Medical Practitioners Disciplinary Tribunal

PO Box 5249 Wellington Telephone (04) 499-2044 Facsimile (04) 499-2045
All Correspondence should be addressed to The Secretary

DECISION NO: 16/97/12C

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 **C** registered medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chairperson)

Professor B D Evans, Dr M-J P Reid, Dr R S J Gellatly,

Ms S Cole (Members)

Ms G J Fraser (Secretary)

Ms K G Davenport (Legal Assessor)

Professor P R Stone (Medical Assessor)

Mrs G Rogers (Stenographer)

Hearing at Auckland on Thursday 30 October 1997

APPEARANCES: R Harrison QC for the Complaints Assessment Committee ("the CAC").

H Waalkens for C ("the respondent").

1. THE CHARGE:

1.1 **THE** respondent is charged by the CAC, pursuant to Section 93(1)(b) of the Medical Practitioners Act 1995, that between 22 April 1993 and 7 May 1993 at xx, in the course of his management of A:

(a) He failed to convey to her the information that growth retardation and polyhydramnios suggest a possibility of congenital and/or chromosomal abnormality;

(b) He failed to expedite a Level III ultrasound scan at xx Hospital;

(c) He failed to manage appropriately the risk of pre-term labour, and in particular to perform a vaginal examination and a more proactive specialist follow-up in view of the risk of "silent" dilatation of the cervix.

This being disgraceful conduct in a professional respect or professional misconduct or conduct unbecoming a medical practitioner which reflects adversely on the practitioner's fitness to practice medicine.

1.2 **IN** opening the case on behalf of the CAC Mr Harrison explained to the complainant that the most significant particular of the charge against the respondent was the first, that is, the failure to convey the information that growth retardation and polyhydramnios suggest a possibility of congenital and/or chromosomal abnormality. Mr Harrison indicated that Mrs A would give extensive evidence about the first particular of the charge and that the other two particulars were of a more clinical nature and did not feature as importantly as the first particular, to Mrs A.

1.3 **MR** Harrison made one other comment in his opening about the charge. Noting that it had been framed in the alternative - namely, disgraceful conduct, professional misconduct, or conduct unbecoming, Mr Harrison explained that the CAC did not continue with an assertion that any misconduct on the part of the respondent was either disgraceful in a professional respect or professional misconduct. The argument would be that it was conduct unbecoming, simply in the sense that it failed to comply with the standard which Mrs A was entitled to expect of an experienced obstetrician to whom she was referred for expert assistance following a scan taken on the 21st of April 1993.

1.4 **MR** Waalkens was able to confirm that he had been informed of the CAC's position with respect to the level of charging prior to commencement of the hearing.

2. BACKGROUND:

2.1 **THE** charge relates to the care and treatment of Mrs A by the respondent in a specialist capacity in the last two weeks of her first pregnancy.

2.2 **ON** 21 April 1993 Mrs A learned the results of a scan which had been carried out at the direction of her general practitioner, Dr D. That ultra-sound scan reported the presence of excessive hydramniosis and intra-uterine growth retardation. Mrs A asked to see a specialist, urgently. She was referred by Dr D to the respondent the next day.

2.3 **IT** is uncontested that the respondent saw Mrs A on 22 April 1993, within a day of the scan, and suggested a programme for her treatment in the remaining weeks leading through her pregnancy.

2.4 **MRS** A had another scan on 29 April 1993, the report of which again referred to the existence of polyhydramnios and noted that the amniotic fluid was high. The report also referred to the existence of asymmetrical intra-uterine growth retardation and recommended further growth scans. Mrs A did not see the respondent again, but at her instigation she was admitted to xx Hospital on 7 May 1993, for relief of abdominal pressure, that is, just over two weeks after first seeing the respondent.

2.5 **MR** Harrison explained that Mrs A would give evidence that for some time she had been particularly concerned about the increase in her abdominal size in the weeks before her referral to the respondent. When she was admitted on 7 May 1993, xx Hospital assessed her condition as being an acute episode of polyhydramnios. She was then 32 weeks pregnant.

2.6 **ON** the day of her admission to xx Hospital Mrs A said she was advised by Dr E, a specialist obstetrician at xx Hospital, that there was a prospect that her child was suffering a genetic abnormality and, in particular, referred to Downs Syndrome as a possibility. This was the first occasion on which Mrs A had been told of the prospect. It caused her great distress and shock.

2.7 **THE** next day after consultation with the hospital staff it was decided that the baby should be delivered by Caesarian section. It was Mrs A's first child. Later that day her daughter, B, was born. The child was immediately diagnosed as suffering from Downs Syndrome, but of more importance, suffering from premature lung disease and a small congenital heart defect.

2.8 **B** was kept alive on a ventilator for a little over a day, and, after consultation with the parents, the artificial breathing assistance was terminated and she died early on the morning of the 9th of May 1993.

2.9 **FOLLOWING** B's death, Mrs A suffered acute and prolonged depression. She believes that one of the main contributing factors to her prolonged and acute depressive illness was the delay in advice to her that she may be carrying a child which suffered an abnormality such as Downs Syndrome. She had little time to adjust to the possibility of an abnormal child prior to the delivery.

2.10 **SO** Mrs A's complaint, in essence, is that the respondent failed to take all proper steps to warn her of the possibility that the baby she was carrying was suffering from a defect and was chromosomally abnormal. Mrs A believes that she should have been given very full advice right from the time that she first consulted the respondent, about the possibility of her child's abnormality.

3.0 PARTICULAR (A) OF THE CHARGE:

"**FAILURE** between 22 April 1993 and 7 May 1993 at xx in the course of management of A, to convey to her the information that growth retardation and polyhydramnios suggest a possibility of congenital and/or chromosomal abnormality."

3.1 EVIDENCE FOR THE CAC:

A:

3.1.1 **MRS** A became pregnant with her first child in November 1992. She was under the shared care of Drs D and F at the xx Centre.

3.1.2 **IN** April 1993 she became concerned about her size and shape. She felt that she was too large and almost hemispherical. She raised with Dr D her particular concern about the rate of increase in the size of her abdomen.

3.1.3 **SHE** first had an ultra-sound scan on 20 January 1993 which did not reveal any abnormalities. However, because of her concerns about her size, Dr D arranged for a second ultra-sound scan on 21 April 1993. The scan reported no foetal abnormality but did report the presence of hydramnios.

3.1.4 **THE** sonographer who took the scan recommended that Mrs A seek immediate assistance from a specialist. At Mrs A's request Dr D arranged for her to see the respondent the next day. The time lapse of one day reflected the concern Mrs A had about her condition and the sonographer's advice after the scan that it showed excessive

hydramnios and intra-uterine growth retardation. The scan showed no foetal abnormality.

3.1.5 **AT** her consultation the next day the respondent warned her to expect an early birth. By that stage she was 29 weeks pregnant. The respondent arranged for her to have another scan at xx Hospital on 29 April 1993. The respondent also advised her to consult her general practitioner twice weekly and to keep in contact with him.

3.1.6 **AS** arranged, she had another scan at xx Hospital on 29 April 1993. Noting again that no foetal abnormality was seen, the report refers to the existence of polyhydramnios, and noted that amniotic fluid was high. It also referred to asymmetrical intra-uterine growth retardation and recommended a "further growth scan".

3.1.7 **MRS** A had seen Dr D on 27 April 1993 as the respondent had advised. She was feeling increasingly uncomfortable with abdominal distention. She felt that her condition was deteriorating. She went to see Dr D again on 4 May 1993, feeling increasingly uncomfortable with abdominal distention.

3.1.8 **THE** respondent telephoned her after the scan on 29 April to advise that there was nothing abnormal and arranged for an appointment at a later date about two weeks away. He continued his advice that she visit her GP twice a week, measure the daily increase in size of her abdomen and ring him if she suffered extreme discomfort. He also advised her to go immediately to xx Hospital if she showed any signs of labour pain.

3.1.9 **ON** 7 May 1993 after speaking to the respondent's receptionist she admitted herself to xx Hospital for amniocentesis "for release of abdominal pressure". She is now aware that xx Hospital assessed her condition as an acute episode of polyhydramnios (xx Hospital's letter of 2 December 1994 to ACC Medical Misadventure Unit). She was then 32 weeks pregnant. She also noted xx Hospital had described the recent ultra-sound on 29 April as showing "a significantly growth retarded baby estimated to be only 1500 g".

3.1.10 **SHE** had another ultra-sound that day. xx Hospital's report of 2 December 1994 to the ACC Medical Misadventure Unit said the scan showed that the baby was not moving.

3.1.11 **AT** that stage she was also found to have begun dilating although she was unaware of this. The specialist obstetrician who treated her, Dr E, ascertained that she knew little about polyhydramnios. Dr E told her the range of causes. It was only then that she learned for the first time that a genetic abnormality such as Downs Syndrome was in fact a possibility.

3.1.12 **SHE** remained in hospital following the scan. In consultation with her husband and herself xx Hospital decided to deliver the baby by Caesarian section. Later that day her first daughter B was born. She was immediately given respiratory assistance.

3.1.13 **AT** about 6.30 pm on 7 May 1993 a hospital paediatrician advised her and her husband that B appeared to have Downs Syndrome. She learned also that B was suffering from

premature lung disease and she had a small congenital heart defect. B was put on a respirator but later removed and sadly she died on 9 May 1993.

3.1.14 **AFTER** B's death Mrs A suffered from severe depression. She was under prolonged medical treatment as a result.

3.1.15 **SHE** does not blame the respondent or hold him responsible for B's death in any way. She knows it would be highly problematic for him to detect from the scans that B was suffering from Downs Syndrome. Her complaint is that he never told her at any time between 22 April when she first consulted him and 7 May when B was born of the possibility of a chromosomal abnormality arising from the excessive polyhydramnios shown by the scan on 29 April. She believes that this failure contributed significantly to the prolonged depression she suffered following B's death. She knew that something was wrong from 21 April. She would have been able to cope with B's deformity and death much more easily if she had been prepared for the possibility. She believes that the respondent should have warned her of it, rather than leaving another doctor to raise it with her just before B's birth.

3.1.16 **SHE** recalled speaking with the respondent after B's death. She asked him why he did not tell her about the risk that she was suffering from Downs Syndrome. His response was "..... that I did not ask him".

3.2 EVIDENCE FOR THE RESPONDENT:

The respondent:

3.2.1 **THE** respondent graduated MB Ch B from xx University in xx. He undertook specialist training in obstetrics and gynaecology at xx Hospital and also had further training and work in other teaching centres in London and elsewhere in England. The national qualifications obtained are Fellowships of the Royal Colleges of Obstetrics and Gynaecology in England (1958) and New Zealand (1982) and the Royal Colleges of Surgeons in Edinburgh (1960) and Australasia (1962). In April 1996 he retired from practice.

3.2.2 **MRS** A had been referred by her general practitioner on account of having excess liquor. At the first maternity consultation at his practice rooms on 22 April 1993 Mrs A described her condition to him as "feeling terrible as if going to pop". Her general practitioner's letter of referral indicated that there had been no other unusual features in the progress of the pregnancy. The usual blood tests had been performed including a polycose test.

3.2.3 **ON** examination he noted the abdomen was enlarged by hydramnios (girth, 100 cm). The foetal heart rate was normal with natural variability. No uterine contractions were felt and the uterus wall was firm and larger than expected from her dates. The foetus was palpated in the longitudinal lie, with head presenting. Blood pressure measured 100/70. There was some oedema in both ankles consistent with the abdominal enlargement.

3.2.4 **HE** also considered the ultra-sound scan reports which were available at that stage. He noted that the early ultra-sound scan conducted on 20 January 1993 reported normal in all respects, including liquor volume. He noted that the ultra-sound scan report of 21 April 1993 quoted, inter alia:

"No foetal abnormality detected. Liquor volume is however significantly greater than normal. .....

Polyhydramnios the cause of which is not identified, ..."

3.2.5 **HE** accepted that he did not discuss with Mrs A the matter of abnormality. He did this because of the absence of structural defects. The measurements did not, in his opinion, indicate growth retardation. The foetus was smallish but well within the range of normality. He recognised a need for another scan to check the growth and confirm there were no defects. This was arranged straight away for a week later (rather than the normal 10-14 days which is the usual time where growth is being monitored) at xx Hospital, to be performed by Dr G.

3.2.6 **PREMATURE** labour was discussed by him with Mrs A as an increased possibility due to hydramnios.

3.2.7 **ROUTINE** blood tests were ordered by him. Polycose was noted in the normal range but because of the hydramnios, a glucose tolerance test to exclude diabetes was requested.

3.2.8 **THE** second scan performed at xx Hospital on 29 April when the maturity was 30w 5d, reported as follows:

"Indications:	*Polyhydramnios*		
Fetal Status:	*Alive*	*Placenta:*	*Posterior*
Fetal Growth:	*I U G R [Asym]*		
Amniotic Fluid:	*High [> 10]*	*Presentation:*	*Cephalic*
Fetal Anatomy:	*No abnormality seen*		

Biometry:			
B P D	*77mm*	*Head Circumference:*	*291mm*
Abdominal Circumference:	*241mm*	*Femur Length:*	*57mm*
Estimated fetal weight:	*1560g*		

Comments

Liquor 13cm. No anatomical abnormality noted on scan. Asymmetrical I U G R, further growth scan recommended. Gestational diabetes to be excluded."

3.2.9 **A** third scan reported at the time of an amniocentesis on 7 May 1993 did not record measurements but noted "Comments: No abnormality seen" by Dr H, an experienced radiologist.

3.2.10 **A** fourth scan performed on 8 May 1993 reported as follows:

"Indications:	*Decreased movements*		
Fetal Growth:	*Normal*	*Presentation:*	*Cephalic*
Biometry:			
B P D	*82mm*	*Head Circumference:*	*305mm*
Abdominal Circumference:	*277mm*	*Femur Length:*	*58mm*
Estimated fetal weight:	*1900g"*		

3.2.11 **OEDEMA** and fluid was seen and foetal distress diagnosed thus leading to a decision to deliver by Caesarian section.

3.2.12 **THE** foetal growth chart is one used in all the hospital's maternity practices and also at xx Hospital. Reference to the chart (attached to his brief of evidence) showed the three scans recorded at the maturities correctly calculated.

3.2.13 **THE** first of the three at 29w 4d on 21 April 1993 shows measurements very near the median for the maturity. One of the four, the abdominal circumference, is a little lower when compared with the others.

3.2.14 **THE** second, a week later at 30w 5d on 29 April 1993 (at xx Hospital) shows expected growth for three parameters, but the abdominal circumference shows no increase.

3.2.15 **WEIGHT** chart shows that 1560g foetus to be small but well within the normal range.

3.2.16 **THE** third scan is nine days later at 32w 0d on 7 May 1993 which was performed on the admission for the purposes of aiding an amniocentesis. That report stated no foetal abnormality was present. Measurements were not taken.

3.2.17 **THE** fourth scan was at 32w 1d on 8 May 1993. The measurements all show increase paralleling the growth line. This scan revealed fluid with oedema present and foetal distress which resulted in the decision to deliver the child by Caesarian section.

3.2.18 **AT** the first consultation with Mrs A he had considered the possibility of undetected defects but thought it better to wait for the next scan expecting that if there were defects

they would show. It was the apparent absence of any pathology shown on the scan which led him to believe that he was not dealing with a major problem. He thought it was an unnecessary stress to Mrs A to discuss these possibilities.

3.2.19 **A** week later when again there were no structural abnormalities reported from the scans, the respondent felt that there was not enough evidence to justify discussing with Mrs A the subject of foetal abnormalities "knowing the fearful effect that this can have on women". The abdominal measurement suggesting the possibility of growth retardation which was *asymmetrical* in relation to other growth parameters may indicate early placental inadequacy. He did not attach ominous significance to this by reference to any foetal abnormality. It is *symmetrical* growth retardation affecting all measurements resulting in a very small foetus which may give an indication of foetal abnormality. This was not the case with Mrs A.

3.2.20 **IN** the event of dealing with foetal abnormality his custom is always to refer to the foetal medicine panel at xx Hospital. He would have done so had he been of the opinion that there was sufficient evidence to do so.

I:

3.2.21 **MR** I is a registered medical practitioner and a specialist obstetrician and gynaecologist of approximately some 30 years experience. He presently works in private practice and holds a 2/10ths public practice at xx Hospital. He had been asked to provide an opinion with regard to the charge brought against the respondent and, in doing so, had considered what he understood to be the medical records available.

3.2.22 **FOCUSING** on growth retardation and polyhydramnios, and the possibility of abnormalities, Mr I entered into some discussion of the ultra-sound scans.

3.2.23 **IN** the second ultra-sound scan reported by Dr J of 21 April 1993, there appear a number of measurements of importance. The head circumference and biparietal diameter were on the mean for that period of gestation. And as can be seen on the flow chart, the abdominal circumference were half way between the 5th and 50th centile and the femur length fairly close to the mean, perhaps around the 30th or 40th centile.

3.2.24 **THE** femur length is a good indicator of the skeletal size and therefore the generic overall size of the baby. From the femur length all other measurements can be related. According to the measurements of the ultra-sound, the baby would appear genetically to be slightly smaller than the mean, perhaps one that would be at 3kg at term and the abdominal circumference indicating that the baby was reasonably well nourished and not what he would call a growth retarded baby.

3.2.25 **THE** next ultra-sound carried out at xx Hospital one week later was normal with expected growth of the head and also of the femur, it remaining a little below the mean.

3.2.26 **TAKING** the femur length into consideration, the abdominal circumference would in fact fall perhaps slightly above the 10th centile and although asymmetric retardation could be considered, it could likewise have been interpreted as a relatively small, slim but normal baby. Probably a more important point is the fact that any growth retardation which was present was asymmetrical and not symmetrical. The cause of

asymmetrical growth retardation is placental inadequacy in which nourishment has not adequately passed through the placenta to the foetus and glucose is not stored in the liver to create a well rounded abdomen. The cause of symmetrical growth retardation is that of a generally small baby and when it falls well below the mean when considering the size of mother and father and others in the family, it can represent an abnormal baby because abnormal babies have less cells making up their constitution than normal babies do.

3.2.27 **WHILE** acknowledging that growth retardation can be a cause of foetal abnormality, this is the case with symmetrical growth retardation and very seldom asymmetrical growth retardation.

3.2.28 **MR** I concluded:

"I can well understand from the above, and knowing C, that he would be very hesitant to bring up the subject of foetal abnormality under these circumstances, when there was no evidence of it. This is because of the stress which a caring and prudent doctor would expect this to cause the mother. It would appear that the degree of polyhydramnios when C saw Mrs A was when in which the foetal parts could easily be felt, and therefore it would not have to an extreme degree. Although it subsequently was found to be due to a foetal abnormality, in my opinion, it could at that stage have been due to an innocent and unknown cause."

3.3 STATEMENT OF PETER RICHARD STONE:

PROFESSOR Stone, Professor of Obstetrics at the Wellington School of Medicine, was employed by the Tribunal as a Medical Assessor. Having listened to the evidence of Mrs A, the

respondent and Mr I, and having asked questions of these witnesses, Professor Stone made a lengthy statement from which can be extracted the following propositions:

3.3.1 **THIS** baby had a large amount of fluid around it and then subsequently, just prior to the baby being delivered, the last scan showed that there was fluid within the baby's abdomen and chest. This is very relevant. If there is just isolated increase in fluid and nothing else, the chance of chromosome abnormality is low. But if that increase in fluid then becomes part of the fluid within the baby, then the baby is said to be suffering from what is called "non-immune hydrops".

3.3.2 **IN** some studies published after 1993, it has been found that in babies with non-immune hydrops, there is a 12% chance, plus or minus a few percent, that the baby would have a chromosome abnormality.

3.3.3 **IN** a larger series which was published in 1990 (originating from a tertiary referral centre), it was found that 16% of such cases had chromosome abnormalities.

3.3.4 **IT** has been found that in the situation where there is increased amniotic fluid and reduced foetal growth, there is a reasonably high chance that there is a chromosome abnormality. These babies often have the so-called asymmetrical growth pattern which is different from the teaching that he had when he was training, and it is certainly different from the teaching that used to be published in standard text books. (Professor Stone said that he put forward this proposition "wearing the hat of a general obstetrician/gynaecologist who may not work entirely in the field that I work in").

3.3.5 **HYPOPLASIA** of the baby's lungs, although it clearly contributed to the baby's death, is not particularly relevant to the problems encountered. Suffice to say it is consistent with a baby that is unwell.

3.3.6 **BY** the time of the review scan undertaken on 29 April 1993, the clinical situation was deteriorating, and irrespective of issues of assessing the chromosome make up of the baby, there certainly would be grounds for a very high level of surveillance.

3.3.7 **THE** issue of the relationship between amniotic fluid and the possibility of a chromosome abnormality, although low but not zero, would be worthy of raising with the pregnant woman, realising that there is some risk of causing anxiety by doing that.

3.4 SUBMISSIONS FOR THE CAC:

IT was Mr Harrison's principal submission that there were a number of important steps in the process of the respondent's treatment of Mrs A:

3.4.1 **THE** first arose from the scan that was taken on 21 April 1993. In the course of that report the sonographer noted: "Liquor volume is however significantly greater than normal".

In answer to questions from members of the Tribunal, Professor Stone acknowledged that the detection of increased liquor volume means that the baby is unwell and that it may have a chromosomal defect. He said as a matter of practice he would communicate that fact to the patient. There is no suggestion in the evidence that the respondent conveyed to Mrs A, the next day, that the baby was unwell.

3.4.2 **THE** second and what Mr Harrison described as the progressively important stage occurred on 22 April 1993 when Mrs A saw the respondent. Following that consultation the respondent provided a report to Dr D on 23 April 1993, a document not discussed so far. Although the report records what was obvious about the increase in size of the abdomen and that the scan did not report any foetal abnormality, there is no reference anywhere in that report to the fact that the baby may be unwell.

3.4.3 **THE** third stage was on 29 April 1993 on which day Dr G sent a report to the respondent following a scan, the terms of which have been outlined. It appears to be accepted among all three obstetric witnesses that the reference to asymmetrical intra-uterine growth retardation in that report was significant. It was a factor that had not been previously raised. It was another very important factor which should have been raised with the patient at that stage. Instead, on Mrs A's evidence, the respondent communicated a positive message to her through her husband that evening. If not on 22 April 1993, certainly on 29 April 1993, the respondent should have advised Mrs A that there was a risk of foetal abnormality.

3.4.4 **ON** 7 May 1993 Mrs A arranged for her own admission to xx Hospital. It was then she learned for the first time of the prospect of foetal abnormality, just before the Caesarian birth of B. She had no idea that her baby was unwell, let alone dying. She was never prepared for that contingency by the respondent.

3.5 SUBMISSIONS FOR THE RESPONDENT:

IN summary it was submitted by Mr Waalkens on behalf of the respondent:

3.5.1 **OF** the criticisms made of the respondent, the first particular is a criticism of a judgement decision made at the time. The absence of positive structural or other abnormality reported from the scans means that it was not unreasonable for the respondent not to have conveyed to Mrs A the possibility of congenital and/or chromosomal abnormality.

3.5.2 **WITH** the benefit of hindsight, it is apparent that the respondent could have embarked upon different management options. However, at the time, given his clinical assessment of the case, his failure to embark upon further management steps was reasonable.

3.5.3 **THE** Tribunal must stand back and review the entire case and its circumstances. The Tribunal must ask itself three questions:

(a) Has the alleged misconduct fallen so sufficiently below the standards of a prudent obstetrician and gynaecologist that such an adverse disciplinary finding is warranted; and

(b) Does the alleged misconduct reflect adversely upon the practitioner's fitness to practise medicine; and

(c) Is such an adverse finding required to protect the public.

3.6 LEGAL PRINCIPLES:

3.6.1 **MR** Waalkens submitted that guidance on the meaning of the expression "conduct unbecoming" can be taken from *B v Medical Council* (High Court, Auckland, 8C11/96 Elias J, 8 July 1996) where at P15 the High Court said:

"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.

.... 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 expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards."

3.6.2 **THAT** patient interests and community expectations are of legitimate concern in the disciplinary process, is borne out by a June 1990 Medical Council of New Zealand Statement For The Medical Profession On Information And Consent, parts of which state:

"The Medical Council of New Zealand takes the view that (except in an emergency or a related circumstance) the proper sharing of information, and the offering of suitable advice to patients, is a mandatory prerequisite to any medical practitioner. This applies whether the procedure is a diagnostic one, a medical or pharmacological regimen, an anaesthetic, or any surgical, obstetric, or operative procedure.

..... The Council affirms that trust is a vital element in the doctor-patient relationship. This trust is more easily achieved if the patients are treated sympathetically and particularly if they are fully aware of their right to confidentiality and their right to full information about their current medical condition (and their health in general) and about the risks and benefits of possible treatment. Information must be conveyed to the patient in such detail and in such a manner, using appropriate language, as to ensure that an informed decision can be made by that particular patient. The necessary standard for this requirement (that is the extent, specificity and mode of offering the information) should be that which would reflect the existing knowledge of the actual patient and the practitioner. More generally, it should also reflect what a prudent patient in similar circumstances might expect.

The prevailing attitude of both the health professions and those who represent health consumers should also, but to a lesser extent be taken into account. The particular patient's autonomy is the over riding consideration but other issues may justifiably modify the doctor's approach to providing information. For example, the patient may decline to discuss detail or desire a limit to the extent of the information. When further information is sought it must be provided. Throughout patient management, there are certain items of information which should always be considered by the doctor.

(a) The nature, status and purpose of the procedure, including its expected benefits, and an indication as to whether it is orthodox, unorthodox or experimental.

(b) The likelihood of the available doctors achieving the specific outcome that the patient seeks.

(c) The appropriate and relevant management options or alternatives with their possible effects and outcomes.

(d) The associated physical, emotional, mental, social and sexual outcomes that may accompany the proposed management.

(e) Significant known risks including general risks associated with procedures such as anaesthesia, the degree of risk and the likelihood of it occurring for that particular patient.

(f) Any likely or common side effects, particularly in drug therapy.

(g) The consequences of not accepting the proposed treatment.

(h) The name and status of the person who will carry out the management and of others, from time to time, who may continue the management.

The Medical Council affirms that if it can be shown that a doctor has failed to provide adequate information and thereby has failed to ensure that the patient comprehends, so far as is possible, the factors required to make decisions about medical procedures, such failure could be considered as medical misconduct and could be the subject of disciplinary proceedings.

..... The Council ..... supports the view that legislation should ensure that any definition of medical misconduct should include the inadequate transfer of information to a patient deciding on a medical procedure."

3.6.3 **ONE** of the findings made by the High Court of Australia in *Rogers v Whitaker* (1992) 175 CLR has particular reference to the information and consent principle which is inherent in the charge brought by the CAC against the respondent in this case. The question is not whether the conduct in question accords with the practice of the medical profession or some part of it, but whether it conforms to the standard of reasonable care demanded by the law. That is a question for this Tribunal and the duty of deciding it cannot be delegated to any profession or group in the community. Accordingly, while the evidence of the respondent, Mr I and Professor Stone is of considerable assistance to the Tribunal, it cannot be completely determinative of the issue under scrutiny.

4.0 DISCUSSION AND FINDING:

4.1 **PROFESSOR** Stone's questioning of Mr I sought to focus on what the latter, as an experienced obstetrician himself, believed to be appropriate practice in the context of the charge brought against the respondent. Professor Stone explained that he wished to gain an understanding from

Mr I of what would be his general standard of practice in the circumstances of the charge being faced by the respondent.

4.2 **AT** the outset it should be clarified that almost the entire proceedings over the course of one full day concentrated on the first particular of the charge, failure to convey the information that growth retardation and polyhydramnios suggest a possibility of congenital and/or chromosomal abnormality.

4.3 **MR** I indicated that he would have tended to recommend, almost insist, that the patient came back after the subsequent scan (presumably the one performed on 29 April 1993), both from the point of view of her clinical state, but also to discuss the scan. Although Mr I acknowledged that it was appropriate for there to be in place, as there certainly was, a day to day or week to week shared caring arrangement, the Tribunal tends to view Mr I's position as being mildly critical of the fact that the respondent did not invite Mrs A to attend another consultation immediately following the scan on 29 April 1993.

4.4 **PROFESSOR** Stone next asked Mr I whether the investigations of Mrs A undertaken during the week commencing 22 April 1993 were effectively adequate or complete up to that time and whether there was nothing further to be gained by a Foetal Medicine Service referral? Mr I replied "it's rather speculative". He explained that he thought the foetal medicine people would have liked to have obtained some amniotic fluid to prove the presence or otherwise of a foetal abnormality, but whether they would want to do it or whether they would be willing to carry it out for that purpose, Mr I said he did not really know. Mr I concluded that he did not think the Foetal Medicine Service would wish to test any foetal blood, because of the dangers, unless there

had been something more major. From this line of questioning the Tribunal draws no conclusion, except to say that it thinks it does demonstrate some ambivalence on the part of Mr I.

4.5 **HOWEVER** there was no element of ambivalence in Mr I's answer to the next question posed by Professor Stone. As a result of the scan on 29 April, which disclosed increasing polyhydramnios, Mr I said he would have tended, then, to admit the patient and ask for an opinion, probably by "xx Team".

4.6 **MR** I went on to explain the type of information or advice which he would give to the patient arising out of the making of such a referral, so that the patient knew what to expect when she became under the care of xx Team. As an example of what he would have told the patient, Mrs A in this case, Mr I said he would be considering reduction of the amniotic fluid, medically or surgically, and at the same time attempting to get some amniotic fluid sent off for assessment. He said he would tell the patient that the purpose of such an assessment would be "for chromosomal abnormalities". Mr I concluded that in warning the patient of the purpose of hospitalisation, "inevitably the subject of foetal abnormality would come up".

4.7 **UNDER** cross examination the respondent conceded to Mr Harrison:

4.7.1 **THAT** the physiology of amniotic fluid is that the volume increases and then decreases;

4.7.2 **THAT** an excessive build up of amniotic fluid represents an imbalance;

4.7.3 **THAT** if the imbalance is gross, there can be an inference, but only in rare cases, that there is a defect in the foetus;

4.7.4 **THAT** polyhydramnios of this degree is most unusual;

4.7.5 **THAT** only in the absence of scanning would it be necessary to warn of an association between polyhydramnios and foetal malformation;

4.7.6 **THE** significance of asymmetrical growth retardation is, in lay terms, of something going wrong, and of the importance to watch the condition of the baby for deterioration and of the need for critical care of the mother.

4.8 **GENERALLY**, however, the respondent would not concede any connection between polyhydramnios and foetal abnormality. The respondent disagreed with the assessment made by Dr xx, Clinical Head of the Maternal Foetal Medicine Service, in his letter of 2 December 1994 to the Obstetrics and Gynaecology Medical Misadventure Unit of ACC, that "a recent ultra-scan showed a significantly growth retarded baby estimated to be only 1500g".

4.9 **IN** re-examination by Mr Waalkens, the respondent re-emphasised the foundation of his defence to the charge, that it was the apparent absence of pathology through scanning which led him to believe that he was not dealing with a major problem.

4.10 **THE** role of Professor Stone as Medical Assessor should be explained. He did not give evidence as such. His role was to assist the Tribunal in understanding the effect and meaning of the technical evidence, much of which there was in this case. As already indicated, questions were asked by Professor Stone of the witnesses, at the times indicated by the Chair for that purpose. At the conclusion of the evidence, and in the presence of the parties, Professor Stone was asked by the Chair to provide a general overview of the technical aspects of the case. Questions were also asked of Professor Stone, by counsel on behalf of the parties, and by members of the Tribunal via the Chair.

4.11 **A** summary has already been provided of the essential elements of the formal statement made by Professor Stone at the conclusion of the evidence. Repetition is unnecessary. Highlighted here will be two aspects of that statement, particular aspects which have been taken into account by the Tribunal in making the finding which follows.

4.12 **IT** was Professor Stone's opinion, wearing the hat of a general obstetrician and gynaecologist who may not work entirely in his field of foetal medicine, that in the situation where there is increased amniotic fluid and reduced foetal growth, it has been found there is a reasonably high chance that there is a chromosome abnormality.

4.13 **PROFESSOR** Stone's further opinion must be noted. If the specialist obstetrician and gynaecologist is placed in the situation where the baby seems to be beginning the pregnancy without complication and later on the fluid is increased, if the baby is small and is asymmetrically grown, "it is worth testing the chromosomes". The Tribunal interprets this opinion as being in the nature of a desirable general practice by a specialist obstetrician and gynaecologist placed in the position which the respondent was placed in in his care of Mrs A.

4.14 **THERE** is a second proposition which has been identified in Professor Stone's statement as being of critical importance. It is his view that the relationship between amniotic fluid and the possibility of a chromosome abnormality "would be an issue worthy of raising with the woman, realising [none-the-less] that there is some risk of causing anxiety by doing that".

4.15 **AGAIN** it is noted Professor Stone has talked in terms of "worthiness". Given the concise Oxford Dictionary definition of "worth" in terms of "value" or "merit" again the Tribunal interprets

this opinion in much the same way as it has interpreted Professor Stone's immediately preceding recorded opinion. Both opinions accord substantially with the concessions which Professor Stone apparently succeeded in extracting from Mr I, and he said as much in concluding his formal statement to the Tribunal.

4.16 **OF** questions put to Professor Stone by Mr Waalkens, mention of but one, and the response, is relevant. Mr Waalkens was seeking to draw from Professor Stone his expectation of the stage of knowledge of what he described as "an older practising general obstetrician and gynaecologist such as Dr C when he was in practice". Professor Stone turned that question into the question which follows: "You are aware that normally a baby that's failing to thrive due to placental failure would have very little amniotic fluid around it?" Mr Waalkens replied "I wouldn't assume I am aware of that at all, doctor". Professor Stone's telling response was "Well, that's the usual situation, so if we are in a situation where we have a baby that's not growing well, and we've got too much fluid, we have to ask ourselves why".

4.17 **INEVITABLY** the Tribunal has been led to the making of a finding, particularly in reliance on some of the evidence given by Mr I, the assistance rendered by Professor Stone as Medical Assessor, and the guidelines contained in the statement issued by the Medical Council of New Zealand For The Medical Profession On Information And Consent, that the respondent had an obligation to convey to Mrs A the information that growth retardation and polyhydramnios suggest a possibility of congenital and/or chromosomal abnormality and that he failed to do so. The Tribunal finds accordingly.

4.18 **IT** remains for the Tribunal to consider and determine whether this finding reflects adversely on the respondent's fitness to practise medicine. As was noted by the Tribunal in a recent earlier decision, such an exercise *"..... entails a consideration of the rather vexed question of the meaning of Section 109(c) of the Act which requires, for a "charge of conduct unbecoming a medical practitioner" to be proved, an added requirement to be met that "that conduct reflects adversely on the practitioner's fitness to practise medicine". As was observed by Mrs Davenport when giving her directions as Legal Assessor towards the conclusion of the hearing, this is not an easy issue for the Tribunal to answer, particularly because there are no clear guidelines in the legislation as to how that determination should be made.*

Mr McClelland has submitted that the Section 109(c) qualification has been added to ensure that the Tribunal does not take steps against a practitioner unless the offending has a bearing on his or her fitness to practise medicine.

Both Mr McClelland and Ms Gibson submitted that guidance can be taken from B v Medical Council (High Court, Auckland, HC/11/96 Elias J, 8 July 1996) in which at P.15 of her Judgement Her Honour stated:

".... "

The Tribunal has received some guidance from the above extract taken from B v Medical Council. In its view the critical assessment which needs to be made, to ensure proper regard is given to the Section 109(c) gloss, is whether the "departure [is] significant enough to attract sanction for the purposes of protecting the public". As was explained

by her Honour, such protection is the basis on which registration under the Act, with its privileges, is available."

4.19 **THE** Tribunal considers that the unbecoming nature of the respondent's conduct in this case could lead to the making of the further finding, that such conduct does reflect adversely on his fitness to practise medicine (Tribunal's emphasis). However, for the reasons which follow, the Tribunal has determined that the deficiencies identified on the part of the respondent in terms of Particular (a) of the charge do not satisfy the Section 109(c) "gloss" taking account of certain perceived mitigating factors, as to attract sanction for the purposes of protecting the public. These factors are as follows:

4.19.1 **IT** is a matter of record that the respondent has retired from practice. Accordingly protection of the public is no longer an issue.

4.19.2 **THE** Tribunal place reliance on a comment made by Mr Harrison in his opening, although hopefully not too literally. He indicated that Mrs A sought a recognition of her complaint, not by way of an extreme or adverse penal sanction against the respondent, but simply a finding that his conduct was unbecoming. Mr Harrison did not address us on his interpretation of the Section 109(c) qualification.

4.19.3 **PROFESSOR** Stone explained, interestingly enough, the research which shows that babies which often have the so-called asymmetrical growth pattern, have foetal abnormalities, is different from the teaching he had when he was training. He said it is

certainly different from the teaching that used to be published in standard text books. Perhaps an inference can be drawn, that for the respondent, his expected state of knowledge could reasonably be expected to start at a somewhat lower threshold. But that is not to say that any lowering of acceptable standards is appropriate, even for an older practitioner.

4.19.4 **IN** context of the almost absolute and exclusive reliance placed by the respondent on his interpretation of the scans, Professor Stone said he sensed the Tribunal was experiencing difficulty in determining whether B was growth restricted or not. Professor Stone conceded, in what he described "as absolute terms", that B probably was not. He explained that she certainly had a weight which was in the range for her gestation. Although there was some reduction in the size of the abdomen relative to the other measures, Professor Stone said it certainly was not a growth reduction. He said that the other features of the pregnancy did not really fit with a baby that was suffering from placental vascular failure where the usual situation is markedly reduced amniotic fluid.

4.19.5 **HAVING** indicated that the relationship between the amniotic fluid and the possibility of a chromosome abnormality could be an issue worthy of raising with Mrs A, Professor Stone qualified that observation. In doing so he explained that no-one engaged in the proceedings knew exactly what was said at xx Hospital and whether whatever was said was deemed to be a serious consideration. Professor Stone had earlier commented that there did not seem to have been any degree of urgency at xx Hospital to resolve a potential problem. It may be recalled when he was questioning Mrs A, he asked her,

if there was a grave concern about the baby's chromosomal normality, why was a foetal blood sample not taken. Mrs A replied:

"When I arrived at xx that was the other test that they said they would be doing on the Monday."

4.19.6 **QUESTIONING** of Mrs A by Professor Stone failed to elicit from her any particular reason why a foetal blood sample was not taken immediately she was admitted to xx Hospital. From the recorded exchange between them it is clear that Mrs A could do no more than speculate for Professor Stone as to a reason why a foetal blood sample was not taken.

4.19.7 **PROFESSOR** Stone explained, in answering questions put by Mr Harrison, that the scan reports were somewhat unhelpful in that there were a number of inconsistencies. He said in his opinion the very first scan was not actually plotted absolutely correctly. He clarified this aspect, saying he thought a scan report, after being referred to xx Hospital suggesting that gestational diabetes be excluded, was not particularly helpful because "that's not really leading us down the path we need to go".

4.19.8 **FINALLY**, it will be recalled Professor Stone earlier had discussed studies which had been published in 1990 and 1993. These studies indicated it had been found in babies with non-immune hydrops that there was a 12% chance, plus or minus a few percent, that the baby would have a chromosome abnormality. In response to Mr Waalkens suggestion that there may well be general obstetricians and gynaecologists who do not

have much of an idea about the results of those studies, Professor Stone replied "Yes, I think that would be fair".

5. PARTICULAR (b) OF THE CHARGE:

5.1 **FAILURE** to expedite a Level III ultrasound scan at xx Hospital.

5.2 **THE** Tribunal considers this second particular of the charge warrants little comment. We say that because there seems to be a general lack of understanding of what is meant by a "Level III ultrasound scan".

5.3 **IN** asking the respondent what exactly did he understand by a Level III scan, Professor Stone asked how it differs from a scan at the Foetal Medicine Service or referral to the Foetal Medicine Service. Professor Stone said even he was not quite sure what was understood by a "so-called Level III scan". The respondent replied "Yes, I don't know what it means either, ..." The respondent went onto explain "I had not heard of the word Level III scan until I received the charges, so I can't answer for the person who wrote it. However, I can say that the patient had a scan from what I call a top person at xx Hospital, and that is what I wanted".

5.4 **IN** opening Mr Harrison emphasised that he would be concentrating on the first particular of the charge, which he described as "the most significant". Unless something very obvious has been missed by the Chair, it would seem that the second particular of the charge has really not been addressed by counsel for the CAC in prosecuting the charge. The particular has not been proved and therefore is dismissed.

6.0 CONCLUSION:

6.1 **THESE** proceedings have been traumatic both for the respondent and Mrs A.

6.2 **WE** record here the respondent's acknowledgement, that he now recognises that he could have discussed the possibility of an abnormality with Mrs A. Having read her letter of complaint, he deeply regrets that he did not raise the possibility of undetected defects with her. Particularly with the benefit of hindsight, the respondent now recognises and understands how Mrs A and her husband have felt about this matter and also sympathises with them and their family for the tragic loss of their first child. Without hesitation the respondent has extended his apology for any part which Mrs A and her husband feel he has played in causing or contributing to their distress. The Tribunal echoes this view and expresses its own sympathy to Mrs A.

6.3 **IN** summary:

6.3.1 **THE** Tribunal finds that Particular (a) of the charge has been proved but makes no finding as it does not find that the respondent's omission reflects adversely on his fitness to practise medicine.

6.3.2 **PARTICULAR** (b) of the charge is dismissed.

6.3.3 **IN** his closing submissions Mr Harrison indicated that he did not propose to proceed with prosecution of the third particular of the charge, which was abandoned.

6.3.4 **ACCORDINGLY** the charge against the respondent is dismissed.

DATED at Auckland this 27th day of November 1997

.....

P J Cartwright

Chairperson

Medical Practitioners Disciplinary Tribunal