Mrs M may not have fully appreciated all that was said to her by Dr P when she met him on 13 November 1998. The reasons for the Tribunal reaching this conclusion are explained when analysing the first particular of the charge. The Tribunal fully understands how difficult it would be for Mrs M to recall all of the information conveyed by Dr P and accepts that it is entirely understandable why Mrs M may have forgotten some aspects of that consultation.

Mr M

36. Mr M also conveyed to the Tribunal that he is an honest person who tried to accurately recall the events of 8 June 1999.

Mrs B

37. Mrs B conveyed the impression that she was reluctant to give evidence against Dr P. Mrs B had also been charged with a disciplinary offence in relation to her role in the tragic events of 8 June 1999. Mrs B learned on the morning she gave her evidence to the Tribunal that the Nursing Council of New Zealand had found her not guilty of the charge brought against her by the Director of Proceedings. The answers which Mrs B gave to questions put by counsel and the Tribunal appeared to be honest and accurate.

Dr P

38. Dr P's recollection of a number of the details of events which occurred on 8 June 1999 was blurred. That is understandable given the passage of time which has elapsed since the events in question. During cross examination Dr P acknowledged that in respect of some questions of fact he was confused. Dr P's exact words to the Tribunal under cross examination were that in relation to his recall of some events he *"… didn't know which way [was] up"*[10]. In relation to other matters Dr P acknowledged inconsistencies between his recollection of events and written records.[11] However, in relation to the crucial factual issues raised in the particulars of the charge the Tribunal finds that Dr P's recollections appeared honest and generally reliable.

Expert Witnesses

39. The Tribunal was very grateful for the objective and insightful expert testimony provided by Dr Dukes and Dr Clark. Both experts gave well considered and reasoned evidence to the Tribunal.

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[10] Transcript, p111, line 7.
[11] Transcript, p90, line 6.

Standard of Proof

40. The requisite standard of proof in medical disciplinary cases was considered by Jeffries J in *Ongley v Medical Council of New Zealand*[12] where the High Court adopted the following passage from the judgement in *Re Evatt: ex parte New South Wales Bar Association*[13]*:*

> *"The onus of proof is upon the Association but is according to the civil onus. Hence proof in these proceedings of misconduct has only to be made upon a balance of probabilities: Reifek v McElroy*[14]*. Reference in the authorities to the clarity of the proof required where so serious a matter as the misconduct (as here alleged) of a member of the Bar is to be found, is an acknowledgement that the degree of satisfaction for which the civil standard of proof calls may vary according to the gravity of the fact to be proved."*

41. The same observations were made by a full bench of the High Court in *Gurusinghe v Medical Council of New Zealand*[15] where it was emphasised that the civil standard of proof must be tempered "having regard to the gravity of the allegations". This point was also made by Greig J in *M v Medical Council of New Zealand (No.2)*.[16]

> *The onus and standard of proof is upon the [respondent] but on the basis of a balance of probabilities, not the criminal standard, but measured by and reflecting the seriousness of the charge."*

42. In *Cullen v The Medical Council of New Zealand*[17] Blanchard J adopted the direction given by the legal assessor of the Medical Practitioners Disciplinary Committee on the standard required in medical disciplinary fora.

> *"The MPDC's legal assessor, Mr Gendall correctly described it in the directions which he gave the Committee:*
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> > *'[The] standard of proof is the balance of probabilities. As I have told you on many occasions, … where there is a serious charge of professional misconduct you have got to be sure. The degree of certainty or sureness*

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[12] (1984) 4 NZAR 369
[13] (1967) 1 NSWLR 609
[14] [1966] ALR 270
[15] [1989] 1 NZLR 139 163
[16] Unreported HC Wellington M 239/87 11 October 1990
[17] Unreported HC Auckland 68,95, 20 March 1996

> *in your mind is higher according to the seriousness of the charge, and I would venture to suggest it is not simply a case of finding a fact to be more probable than not, you have got to be sure in your own mind, satisfied that the evidence establishes the facts."*

43. The allegations levelled against Dr P are not as serious as some allegations which the Tribunal is required to consider. In this case the Tribunal has applied the civil standard of proof, without modification, when considering the particulars of the charge.

Professional Misconduct

44. In recent years, those attempting to define professional misconduct have invariably commenced their analysis by reference to the judgment of Jefferies J in *Ongley v Medical Council of New Zealand.*[18] In that case His Honour formulated the test as a question:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct?… The test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the position of the Tribunal which examined the conduct."*

45. In *Pillai v Messiter* [No.2][19] the New South Wales Court of Appeal signalled a slightly different approach to judging professional misconduct from the test articulated in *Ongley*. In that case the President of the New South Wales Court of Appeal considered the use of the word "misconduct" in the context of the phrase "misconduct in a professional respect". In his view, the test required more than mere negligence. At page 200 of the judgment Kirby P. stated:

> *"The statutory test is not met by mere professional incompetence or by deficiencies in the practice of the profession. Something more is required. It includes a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner."*

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[18] supra
[19] (1989) 16 NSWLR 197

46. In *B v The Medical Council*[20] Elias J said in relation to a charge of "conduct unbecoming" that:

> *"… it needs to be recognised conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards".*

Her honour then proceeded to state:

> *"That departure must be significant enough to attract a sanction for the purposes of protecting the public. Such protection is a basis upon which registration under the Act, with its privileges, is available. I accept the submission of Mr Waalkens that a finding of unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which is unfair to impose. The question is not whether the error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligation."*

Her Honour also stressed the role of the Tribunal and made the following invaluable observations:

> *"The inclusion of lay representatives in the disciplinary process and the right of appeal to this Court indicates the usual professional practice while significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the Court to determine, taking into account all the circumstances including not only usual practice, but patient interest and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards."*

47. In *Staite v Psychologists Board*[21] Young J traversed recent decisions on the meaning of professional misconduct and concluded that the test articulated by Kirby P in *Pillai* was the appropriate test for New Zealand.

48. In referring to the legal assessor's directions to the Psychologists Board in the *Staite* case, Young J said at page 31:

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[20] Unreported HC Auckland, HC11/96, 8 July 1996
[21] (1998) 18 FRNZ 18.

> *"I do not think it was appropriate to suggest to the Board that it was open, in this case, to treat conduct falling below the standard of care that would reasonably be expected of the practitioner in the circumstances – that is in relation to the preparation of Family Court reports as professional misconduct. In the first place I am inclined to the view that "professional negligence" for the purposes of section 2 of the Psychologists Act should be construed in the Pillai v Messiter sense. But in any event, I do not believe that "professional negligence" in the sense of simple carelessness can be invoked by a disciplinary [body] in [these] circumstances …".*

49. In *Tan v Accident rehabilitation Insurance Commission*[22] Gendall and Durie JJ considered the legal test for "professional misconduct" in a medical setting. That case related to a doctor's inappropriate claims for ACC payments. Their Honours referred to *Ongley* and *B v Medical Council of New Zealand.* Reference was also made in that judgment to *Pillai v Messiter* and the judgment of Young J in *Staite v Psychologists Registration Board.*

50. In relation to the charge against Dr Tan the Court stated at page 378:

> *"If it should happen that claims are made inadvertently or by mistake or in error then, provided that such inadvertence is not reckless or in serious disregard of a practitioner's wider obligations, they will not comprise "professional misconduct". If however, claims for services are made in respect of services which have not been rendered, it may be a reasonable conclusion that such actions fell seriously short of the standard required of a competent and reasonable practitioner. This may be especially the case if such claims are regularly made so as to disclose a pattern of behaviour".*

51. In the Tribunal's view, the test as to what constitutes professional misconduct has changed since Jefferies J. delivered his judgment in *Ongley*. In the Tribunal's view the following are the crucial considerations when determining whether or not conduct constitutes professional misconduct:

> The first portion of the test involves an objective evaluation of the evidence and answer to the following question:
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> *Has the doctor so behaved in a professional capacity that the established acts and/or omissions under scrutiny would be reasonably regarded by the doctor's*

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[22] (1999) NZAR 369

colleagues and representatives of the community as constituting professional misconduct?

If the established conduct falls below the standard expected of a doctor, is the departure significant enough to attract a disciplinary sanction for the purposes of protecting the public and/or maintaining professional standards, and/or punishing the doctor?

52. The words "representatives of the community" in the first limb of the test are essential because today those who sit in judgment on doctors comprise three members of the medical profession, a lay representative and a chairperson who must be a lawyer. The composition of the medical disciplinary body has altered since Jeffries J delivered his seminal decision in *Ongley*. The new statutory body must assess a doctor's conduct against the expectations of the profession and society. Sight must never be lost of the fact that in part, the Tribunal's role is one of setting standards and that in some cases the community's expectations may require the Tribunal to be critical of the usual standards of the profession.[23]

53. The second limb to the test recognises the observations in *Pillai v Messiter, B v Medical Council, Staite v Psychologists Board* and *Tan v ARIC* that not all acts or omissions which constitute a failure to adhere to the standards expected of a doctor will in themselves constitute professional misconduct.

54. In the recent High Court case of *McKenzie v MPDT*[24] Venning J endorsed the two question approach taken by this Tribunal when considering whether or not a doctor's acts/omissions constitute professional misconduct. The same judgment of the High Court cautioned against reliance in this country upon the recent judgment of the Privy Council in *Silver v General Medical Council*[25].

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[23] *B v Medical Practitioners Disciplinary Tribunal* (supra); *Lake v The Medical Council of New Zealand* (unreported High Court Auckland 123/96, 23 January 1998, Smellie J) In which it was said: "If a practitioner's colleagues consider his conduct was reasonable the charge is unlikely to be made out. But a Disciplinary Tribunal and this Court retain in the public interest the responsibility of setting and maintaining reasonable standards. What is reasonable as Elias J said in *B* goes beyond usual practice to take into account patient interests and community expectations".

[24] Unreported, High Court Auckland, CIV 2002-404-153-02, 12 June 2003

[25] [2003] UK, PC33

55. The Tribunal has examined the charge by addressing the questions posed in paragraph 51 of this decision in relation to each particular of the charge.

First Particularised Allegation:

On or about 13 November, or at any time after that, Dr P failed to adequately inform Mrs M of the possible consequences for her baby were her uterus to rupture during trial of labour/scar

56. The Tribunal is confident that when Dr P met Mrs M on 13 November 1998 he explained to her that there was a remote possibility her baby could be injured or even die if Mrs M's uterus were to rupture during a trial of labour.

57. The consultation on 13 November 1998 took approximately 40 minutes. Mrs M went to the appointment with a series of questions which Dr P answered.[26] After the meeting on 13 November Dr P wrote to Mrs M's general practitioner. In that letter Dr P said they "*… talked about trial of labour at length and in detail.*"

58. In his evidence Dr P said that he told Mrs M the risk of foetal death following uterine rupture was 1:10,000. In her evidence Mrs M also referred to Dr P talking about a 1:10,000 risk. However Mrs M thought Dr P was referring to the risk of uterine rupture, not the risk of death to her baby.

59. The Tribunal was told by Dr P that the figure 1:10,000 is the figure he always mentions and relies upon when explaining the risk of foetal death in the event of a uterine rupture during a trial of labour.[27]

60. Dr P advised the Tribunal that the risk of uterine rupture is reported in the literature to be .5-1% in pregnant women. This figure was confirmed by Dr Dukes.[28] Dr P does not and has never considered the risk of uterine rupture to be 1:10,000.

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[26] Transcript, page 111, line 7
[27] Paragraph 18, D. P.
[28] Paragraph 52, P. Dukes.

61. Both Mrs M and Dr P recall Dr P referring to a 1:10,000 risk. The Tribunal is satisfied that when Dr P referred to that statistic he was referring to the risk of foetal death following uterine rupture. This conclusion is consistent with the recognised risks in this field of obstetrics.

62. There is another factor which influences the Tribunal in concluding Dr P did warn Mrs M of the risk (albeit remote) of foetal death following uterine rupture. Dr P has had the misfortune to have experienced this type of tragic outcome on two previous occasions.[29] Those experiences would be indelibly imprinted on Dr P's mind. In light of his experiences Dr P is unlikely to ever overlook warning a woman of the tragic but remote outcome which occurred in this case.

63. For the reasons set out in paragraphs 57 – 62 of this decision the Tribunal is satisfied Dr P did warn Mrs M that there was a risk of foetal death if she suffered a ruptured uterus and that he warned her of this possibility during the course of the consultation which occurred on 13 November 1998. The first particular of the charge has not been established.

Second particularised allegation:

On 8 June, between 08.00 hours and 09.00 hours, or thereabouts, as on-call xx for the delivery suite at xx Hospital Dr P failed to adequately assess Mrs M or ensure she was adequately assessed by a medical practitioner

64. It is necessary to explain the LMC module in place in 1999 in order to appreciate why the Tribunal has not found this particular of the charge proven.

65. The delivery of obstetric services in New Zealand underwent a series of significant changes in 1993 when the Health and Disability Services Act 1993 was passed. That Act transformed the way in which public health services were funded and delivered in New Zealand. An integral part of the Health and Disability Services Act 1993 was s51 of that Act. That section provided that those who supplied public health services were to do so in accordance with notices issued by the Government agency responsible for the purchase of public health services. Comprehensive notices were issued by the Government agency

[29] Transcript, p137, line 6.

relating to every type of health service provided in New Zealand. The notices issued under s51 included detailed specifications for the delivery of obstetric services. The Health and Disability Services Act 1993 was repealed by the New Zealand Public Health and Disability Act 2000. The equivalent of what was s51 in the Health and Disability Services Act 1993 can now be found in s88 of the new Act.

66. The parties did not provide the Tribunal with a copy of the s51 notice relating to the delivery of obstetric services in place in 1999. The Tribunal understands however that the s51 notices endeavoured to specify the duties of a LMC and the circumstances under which responsibility for the care of a patient should be transferred from the LMC to a specialist. The Tribunal understands the s51 notice placed responsibility on the LMC to determine when a transfer of care was necessary. When Dr Clark gave his evidence he confirmed the Tribunal's general understanding of the s51 notice relating to the delivery of obstetric services. More importantly, Dr Clark advised that the Royal New Zealand College of Obstetricians and Gynaecologists responded to the changes in the way obstetric services were delivered in New Zealand as a result of the s51 notices by issuing guidelines for members of the College concerning their responsibilities when consulted about a patient under the care of a LMC (College Guidelines). It transpired Dr Clark was one of the authors of the College Guidelines. The Tribunal produced a copy of the College Guidelines as an exhibit (exhibit 22).

67. The College Guidelines recognised that the provision of obstetric services should involve a team approach utilising the skills of midwives, doctors trained in obstetrics, and specialist obstetricians and gynaecologists. The Guidelines also recognised that a specialist might be consulted in a variety of ways, from a telephone inquiry through to a complete hand over of care. The Guidelines warn that if there is a consultation it is important for all concerned to be aware of the responsibilities of each professional following a consultation.

68. In the case before the Tribunal Mrs B was the LMC from the time Mrs M arrived at xx Hospital until Dr P took over her care for the purposes of performing the caesarean section. Mrs B became the LMC at approximately 00.20 hours on 8 June and remained the LMC until approximately 14.45 hours that day. At no time prior to 14.45 hours did Mrs B seek to transfer Mrs M's care to the secondary (specialist) services.

69. When Dr P examined Mrs M's notes at approximately 08.00 hours on 8 June he did not take over Mrs M's care. Dr P was simply familiarising himself with cases in the maternity suite who might require specialist care and assistance. Similarly, when Dr P agreed to Mrs M receiving syntocinon in accordance with the hospital guidelines, he was not being asked by Mrs B to accept responsibility for Mrs M's care. Dr P agreed to Mrs M receiving syntocinon in the belief that he would be contacted if his services were required.

70. In these circumstances the Tribunal agrees with Dr Clark's opinion that Dr P did not have a professional responsibility to personally examine Mrs M, or arrange another doctor to examine her between 08.00 and 09.00 hours (or thereabouts).

71. The Tribunal believes that it may have been appropriate for Dr P to have insisted that he be allowed to assess Mrs M's progress after syntocinon had commenced. In the Tribunal's view Dr P should have arranged, as part of his 08.30 telephone consultation, a formal follow-up approximately two hours after the introduction of syntocinon. This would have allowed him to assess the effect of syntocinon and to ensure satisfactory progress was being achieved. Ideally this follow-up should have been by a personal assessment and examination. The Tribunal accepts the view that in a provincial setting it is appropriate and indeed ideal that an LMC midwife should work closely with the Obstetrician on call, and take some of the responsibility normally carried by a medical team in larger hospitals. The Tribunal is also of the view that the second particular of the charge cannot be stretched to encompass Dr P's failure to personally assess Mrs M approximately 2 hours after syntocinon had commenced. The Tribunal wishes to emphasise that in making these observations it is not suggesting that it would have necessarily found Dr P guilty of professional misconduct if the second particular of the charge had been framed in broader terms. The Tribunal also stresses that even if there had been an examination of Mrs M during the course of the morning of 8 June by Dr P then there can be no assurance that the ultimate outcome would have been any different.

72. For the reasons set out in paragraphs 65 – 71 of this decision the Tribunal finds Dr P did not have a duty to personally assess Mrs M (or arrange for a doctor to assess her) during the period 08.00 and 09.00 hours (or thereabouts) on 8 June 1999 and that accordingly,

the first limb of the test of professional misconduct has not been satisfied in relation to the second particular of the charge.

73. The Tribunal recognises the force in the Director of Proceedings submission that, notwithstanding Dr Clark's evidence about the scope of Dr P's duties and responsibilities on 8 June, the Tribunal should nevertheless hold Dr P had a duty to personally examine and assess Mrs M between 08.00 and 09.00 (or thereabouts). That submission was based on:

73.1 Dr Duke's criticism of Dr P for not personally assessing Mrs M between 08.00 and 09.00 (or thereabouts); and

7.32 The importance of the Tribunal's role in setting professional standards.

74. The Tribunal believes Dr Dukes' criticisms of Dr P may not have taken full account of the LMC module in place in 1999, and the team approach to obstetric services in xx. Even if the Tribunal had held that Dr P needed to personally assess Mrs M between 08.00 and 0.900 (or thereabouts), or arrange for an appropriate assessment by another doctor, the Tribunal would have found such a breach did not justify a disciplinary finding in the circumstances of this case. That conclusion, if it had needed to be reached, would have been based on the fact Dr P was justified in relying on the information he received from the experienced and skilled health care professionals who were managing Mrs M's labour.

75. The Tribunal is very mindful of the fact Mrs and Mr M are likely to feel frustrated by the Tribunal's decision. The Tribunal understands that Mrs M laid complaints with the Health and Disability Commissioner about the conduct of Mrs B, Dr P and Dr A. Ultimately none of the health professionals involved in the care of Mrs M and Baby L have been held accountable by the health disciplinary bodies. The Tribunal can understand if Mr and Mrs M are dissatisfied at this outcome. This Tribunal however can only make an assessment of the culpability of a doctor on the basis of the charge brought before the Tribunal. In this case Dr P is not guilty of the charge brought against him.

Name Suppression

76. Dr P currently has interim name suppression. That order will continue in force until the Tribunal has had an opportunity to consider any submissions which the parties may wish to make on this topic. If Dr P wishes to apply for a continuation of name suppression then his submissions should be filed and served by **Friday 3 October 2003** The Director of Proceedings should reply by **Friday 10 October 2003**.

Summary

77. The Tribunal finds the charge of professional misconduct brought by the Director of Proceedings against Dr P has not been established.

78. The Tribunal directs the Secretary of the Tribunal publish a summary of the Tribunal's findings in the New Zealand Medical Journal. That order is made pursuant to s138(2) of the Act.

DATED at Wellington this 24th day of September 2003

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D B Collins QC

Chair

Medical Practitioners Disciplinary Tribunal