Medical Practitioners Disciplinary Tribunal

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DECISION NO: 17/97/11C

NAME OF RESPONDENT

NOT FOR PUBLICATION

(Refer NOTE at conclusion of DECISION)

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by a Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against **H** medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Deputy Chairperson)

Associate Professor Dame Norma Restieaux, Dr A F N Sutherland,

Dr B J Trenwith, Mr G Searancke (Members)

Mr R Caudwell (Secretary)

Ms K G Davenport (Legal Assessor)

Mrs M Walker (Stenographer)

Hearing held at xx on Tuesday 21 October 1997

APPEARANCES: Mr K W Harborne for the Complaints Assessment Committee ("the CAC").

Mr H Waalkens for Dr H ("the respondent").

1. THE CHARGE:

'**THE** Complaints Assessment Committee pursuant to s93(1)(b) of the Medical Practitioners Act charges that Dr H, Medical Practitioner of xx, on or between 15 April 1996 and 27 April 1996 failed to take any or proper steps to diagnose the condition of and/or prescribe adequate care and treatment for the late Mr A, a patient who died at xx on 27 April 1996, being conduct unbecoming a medical practitioner which reflects adversely on the practitioner's fitness to practice medicine.

For the CAC it is said that the allegations in the charge include:

1. Failure to carry out a physical examination of the patient including a rectal examination;
2. Failure to arrange for a urine sample to be taken for analysis especially on 15 and 18 April 1996;
3. Ignoring or failing to recognise the seriousness of Mr A's illness;
4. Failing to place appropriate weight on the expressed concerns of family as to their perception of the seriousness of Mr A's illness;
5. Failing to refer for specialist opinion;
6. Failing to refer the patient for an assessment at or admission to xx Hospital;
7. Failing to provide effective pain relief;

8. Failing to initiate the administration of intravenous or subcutaneous fluids when the patient's condition had deteriorated to the extent that receipt of fluids orally was not effective;

9. Maintaining a diagnosis of urinary tract infection after the diagnosis had become unsustainable.

10. Keeping inadequate patient records.

For the CAC it is alleged that these factors amount to conduct unbecoming."

2. THE BACKGROUND:

2.1 **THE** events giving rise to this complaint concerned Mr A, a patient of Dr H's since 1989. Mr A died on 27 April 1996, following a period of illness, which commenced on 13 April 1996. Throughout the period of his last illness, Dr H was Mr A's general practitioner and was primarily responsible for Mr A's medical care and treatment.

2.2 **PRIOR** to his becoming ill, Mr A apparently kept good health. He was fit and active and, on the afternoon of the day he became unwell, he had played outdoor bowls. Mr A's widow, together with his daughter and son-in-law, gave evidence at the hearing of this complaint, and presented an impression to the Tribunal of a fit and quite healthy elderly gentleman, generally enjoying life and undertaking all of the usual chores and activities of retirement.

2.3 **MRS** A's evidence was that Mr A became ill quite suddenly the evening of 13 April 1996 and vomited. Mr A was unwell for the next few days and was disinterested in eating and drinking. As a result he ate and drank very little over the weekend and began to have rigors. By Monday

morning Mrs A was sufficiently concerned to contact Dr H and ask him to attend to Mr A at their home.

2.4 **DR** H diagnosed a "query" urinary tract infection and gave Mrs A a prescription for a three day course of antibiotics. Mr A took the antibiotics as prescribed but did not improve. He remained in bed apparently suffering rigors and becoming progressively weaker.

2.5 **MRS** A spoke to Dr H by telephone on 18 April 1996, and it seems that from what passed between them in the course of their discussion Dr H, quite wrongly as it turned out, gained the impression that Mr A's condition was improving. Dr H prescribed another further three day course of Noroxin.

2.6 **BY** 23 April 1996 Mr A's daughter, Mrs B, who was in telephone contact with Mrs A, was sufficiently concerned by what was relayed to her by Mrs A to travel to xx to help Mrs A care for her father.

2.7 **MR** and Mrs B had visited xx the previous Saturday and, even at that earlier stage, were concerned about Mr A's appearance and demeanour, and at the apparent severity of his symptoms. Both Mr and Mrs B described Mr A as looking terribly unwell and they were sufficiently concerned about his condition to maintain daily telephone contact with Mrs A after that visit.

2.8 **BY** 24 April 1996 Mrs B was becoming increasingly concerned about her father's condition. She tried contacting Dr H early in the morning but was unable to speak to him. She subsequently spoke to her husband and he contacted Dr H. Dr H again attended Mr A at his home.

2.9 **AT** this visit, Dr H examined Mr A and discovered that he now had oral thrush and gave him a prescription for that. Dr H told Mrs A and Mrs B that all Mr A needed was plenty of fluids, that the tests which he had earlier taken did not disclose anything definitive. He said that he expected Mr A to be up and about in two or three days.

2.10 **THE** following day both Mr and Mrs B and Mrs A were even more concerned about Mr A's condition. They again contacted Dr H and told him that the family believed the situation was now desperate and that it was imperative that Mr A be admitted to hospital. Dr H reiterated his opinion that all Mr A required was nursing care, fluids and food and he told the family that he would try to get Mr A into a private hospital.

2.11 **WHEN** Dr H called to see Mr A later that day, he witnessed Mr A's rigor and he told the family that he had been in contact with xx Hospital and that the registrar with whom he had spoken had refused to admit Mr A. Dr H once again advised the family that Mr A just needed fluids and nursing care and that he would admit Mr A to xx Medical Hospital. He reassured the family that Mr A would receive appropriate treatment at xx Medical Hospital, and that he was still of the belief that Mr A would be up and about in two or three days.

2.12 **MR** A was admitted to xx Hospital that day. He was not given any intravenous fluids but a record of fluids input and output seems to have been commenced and he was given Panadol.

That appears to have been the extent of Mr A's clinical treatment and both Mrs A and Mrs B were critical of the nursing care which was given to Mr A at xx Medical Hospital.

2.13 **ON** the evening of 26 April 1996, Mr A apparently fell from his bed. He was found lying on the floor and was attended to by Dr C who was visiting xx at that time. Dr C arranged for Mr A's immediate admission to xx Hospital.

2.14 **ON** admission to xx, Mr A was diagnosed with generalised peritonitis and septicaemia. An emergency laparotomy was undertaken to ascertain the origin of the infection, but the source of the infection was unable to be determined at surgery. Mr A succumbed to his illness the next morning, 27 April 1996.

2.15 **AT** post mortem, the opinion of the Pathologist was that Mr A died as a result of multi-organ failure due to septic shock secondary to ischaemic bowel.

3.0 **THE EXPERT EVIDENCE:**

3.1 **TWO** very experienced general practitioners, Drs Brabazon and O'Connell, were called to give evidence on behalf of the CAC. Both doctors were critical of the extreme brevity of Dr H's clinical records. Dr H's notes for the entire period of Mr A's illness, covered just eight lines. However, as a matter of fairness, it should be borne in mind that Dr H visited Mr A in his home and therefore would have been updating Mr A's clinical record upon his return to his surgery.

3.2 **BOTH** Dr Brabazon and Dr O'Connell were also critical of Dr H's maintaining a diagnosis of urinary tract infection over the entire period of Mr A's illness. It was Dr Brabazon's evidence that

urinary tract infection in an 81 year old male patient is uncommon in his experience, in the absence of prostatic disease or other causes of obstruction to the urinary tract. Dr H did not undertake any rectal examination of Mr A, which examination might have eliminated or confirmed the presence of prostatic disease or some other cause of obstruction, thereby confirming or enabling Dr H to discount the "query UTI" diagnosis.

3.3 DR W G G O'CONNELL:

3.3.1 **DR** O'Connell gave evidence of his experience as a geriatrician and developed the tenor of the evidence given by Mr A's family that Dr H did not appear to consider Mr A to be a desperately ill man. To the extent that he was critical of Dr H's care of Mr A, it was Dr O'Connell's evidence that Dr H should have excluded other diagnoses before concluding that Mr A was suffering from a urinary tract infection. It was Dr O'Connell's evidence that in view of the symptoms of fever, rigors frequency and vomiting for two days by the time Dr H first saw Mr A, it would have been useful for him to have arranged for a urine specimen to be examined that day prior to commencing treatment with Noroxin.

3.3.2 **DR** O'Connell's rationale was that if there had been no improvement with the Noroxin medication a laboratory report would have been available promptly to either confirm or exclude the presence of infection. If infection was present identification of the organism and its sensitivity to medication would have been useful for further management if this was indicated. If not present, other causes would immediately be sought. It was Dr O'Connell's view that the rigor suffered by Mr A might have suggested the presence of

a more serious infection than average and, if they continued, would have been a signal to him to move cautiously.

3.3.3 **IN** his evidence Dr O'Connell also referred to the note made by Dr D, who was the Duty Doctor at xx Accident and Medical Clinic, following his home visit to Mr A on Sunday, 21 April 1996. In Dr H's absence, Dr D was called to visit Mr A by Mrs A, because she was concerned at what she considered to be Mr A's deteriorating condition.

3.3.4 **NOTWITHSTANDING** the level of concern no doubt expressed by Mrs A, Dr O'Connell conceded that, from what can be ascertained from Dr D's note, Mr A did not appear to Dr D at that time to be a man who was desperately ill. He recorded that Mr A was *"able to walk some slight loss of balance ... Abdo soft, dehydration ... ® ? Underlying Bowel problem ... Further investigation ... Follow up Dr H"*.

3.3.5 **WHEN** Dr H saw Mr A the following day he had the benefit of a laboratory report, which he had previously ordered, reporting obstructive jaundice and hypocalemia (low potassium), hypoalbuminaemia, anaemia and thrombocytopenia (low platelets), an elevated white blood count and ESR evident, indicating infection. In evidence, Dr H said *"on examination, apart from a slight tenderness of the liver and a hint of jaundice, there were no other abnormalities. I therefore arranged an abdominal ultrasound and repeat blood count and liver function tests after two days."*

3.3.6 **DR** O'Connell however gave evidence that he considered that Mr A's condition by 22 April 1996 *"had become more alarming"*. In view of Mr A's age and his clinical condition, together with there not being any definitive diagnosis or act of treatment in place, it was Dr O'Connell's view that specialist advice should have been sought at this stage. Additionally of course, there was the increasing family concern being expressed to Dr H at this time and the family's repeated requests that Mr A be admitted to hospital.

3.3.7 **MR** A however remained at home in the care of his family. By this stage no cause for the "hint of jaundice" had been identified, Mr A was not receiving any active treatment, a urinary tract infection had been excluded, the family's concern was growing and their perspective of Mr A's level of pain was being firmly expressed to Dr H. Dr O'Connell was most critical of Dr H for not seeking specialist assistance by this point at the latest, and his assessment that Dr H did not seem to appreciate just how sick Mr A was appeared to the Tribunal to be correct.

3.3.8 **DR** O'Connell, perhaps most tellingly, gave evidence that the elderly often do not show that they are as ill as they in fact are. For Dr O'Connell, this fact requires a doctor to be doubly alert when caring for elderly patients. Additionally, Dr O'Connell stated that *"it is usually dangerous to disregard repeated pleas by the family for further action to be taken in the case of an illness that is not abating or where a diagnosis has not been made."* The Tribunal considers that to be a prescription for general practitioners caring for elderly patients, and a factor that Dr H ought perhaps to have

borne in mind. The difference between the description of Mr A's condition described by his family, and Dr H's description of Mr A as *"not an unwell man"* is startling.

3.3.9 **FINALLY**, Dr O'Connell commented on Dr H's records, and particularly on their brevity. It must be borne in mind that Dr H saw Mr A at Mr A's home and would have written up his notes on his return to his surgery. In those circumstances, it is perhaps not surprising that Dr H recorded only the barest of details, but in this present case where no definitive diagnosis emerged, Dr O'Connell's comment that he would have expected a fuller notation particularly of clinical findings is, in the Tribunal's view, justified.

3.4 DR A B BRABAZON:

3.4.1 **DR** Brabazon also gave evidence for the CAC. Dr Brabazon is a retired general practitioner, and also an experienced geriatrician. Dr Brabazon gave evidence that he also was struck by the extreme brevity of Dr H's notes. Particularly, there was nothing in Dr H's note to indicate how he arrived at his initial diagnosis of *"query UTI"* and, whilst the results of laboratory tests and the ultrasound report obtained by Dr H are recorded in the notes, Dr H provided no comments on the significance of these tests, or how they may have affected or altered his initial clinical assessment.

3.4.2 **DR** Brabazon was also critical of Dr H's failure to record such basic findings as temperature, pulse and blood pressure. It was Dr Brabazon's opinion that Dr H's notes failed to record basic elements such as symptoms, examination findings, provisional diagnoses, treatment, or investigations.

3.4.3 **IT** was also Dr Brabazon's evidence that a urinary tract infection in an 81 year old male is uncommon in his experience in the absence of prostatic disease or other causes of obstruction to the urinary tract. Dr H at no time performed a rectal examination which might have indicated, or discounted, an underlying cause for any urinary tract infection.

3.4.4 **DR** Brabazon was most critical of Dr H's failure to manage Mr A's ongoing treatment and care. In his view, Dr H either ignored or did not recognise that Mr A was ill but undiagnosed and Dr H's decision to admit a febrile, dehydrated, jaundiced but undiagnosed patient to a private hospital in this condition merely to push fluids and administer oral potassium seemed illogical. If facilities for the administration of intravenous fluids were present at xx Hospital these were not ordered.

3.4.5 **DR** Brabazon considered that a provisional diagnosis of urinary tract infection became untenable on the basis of a urine report which Dr H would have seen on 23 April, and Dr H should have 'grasped the metal' and taken more active steps to ascertain the cause of Mr A's illness rather than simply admitting him to xx Hospital. On admission, on 25 April, two days after Dr H knew that no urinary tract infection was present, this was the diagnosis recorded on the admission records. By this stage Mr A was also suffering oral thrush which said Dr Brabazon, was a further pointer to the fact that Mr A was now a sick old man. Dr Brabazon concluded that he found it a matter of concern that Dr H, even with the wisdom of hindsight, maintained his view that his management of Mr A's case was appropriate.

3.5 DR E:

3.5.1 **DR** E a general practitioner of xx gave evidence for Dr H. Dr E admitted in cross-examination that he was a long time friend, and former student, of Dr H's. Whilst Dr E's evidence was careful and thorough, the Tribunal was left with the impression that it was more the evidence of a loyal friend and colleague rather than that of an independent expert. Not unsurprisingly, he rejected the evidence given by Drs Brabazon and O'Connell.

4.0 SUBMISSIONS - FOR THE CAC:

4.1 **FOR** the CAC, Mr Harborne relied upon the experience and knowledge of Drs Brabazon and O'Connell. Mr Harborne referred to the specific criticisms made of Dr H's management of Mr A's care and treatment and submitted that, overall, Dr H did not do enough to ascertain just what was wrong with Mr A, and to ensure that he received adequate and appropriate treatment. By 22 April 1996 Dr H's initial diagnosis of a urinary tract infection could not be sustained. The laboratory picture indicated an infection, but the source of that infection was not identified.

4.2 **MR** A's condition, particularly the deterioration of his condition which was obvious to his family but not apparently to Dr H, was alarming and, in the absence of a firm diagnosis, specialist intervention was indicated. Mr Harborne referred to Dr O'Connell's evidence that 24 April 1996 was the latest date by which Dr H ought to have sought assistance. However, Dr H appeared not to have recognised the seriousness of Mr A's illness. He was not listening to the family's concerns. Mr A's wife and family understood from Dr H that he had discussed Mr A's case with a Registrar at xx Hospital but, he said, xx Hospital refused to admit Mr A. Mrs A in particular recalls specifically being told by Dr H that he was watching Mr A's condition carefully and that

he was working closely with the Hospital Registrar. Mr A's family were vocal in relaying their concerns to Dr H as they witnessed Mr A's deteriorating condition and in particular his pain and the multiplicity of rigors.

4.3 **IN** the face of all of this, Dr H maintained his opinion that Mr A was not seriously ill. Dr H's decision to admit Mr A to xx Hospital, rather than to insist upon his being admitted to xx, reflected his determination that Mr A was not seriously ill but required fluids, and to have his fluid intake and output monitored, and general nursing care. Dr H consistently told the family that Mr A was likely to be up and around in two to three days and he seems to have continued to believe that it was possible but Mr A was not sufficiently motivated to this end. It was Mr Harborne's submission that the Tribunal should look at the overall picture and, on this occasion, this practitioner's conduct fell short of acceptable standards.

5.0 SUBMISSIONS ON BEHALF OF DR H:

5.1 **FOR** Dr H, Mr Waalkens submitted that the Tribunal might be critical of the way Dr H had managed Mr A's case but that the CAC had not met the required threshold to find Dr H guilty of any disciplinary offence. Mr A's condition was complex and to require Dr H to have performed satisfactorily in terms of all of the issues raised by the CAC was the counsel of perfection.

5.2 **FOR** Dr H, Mr Waalkens relied heavily upon the pathologist's report from the autopsy performed at the direction of the Coroner. He did not however call the pathologist to give evidence to the Tribunal although in the course of the hearing he endeavoured to telephone her to request her appearance. The pathologist's report did not support the case advanced by the

CAC that Mr A was seriously unwell over a period of time. Instead, said Mr Waalkens, the pathologist's catastrophic event scenario was equally possible. Dr H is a caring and competent doctor. Mr Waalkens emphasised two aspects of the CAC's case:

5.2.1 **THAT** Dr H had not carried out a rectal examination on the first occasion he saw Mr A, prior to making his initial diagnosis that Mr A was suffering from a urinary tract infection.

On this point, Mr Waalkens submitted that it was Dr H's assessment that a rectal examination was not clinically indicated and that was a reasonable assessment for him to make in the circumstances. It might have been appropriate for Dr H to have excluded prostate involvement before making that initial diagnosis, but, as subsequent events proved, prostatic involvement was not a factor and the fact that Dr H had not carried out a rectal examination had no bearing on the ultimate outcome.

5.2.2 **DR** H did not take a urine sample prior to diagnosing urinary tract infection.

Dr H had however performed an immediate Uriscreen Test which was clearly positive for bacteria. Dr H was accustomed to using this method of testing and, in his experience, this was an accurate test with a high sensitivity and specificity, the results of which correlate very well with laboratory testing.

5.3 **MR** Waalkens also referred to the evidence given by Dr O'Connell, largely on cross-examination, as to whether a clinician ought to rely on clinical signs, or biochemical results. It was

Dr O'Connell's evidence that if the patient's condition is poor, and the patient is obviously ill, then the clinical signs and symptoms will be more influential. If the biochemical results are very abnormal, but the patient is not obviously sick, then the biochemical results would be more influential in determining appropriate care and treatment. However, in Mr A's case, neither of those scenarios applied. It was Dr H's evidence that Mr A's condition was not deteriorating, that his condition did not appear to him to be as bad as the family were alleging, and that he was not clinically seriously ill.

5.4 **NEITHER** did the biochemical results obtained from testing ordered by Dr H ring any alarm bells for Dr H. The biochemical results are more significant with the benefit of hindsight only. In the circumstances which existed at the time, Dr H had made a judgement call, in good faith, and Dr H's clinical decisions were reasonably made. The pathologist's report bore out the correctness of Dr H's assessments.

6.0 **THE FINDINGS:**

6.1 **DR** H faces a single charge, particularised in ten respects. The central issues for the Tribunal are to determine just how ill Mr A was between 15 April and 26 April 1996; what should have been done by Dr H to identify the nature and extent of Mr A's illness; was what was done adequate?

6.2 **CLEARLY** on the basis of the laboratory reports, Dr H's diagnosis of urinary tract infection was not sustainable by the time Mr A was admitted to xx Hospital on 25 April 1996. Further, it does not appear from the evidence that Mr A was admitted to hospital for clinical reasons. Dr H appears to have made the decision to admit Mr A because his family were insisting to him that Mr A be admitted to a hospital, he was not receiving adequate fluids, he needed to be

encouraged to drink and he needed nursing care to assist him to get back on his feet and, in Dr H's assessment, to get him motivated to get well.

6.3 **THE** evidence from Dr H was that Mr A was not a seriously unwell man. Certainly, that appears to be borne out by Dr D's record of his examination of Mr A on 21 April 1996. Dr D recommends further investigation, but no sense of any alarm on the part of Dr D can be discerned from his notes.

6.4 **SIMILARLY**, on 24 April 1996, the day before Mr A was admitted to xx Hospital, he was taken by his family to xx Radiology Group for an ultrasound examination, ordered by Dr H. Again no alarm is evident either on the part of the radiologist, or in the radiologist's report, such that the Tribunal could infer that any other persons outside of his immediate family who saw Mr A were alarmed or otherwise had significant concerns about Mr A's condition.

6.5 **AS** noted earlier in this Decision, although he relied heavily on the pathologist's report, Mr Waalkens did not present the pathologist to give evidence. Nor was any expert evidence called to support the hypothesis advanced by the pathologist that *"the most likely sequence of events is a vascular cause of ischaemic small bowel with bacterial invasion of bowel wall, peritonitis, anaerobic septicaemia and septic shock culminating in multi-organ failure. The initial cause of ischaemic small bowel is most likely to be embolus from aortic and/or mitral valve vegetations."*

6.6 **THE** pathologist reported an infarcted bowel. Examination of the mitral and aortic valves revealed fragments of fribinous inflammation vegetations. Particularly in the absence of any

opportunity to make further inquiries of the pathologist, that report must be accepted by the Tribunal on its face. The pathologist's findings that Mr A's death resulted from multi-organ failure due to septic shock secondary to ischaemic bowel was accepted by the Coroner and, on that basis, must be relied upon by this Tribunal.

6.7 **ACCEPTING** the accuracy of that report, it is likely that Mr A's condition deteriorated rapidly on 25 or 26 April 1996 and, once the infarction occurred, Mr A would have been unlikely to survive. The presence of inflammatory cells reported by the pathologist in the mitral and aortic valves indicates an endocarditis. This is a likely cause of the bacteraemia and may explain the rigors suffered by Mr A.

6.8 **THE** clinical evidence indicates that Mr A did present with a urinary tract infection and Dr H was correct to prescribe antibiotics. Further, Dr H did order further tests such as blood cultures and blood counts, all of which were clinically indicated. The taking of blood cultures also is not commonly ordered by general practitioners and Dr H's requiring these was prudent.

6.9 **AT** least until 23 April 1996 Mr A seems to have been functioning reasonably well. At that stage, Dr H was still seeking a firm diagnosis but the test results which he was receiving were inconclusive.

6.10 **THE** affidavit of Dr F an xx pathologist, was presented to the Tribunal in support of Dr H. Dr F deposed to Dr H's assertion that he spoke to Dr F on 26 April 1996 regarding the results of blood cultures taken from Mr A on 24 April 1996. It was Dr H's evidence that Dr F recommended oral Augmentin be started until further information was available.

6.11 **DR** F was unable to recall any such conversation with Dr H, however he was able to say that the advice which Dr H attributed to him would have been what he would have advised had he been asked. Dr F deposed that the normal white blood cell count combined with the finding of two different looking bacteria in only two of the four blood culture bottles, would not have been enough to recommend Mr A's admission to hospital. Had he been consulted by Dr H in respect of these blood culture results, Dr F says that he *"could very well"* have advised that Mr A be given oral Augmentin while awaiting further results from the blood cultures and any new developments in his clinical condition. The final blood culture results were not available until 29 April which was after Mr A's death.

6.12 **THERE** was no indication, in Dr F's opinion, from the blood culture results of any ongoing disease such that a general practitioner could have been put on guard about this. Mr A's death was much more likely to have been the result of an acute degeneration or sudden/unsuspected turn of events, which Dr F considered it unfair to have expected Dr H to have anticipated.

6.13 **DR** F also deposed to Dr H's habit of telephoning him from time to time to make inquiries such as of the type he said he made in relation to Mr A. Such contact, said Dr F, is unusual and it shows a prudent and caring approach on the part of Dr H towards the welfare of his patients.

6.14 **THUS**, it is not the case that the blood test results showed any significant deterioration of Mr A's condition. Similarly, the ultrasound examination ordered by Dr H was unhelpful in that it may have lulled him into a false sense of security reporting as it did no signs of cholecystitis or biliary obstruction, no sign of liver tumour, normal IVC and aorta apart from atheroma and no abnormality in the kidneys or pancreas and no lymphadenopathy was detected. Clinical and

biochemical follow-ups were said to be required and CT was suggested if there was any further deterioration.

7.0 BURDEN OF PROOF:

7.1 **THE** burden of proof lies upon the CAC. In order to prove the charge made against Dr H it is necessary for the CAC to prove if not all, then at least a majority of the several particulars alleged to support the charge. Although proof of even a single particular would suffice to establish a charge if sufficiently serious to warrant the sanction of a disciplinary penalty.

7.2 **THE** standard of proof is the balance of probabilities. Dr H was charged with conduct unbecoming. By virtue of Section 109(c) of the Medical Practitioners Act 1995, the Tribunal must also be satisfied that Dr H is guilty of conduct unbecoming, **and** that conduct reflects adversely on Dr H's fitness to practise medicine.

7.3 **IN** this regard, Mr Waalkens submitted that, by the addition of this rider, Parliament clearly intended to raise the threshold of offending or error in respect of "conduct unbecoming" to be met before a practitioner is found guilty of such conduct. The statement as to what constitutes conduct unbecoming made by Justice Elias in *B v The Medical Council*, HC11/96 (at page 15) is now generally accepted as an accurate and pragmatic definition:

> *"There is little authority on what comprises "conduct unbecoming." The classification requires assessment of degree. But it needs to be recognised that conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards. That departure must be significant enough to attract sanction for the purposes of protecting the public. Such protection is the basis upon which registration under the Act, with its privileges, is available. I accept the submission of Mr Waalkens that a finding*

of conduct unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which it is unfair to impose. The question is not whether error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations. The threshold is inevitably one of degree. Negligence may or may not (according to degree) be sufficient to constitute professional conduct or conduct unbecoming: Doughty v General Dental Council [1988] 1 AC 164, Pillai v Messiter (No. 2)(1989) 16 NSWLR 197; Ongley v Medical Council of New Zealand (1984) 4 NZAR 369. The structure of the disciplinary processes set up by the Act, which rely in large part upon judgment by a practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standards applied by competent, ethical, and responsible practitioners. But the inclusion of lay representatives in the disciplinary process and the right of appeal to this court indicates that 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 also patient interests and community expectations, including the exception that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards."

7.4 **WHILST** the additional words attached to "conduct unbecoming" in Section 109(c) effectively add a 'rider' to the offence, for all practical purposes the indicia of "conduct unbecoming" appears to this Tribunal to be unchanged in the 1995 Act. What is required is conduct which departs from acceptable professional standards and that departure is significant enough to warrant sanction in the interests of the public generally. The practitioner's conduct is to be adjudged without employing the wisdom of hindsight, and mere error or omission will not suffice. As Her Honour Justice Elias stated, *"the threshold is inevitably one of degree"*. In certain circumstances even negligent acts or conduct may not cross the threshold into "conduct unbecoming".

7.5 **IN** this present case, Dr H was faced with a complex, even puzzling, clinical case. Dr H had been Mr A's general practitioner since approximately 1989. There was some evidence that, in 1995, Mr A had a period of illness during which he took to his bed and, for a time, was listless. That seems to have been a factor which influenced Dr H when Mr A again became ill and did not recover as anticipated, and the tests ordered, and the clinical picture generally, were inconclusive. Whilst Mr A was generally active and enjoyed good health, the possibility that he had simply "given up on life" was one hypothesis which Dr H considered.

7.6 **THE** descriptions of Mr A's clinical condition given by Dr H, and those members of Mr A's family who gave evidence to the Tribunal, differ markedly. The Tribunal is satisfied that all of the witnesses truthfully and sincerely gave accounts of the facts and circumstances of Mr A's last two weeks of his life as they witnessed it.

7.7 **RIGHTLY** or wrongly, the Tribunal is satisfied that, following his discussion with Mrs A on 18 April 1996, Dr H got the impression that Mr A was improving. On each occasion he was asked to, Dr H attended to Mr A in his home and neither Dr D, who saw Mr A on 21 April 1996, nor the xx Radiology staff who saw Mr A on 24 April 1996, two days before he died, expressed any alarm at his condition. Nor is it possible to discern any reluctance on the part of the xx Hospital staff to admit and care for Mr A at xx Hospital where he would receive general nursing care, rather than to a general hospital where he would have received acute care and treatment.

7.8 **THE** Tribunal also accepts the evidence of Drs O'Connell and Brabazon for the CAC. However, whilst the Tribunal is of the view that there were shortcomings on the part of Dr H in relation to the brevity of his clinical recordings, his communication with Mr A's family, and his

measured, almost casual, pursuit of a diagnosis after his initial "query UTI" diagnosis became untenable, the Tribunal is not satisfied that those shortcomings, either collectively or individually, constitute such a departure from acceptable professional standards as to warrant the sanction of a finding of conduct unbecoming. In coming to this finding, the Tribunal is influenced by the addition of the statutory requirement that the conduct under review be such a significant departure as to reflect adversely on Dr H's fitness to practise medicine.

7.9 **WHILST** viewed in its totality, Dr H's management of Mr A's illness may fairly be criticised, such criticisms as can be made arise, in the main, with the benefit of hindsight. The Tribunal accepts his counsel's submissions that, in this particular case, Dr H's shortcomings in his clinical management of Mr A, and his communication with Mr A's family, do not fall sufficiently below acceptable professional standards as to necessitate a disciplinary finding, nor does his conduct reflect adversely on his fitness to practise medicine. The Tribunal also expects that inevitably the re-examination of Mr A's case both by the CAC and this Tribunal will positively influence the way Dr H practises medicine in the future. Undoubtedly, any medical practitioner who faces disciplinary charges finds it a salutary and chastening experience, even a doctor as experienced as Dr H.

7.10 **IN** conclusion, the Tribunal is not satisfied that any errors of clinical judgement, or omissions, on the part of Dr H which, with the benefit of hindsight, are established constitute conduct unbecoming a medical practitioner that reflects adversely on Dr H's fitness to practise medicine. Accordingly, the Tribunal does not find that the charge laid against Dr H has been established against him. This case should serve to warn practitioners of the necessity to seek specialist

advice promptly, and to be more insistent in seeking hospital admission for patients, in particular for geriatric patients, who present with undiagnosed or 'soft' symptoms.

7.11 **IN** light of the Tribunal's decisions there are no issues as to costs.

7.12 **IN** a Decision dated 29 August 1997 this Tribunal ordered:

7.12.1 **THAT** the whole of the hearing of the charge be held in private.

7.12.2 **THAT** the publication of any report or account of any part of the hearing by the Tribunal in any manner in which the applicant is named or identified be prohibited pending further order of the Tribunal.

7.12.3 **THAT** the publication of the name or any particulars of the affairs including the occupation place of residence/practice of the practitioner be prohibited pending further order of the Tribunal.

In light of the findings made in this Decision that the charge is not established against Dr H, the Tribunal confirms those Orders, sine die.

DATED at Auckland this 12th day of December 1997

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W N Brandon

Deputy Chairperson

Medical Practitioners Disciplinary Tribunal