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: 11/97/8&9C

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) the Act against **H** registered medical practitioner of xx and **G** registered medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chairperson)

Dr R A Cartwright, Dr J W Gleisner, Dr A D Stewart

Ms S Cole (Members)

Mr R P Caudwell (Secretary)

Mrs K G Davenport (Legal Assessor)

Mrs G Rogers (Stenographer)

Hearing held at xx on Tuesday 12 August 1997

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

Mr A J Knowsley for Dr H and Dr G.

WITNESSES: Mr R P Caudwell, Mrs A, Mr A, Dr D J Court,

Dr H, Dr G, Dr R A Speed

UPON ENQUIRING into the charge brought by the Complaints Assessment Committee and after hearing evidence from the witnesses referred to, and after considering the submissions made by counsel for the Complaints Assessment Committee, and Dr H and Dr G,

THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL FINDS:

1. THE CHARGE:

1.1 '**THE** Complaints Assessment Committee, pursuant to s.93(1)(b) Medical Practitioners' Act 1995, charges that Dr H, Medical Practitioner of xx on or about 28 September 1990 at xx. In the course of her management of A; failed to recognise the significance and therefore to act on the deteriorating Gestational Proteinuric Hypertension.

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 '**THE** Complaints Assessment Committee, pursuant to s.93(1)(b) Medical Practitioners' Act 1995, charges that Dr G, Medical Practitioner of xx, on or about 29 September 1990 at xx:

In the course of his management of A:

(1) Failed to recognise the significance of the abnormal CTG trace.

(2) Delayed in initiating steps to deliver the baby after its initial assessment of the patient.

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."

2. THE FACTS - BACKGROUND:

2.1 **IN** 1990 the complainant, Mrs A, became pregnant and was cared for throughout her pregnancy by her general practitioner, Dr H. This was Mrs A's second pregnancy and Mrs A had a history of cardiac disorder in her late teens.

2.2 **DR** H was the A family general practitioner. Dr H had also cared for Mrs A during her first pregnancy which ended in a miscarriage. Between February and September 1990 Dr H attended to Mrs A's antenatal care in the course of some 16 visits. Details of that care are recorded in Dr H's antenatal records which were made available to the Tribunal at the hearing.

2.3 **IN** addition to the antenatal care provided by Dr H, Mrs A was also referred to a specialist obstetrician (Mr B) of xx on four occasions, twice in September 1990, in the 36th and 38th weeks respectively of her pregnancy. Mr B's reports to Dr H were also made available to the Tribunal.

2.4 **IN** addition to her antenatal visits, Mrs A was also referred to Dr C, physician, of xx for checking of her cardiovascular situation.

2.5 **AT** the time of her first antenatal visit, Mrs A's 'booking' blood pressure was recorded at 90/60. Mrs A's blood pressure rose steadily in the course of her pregnancy and from July onwards her diastolic pressure was recorded at 70, 60, 80, 70, 76, 84, 86, 80, 80 pressure.

2.6 **ADDITIONALLY**, at visits occurring in July, August and September a trace of proteinurea is recorded. On 7 July, 20 July, 14 September and 21 September 1990 a single "plus mark" is recorded.

2.7 **MRS** A also presented with oedema and from 16-18 July 1990 Mrs A was admitted to hospital for bed rest.

2.8 **IN** his reports to Dr H, Mr B advised Dr H that there was "no evidence of toxaemia"; see his reports dated 14 August 1990, 6 September 1990 and 19 September 1990.

2.9 **MRS** A's estimated due date was 19 September 1990. This was subsequently revised after an ultrasound scan in May 1990, to 25 September 1990.

2.10 **ON** 21 September 1990, Mrs A attended Dr H for her regular antenatal visit. At that visit Dr H has recorded "plus mark" proteinurea; weight 82.7 (down from 83 one week earlier); blood pressure 130/80. The other details recorded are not significant in the present context. Dr H also made a note to herself "keep eye on wt".

2.11 **ONE** week later, on 28 September 1990 (the recorded dated of 29 September 1990 was agreed by both Mrs A and Dr H to be incorrect), Mrs A attended for what proved to be her final antenatal visit to Dr H. At that visit Dr H has recorded that Mrs A was at term; proteinurea "++"; weight 83.4; BP 130/80. Dr H also noted "we will see 1/52".

3. THE EVENTS OF 29 SEPTEMBER 1990:

3.1 **MRS** A went into labour in the early hours of Saturday 29 September 1990. Mrs A presented herself at xx Hospital at 8.45 am that morning. On arrival Mrs A was seen by a midwife who contacted Dr H. Mrs A's hospital records record:

(1) On arrival Mrs A was rather distressed with moderate contractions, 1x5, her blood pressure was 160/80 "(?apprehension - B/P in Dr's rooms yesterday 130/80) T. 36 5, P. 84. P.U. (conc., sm. amt - 20mls,) alb. ++, otherwise nad".

3.2 **MRS** A was examined by a midwife at 9.00 am and Dr H appears also to have been contacted at approximately 9.00 am. Dr H ordered Omnipon 10 mg and Phenegan 25 mg as sedation. At 10.45 am Mrs A was seen by Dr H however, at that stage Mrs A was in the bath and Dr H waited for her until 11.00 am before carrying out an examination.

3.3 **ON** examination, Dr H recorded:

BP 160/90 m Hg.

HS normal

Having mild contractions but patient appears in more pain than one would expect.

11 am BP 150/90. 150/85 - very little beat to beat variation - 'flat straight line' probably on CTG

Up to 176/min. at height of contraction

Albumururia 2+

P.D.A. repair

Then again at times

Erratic from 160/mm → 120/mm just after contraction

Problems 1. Early labour and development PET

2. Foetal Tachycardia

3. Previous PDA. Operation.

4. Will require monitoring"

Mrs A's xx Hospital records for that day conclude -

11.30 hr B/P 160/100 FH reg

Discussed with xx and decision made to transfer patient"

Mrs A was transferred to xx Hospital by ambulance. She was accompanied by a midwife and her husband followed by car.

3.4 **BOTH** Mr and Mrs A gave evidence that as far as they were aware, Mrs A was being transferred to xx for monitoring only. Neither Mr or Mrs A recalls being told that the reason for her transfer was in fact foetal distress and were upset at this omission.

3.5 **MRS** A was admitted to xx Hospital at 12 noon on 29 September 1990. Mrs A's xx Hospital admission sheet records her transfer to xx Hospital with the notation "foetal distress".

3.6 **MRS** A was admitted to xx Hospital at approximately 1 pm. Mrs A's records from xx Hospital apparently did not arrive with her at xx Hospital, and no explanation for this is available.

3.7 **ON** admission, cardiotocograph monitoring was commenced and Mrs A was seen by Dr G at approximately 2 pm. Dr G recorded that Mrs A was noted to be contracting well with 1/5th of the foetal head palpable abdominally. The cervix was 4 cm dilated with intact membrane. The cardiotocograph (CTG) showed foetal tachycardia with poor variability and late decelerations.

3.8 **DR** G's plan at this time was to maintain the CTG monitoring, to check blood pressure hourly and to avoid giving Mrs A any further sedation. An artificial rupture of membranes (ARM) was not performed.

3.9 **AT** 4.55 pm spontaneous membrane rupture occurred with meconium stained liquor draining. Examination at this time showed the cervix to be 6 cm dilated and blood pressure was 180/110 with +++ proteinurea. The CTG showed more marked decelerations.

3.10 **AT** 5.50 pm an emergency Caesarean section was arranged for foetal distress. An asphyxiated baby girl (C) was delivered at 6.39 pm and was immediately placed in the care of a paediatrician.

3.11 **THE** paediatrician reported that C appeared "mature but wasted", her weight was 2360 grams, she was asphyxiated. C was resuscitated but the subsequent paediatric reports suggest that the asphyxial brain damage could well be related to her mother's labour and the birth process. Mr and Mrs A gave evidence of C's present situation.

4. THE EVIDENCE:

4.1 MR AND MRS A:

THE evidence of both Mr and Mrs A set out the factual background to the events giving rise to the charges before the Tribunal. Most significantly Mrs A gave evidence that throughout her pregnancy she was reassured that everything was proceeding normally. It was Mr and Mrs A's evidence that even when transferred to xx Hospital neither of them were given any appreciation of any concerns for either Mrs A or her baby and they were given to understand only that she was being transferred for further monitoring.

4.2 DR H:

4.2.1 **DR** H gave evidence of her background, qualifications and experience. Dr H gave evidence that, after examining Mrs A on 29 September 1990, she telephoned xx maternity and spoke to the midwife on duty about Mrs A's transfer. Dr H was told there was no specialist obstetrician available; that she was assured by the midwife in charge that Dr D, a general practitioner undertaking obstetrics in xx to whom Dr H had previously referred patients, would be contacted. Dr H took no further steps in Mrs A's care until late afternoon when she telephoned to inquire how Mrs A had fared during the day and she was told that she was being prepared for an emergency Caesarean section and that Dr G was the doctor in charge.

4.2.2 **DR** H gave evidence of her belief that Mrs A's PET condition was acute and gave evidence of the symptoms and indicia of severe hypertension, imminent eclampsia and eclampsia which she had been taught.

4.2.3 **IN** 1990 when the events at issue occurred Dr H was not aware that the definition of severe hypertension, imminent eclampsia and eclampsia included a rise in blood pressure of 20 mm Hg in both diastolic and systolic pressures on the booking BP reading.

4.2.4 **DR** H also gave evidence of the reassurance she received from the reports given by the specialist obstetrician, Mr B, who saw Mrs A on four occasions during her pregnancy. Neither Dr H nor Mr B detected any placental insufficiency or intrauterine growth retardation. Ultra sound scans done at 20 weeks and 30 weeks also showed that Mrs A's dates were consistent with the gestational age/growth.

4.2.5 **DR** H conceded that the finding of proteinurea at ++ on 28 September 1990 "could obviously have been the first concrete suggestion of approaching PET and my sixth sense should have reacted". Dr H stated that if she had suspected PET then she would have admitted Mrs A to hospital for bed rest and for foetal and maternal monitoring. Mrs A could not have been induced at xx Hospital as it lacked sufficient facilities for anything other than normal, uncomplicated deliveries, and induction at xx Hospital would also not have been possible on 28 September 1990 with no specialist obstetrician on call. Finally, Dr H also gave evidence that the 28th of September 1990 was a Friday and she saw Mrs A late in the afternoon. No laboratory facilities were available in xx at that particular time. Dr H also gave evidence that subsequent to Mrs A's visit she had second thoughts as to the wisdom of leaving Mrs A's next antenatal visit for one week and that she intended to contact Mrs A on Monday morning to arrange an earlier visit. In the event, subsequent events overtook any such action.

4.3 DR G:

4.3.1 **DR** G gave evidence that on Saturday 29 September 1990 he was providing general practitioner cover for the towns of xx and xx. This included cover for the obstetric ward at xx Hospital, in the absence of the sole obstetrical specialist. Dr G had some obstetrical experience and had undertaken the Diploma in Obstetrics course and examination at xx University between 1987 and 1990, when he was a general practitioner in xx.

4.3.2 **DR** G's direct recall of the events was limited as he had left xx in October 1990 and it was not until October 1994 that he was made aware of the problems surrounding C's birth. Dr G confirmed that he reviewed the CTG trace as part of his initial examination of Mrs A and that he had noted several abnormalities in the trace at that time. He made a diagnosis of non-fulminating pre-eclampsia developing during labour with signs of foetal depression on CTG. Dr G considered that the CTG abnormalities were possibly induced by the administration of sedatives earlier in the day.

4.3.3 **DR** G gave instructions for the CTG and BP monitoring to be maintained, that any further sedation was to be avoided and, after discussing the situation with Mr and Mrs A, Dr G left the hospital and did not return until summoned at approximately 4.55 pm following the spontaneous rupture of membranes occurring, at which time the appearance of meconium stained liquor evidenced severe foetal distress.

4.3.4 **DR** G immediately set about arranging a Caesarean section and C was delivered at 6.39 pm.

4.3.5 **DR** G gave evidence that the combination of a misjudgment of foetal lie (made by him on initial examination); his allowance for the effects of sedation given to Mrs A earlier in the day; and his failure to artificially rupture membranes when he saw Mrs A at 2 pm, may all have influenced his decision to allow labour to continue during the afternoon despite the CTG abnormalities which were apparent and recognised by him when he first saw Mrs A earlier in the afternoon. Dr G conceded that had the Caesarean section been arranged after his initial examination delivery would have occurred at approximately 3 pm, as opposed to nearly 7 pm, an interval which could have improved C's outcome considerably.

5. EXPERT EVIDENCE:

5.1 DR COURT:

5.1.1 **DR** Court, a specialist obstetrician and gynaecologist, gave evidence for the CAC. He also canvassed the factual background which has already been set out. In respect of Dr H's conduct, it was Dr Court's opinion that Dr H did not appear to appreciate the clinical manifestations of raised BP and ++ proteinuria, evident on 28 September 1990 when Mrs A presented for her scheduled antenatal visit. It was Dr Court's opinion that both clinical manifestations, in particular the ++ proteinurea, constituted "a significant deterioration in the antenatal status" of Mrs A which required action at that time. Certainly laboratory investigations ought to have been undertaken, however there were no laboratory facilities available in xx on that afternoon or at that time of day. Dr H conceded, that with the benefit of hindsight, Mrs A's antenatal visit ought to have been scheduled for a time which would have allowed the appropriate investigations to have been undertaken if indicated. Notwithstanding her evidence that she had had second

thoughts and intended to contact Mrs A on Monday morning to recall her earlier than the week scheduled on the Friday afternoon, it is clear that, on the Friday afternoon when she did see Mrs A, Dr H did not respond to the finding of the ++ proteinuria, when she should have. As a result, Dr H was not alerted to Mrs A's deteriorating antenatal status caused by the onset of pre-eclamptic toxaemia.

5.1.2 **IN** Dr Court's view, whilst it was unlikely that laboratory investigations undertaken on the Friday afternoon would have been completed to provide clinical information to Dr H which would have confirmed Mrs A's developing PET, nevertheless such arrangements were part of an appropriate standard of care which Dr H ought to have delivered to Mrs A.

5.1.3 **DR** H's management of early labour at xx Hospital was appropriate and she recognised the need for transfer and acted on this appropriately. However it was Dr H's responsibility to ensure that the appropriate documentation accompanied Mrs A and this responsibility was not fulfilled, although it seems unlikely that this failure on the part of Dr H had a significant impact on the subsequent course of events.

5.1.4 **IN** relation to Dr G's care, Dr Court's evidence was consistent with the evidence given by the respondent's expert witness that Dr G ought to have been able to interpret the CTG tracing, (and, in fact, did detect abnormalities) and having appreciated the existence of abnormalities, and the degree of the CTG abnormality which was evident at the initial assessment at 2 pm, it was mandatory for him to have performed an artificial rupture of membranes. Had an ARM been performed at that time meconium liquor

would "undoubtedly have been revealed". If that had occurred, then it is likely that a Caesarean section would have immediately been arranged and the baby delivered shortly thereafter.

5.1.5 **IN** oral evidence Dr Court, whilst he expressed the caveat that there is no consensus as to when labour ought to be induced, nevertheless considered that the clinical indication of ++ proteinurea was sufficient to indicate that induction within a short time frame was appropriate. This was especially so given that Mrs A's pregnancy was at term. Dr Court explained the difference of approach to induction in the context of the duration of the pregnancy. At term the number of risk factors to the foetus if delivery is induced diminishes. In the absence of concerns regarding the premature birth of the infant, induction is indicated.

5.1.6 **ACCORDINGLY**, when Mrs A presented for her antenatal visit on 28 September 1990 the ++ proteinurea, accompanied by a rise in her diastolic blood pressure of about 20 mg over her booking BP induction, indicated that ongoing monitoring, at a facility which had proper services available, was required.

5.1.7 **DR** Court also gave evidence as to the significance of a rise in blood pressure during the pregnancy. Dr Court's evidence was that there is no absolute consensus, but a time honoured criteria is that a rise in diastolic BP of 15-20 mg through the duration of the pregnancy indicates "mild" PET. Dr Court also gave evidence as to the significance of the absence of a mid-trimester drop in blood pressure as an indicator of persistent but "mild" PET.

5.1.8 **IN** relation to the events of 29 September 1990, and Mrs A's care at xx Hospital, Dr Court conceded that it can be difficult to interpret the clinical significance of CTG recordings, but in this case the CTG tracing was one of the less difficult traces to read given the clinical context. Dr Court gave evidence that he would have been "quite alarmed" by the tracing at 1400 hours "if all of the circumstances had been known to me". Dr Court conceded that Dr G was not a specialist obstetrician, however, in his opinion, a practitioner with a diploma in obstetrics should be expected to be able to correctly interpret the CTG tracing which was available at the time. Dr G's assessment that the CTG abnormalities were most likely caused by the sedatives given to Mrs A earlier in the day was incorrect. Whilst conceding that sedatives, such as Omnipon and Phenegan which were given to Mrs A, can have significant effects on a foetal heart rate Dr Court could not recall having seen an effect of this intensity caused by a sedation administered to the mother. Whilst sedation can reduce a beat to beat variability, and sedation given to the mother obviously also sedates the foetus thereby inducing a somulent state in the foetus. Sedation would not have accounted for all of the features shown in C A's CTG tracing, in particular for the tachycardia which was evident.

5.1.9 **BOTH** Dr Court and Dr Speed were critical of the absence of specialist obstetrical services at xx over the weekend and expressed the view that Dr G was improperly and incompletely backed up. However, in Dr Court's view, a specialist obstetrician would have been available at either xx or xx Hospitals and, whilst no formal protocol was in place, or is generally adhered to, it would be ethically unwise for any specialist obstetrician available, and from whom advice was sought, not to give that advice. Whilst

it is difficult to give clinical information over the telephone, nevertheless this was not an option either considered or pursued by Dr G.

5.1.10 **IN** response to cross-examination by Mr Knowsley, Dr Court's evidence was that, putting himself in the shoes of a general practitioner in xx in 1990, the clinical context would have raised concerns and strengthened the necessity for induction. The ++ proteinurea would have reinforced the need for a speedy clinical response, in particular transfer to xx Hospital for induction.

5.1.11 **IN** response to questions from members of the Tribunal regarding the diagnosis and treatment of PET with reference to Mrs A's clinical records, Dr Court diagnosed a "clear though mild" toxaemic condition.

5.1.12 **IT** was evident from Dr H's evidence that her focus in the context of her being alert for signs of PET, was directed at looking for signs of severe toxaemia, with consequent risk to the mother, rather than any risk to the foetus caused by persistent though mild PET. In evidence, Dr H conceded that she did not recognise ++ proteinurea as a warning sign for toxaemia. It was unfortunate that Dr H also took reassurance, falsely as it turned out, from the reports she was given by the specialist obstetrician who also saw Mrs A. Although Dr H does not currently, and does not intend in the future, to practise obstetrics, her present knowledge is that a ++ proteinurea together with blood pressure readings of 15-20 mg Hg above booking BP does indicate the onset of PET with consequent risk for both mother and foetus. However, it was not until she saw Mrs A in xx Hospital on the Saturday morning that Dr H became concerned about the rise in

blood pressure, and she attributed this, at least in part, to Mrs A's very anxious state and thought that some sedation would settle her. It was not until she had completed her examination of Mrs A that the whole clinical picture presented and she diagnosed foetal distress. She immediately arranged for Mrs A to be transferred to xx either for delivery, monitoring and delivery, or monitoring and Caesarean section.

5.1.13 **DR** H also gave evidence that, as a general practitioner in xx, she felt constrained about making a diagnosis of foetal distress to xx Hospital staff and that she expected that Mrs A would be assessed and monitored at xx. Unless there was some event requiring urgency, (Dr H gave post-partum haemorrhage or a prolapse cord as examples) which would necessitate the preparation of a theatre to receive the patient being transferred, xx Hospital staff would monitor the patient and make their own assessment of what is required.

5.1.14 **IT** was also Dr H's understanding that the patient records would accompany the patient being transferred and she could give no explanation for why that did not happen in this case.

5.2 DR SPEED:

5.2.1 **FOR** the respondents, Dr R A Speed, a specialist obstetrician and gynaecologist made a number of general comments regarding the management of Mrs A's pregnancy and labour. In particular, Dr Speed noted in relation to Dr H's care of Mrs A that the appropriate antenatal care with specialist involvement was given. Dr Speed considered that Dr H's conduct in relation to the onset of labour managed at xx Hospital was

appropriate. Dr H examined Mrs A appropriately, and "in fact without a CTG did well to identify foetal distress". However, whilst transfer to xx Hospital was arranged by Dr H, this was done "without any apparent sense of urgency or direct doctor to doctor communication".

5.2.2 **HOWEVER**, Dr Speed went on to comment, there was "a theme of lack of urgency" from the point at which foetal distress was identified. Dr Speed pointed out that a diagnosis of IUGR had been missed by all of Mrs A's attending clinicians. Dr Speed noted that a growth retarded foetus is more prone to foetal distress and hypoxia in labour than one that has grown normally.

5.2.3 **IN** relation to Dr G's role, it was Dr Speed's evidence that "clearly he should have recommended Caesarean section when he first assessed Mrs A. The assessment of the foetal heart tracing as probably being related to opiates was incorrect (opiates may cause a flat tracing but <u>not</u> late decelerations, which usually indicate hypoxia)".

5.2.4 **HOWEVER**, Dr Speed went onto note that there was apparently no concern expressed by any of the nursing staff and, in his opinion, a competent midwife should have questioned Dr G's assessment, "particularly as he was GP obstetrician and not a specialist".

5.2.5 **ON** the issue as to whether or not Dr G ought to have artificially ruptured membranes at the time he first examined Mrs A (2 pm), both experts for the CAC and for the

respondents agreed. Rupturing of the membranes at the time of the initial assessment might have shown meconium stained liquor and led to a different decision.

5.2.6 **NOTWITHSTANDING** that the foetal heart pattern remained abnormal throughout the afternoon, no attempt was made to notify Dr G until meconium stained liquor was made evident by the spontaneous rupture of membranes at 4.55 pm. In Dr Speed's view, Dr G should have reassessed Mrs A during the afternoon.

5.2.7 **HOWEVER**, Dr Speed also went on to express his opinion that, as a GP obstetrician only, Dr G "should not have been placed in a position where he had to manage such a high risk case". Dr Speed was critical of the system of obstetric cover at xx at the time. It was his belief that the system was flawed and complications such as occurred in this case were inevitable. However, it was Dr Speed's conclusion that Dr G could reasonably have been expected to identify foetal distress and, presumably, having made that diagnosis, to have managed Mrs A's care appropriately, and with the proper degree of urgency which the situation clearly required.

6. SUBMISSIONS ON THE CHARGES LAID:

6.1 **BOTH** counsel made submissions as to the grounds upon which a medical practitioner might be disciplined under the Medical Practitioners Act 1995 ("the Act"). For the CAC, Mr Harborne accepted that the burden of proof was borne by the CAC and that the standard is the civil standard, the balance of probability, recognising that the level of proof required will vary according to the seriousness of the charges faced by the practitioner - the more serious the charge or charges, the higher the standard which must be met.

6.2 **AS** to the level of misconduct present in this case, it was Mr Harborne's submission that Dr H failed to recognise the warning signs of mild, but persistent, PET, and therefore failed to act in circumstances where she should have acted. Although there was no consensus of what ought to have been done, there was, in Mr Harborne's submission, a measure of agreement between the experts giving evidence that admission to xx Hospital on Friday 28 September 1990 would have been prudent. Dr H failed to realise that there was any risk to C A as a result of mild toxaemia present in the mother. On the Saturday morning when Mrs A presented at xx in labour, there was no immediate recognition on the part of Dr H of what she was dealing with. Dr H merely passed Mrs A on for monitoring, and failed to ensure that her notes, particularly the notes of her examination of Mrs A at xx Hospital, accompanied her to xx. Notwithstanding that Dr H was a GP, nevertheless she held herself out as having skill and expertise in obstetrics and she deferred too long in taking appropriate steps to ensure the safety of both Mrs A and her baby.

6.3 **IN** Mr Harborne's submission, Dr H's conduct was not disgraceful; the Tribunal might consider it professional misconduct; but it was certainly conduct unbecoming. Mr Harborne referred to the re-wording of "conduct unbecoming" in the new Act, and to the requirement that it be "conduct unbecoming which reflects adversely on the practitioner's fitness to practise medicine". Mr Harborne noted that in this case, both practitioners have indicated, indeed assured, the Tribunal that they no longer practise obstetrics, and have no intention of practising obstetrics in the future.

6.4 **IN** respect of Dr G, Mr Harborne noted that Dr G had given very candid evidence. He was contrite and clearly distressed by the outcome of this delivery. However he had undertaken some specialist training in obstetrics and, whilst he was capable of, and responsible for, making his own

assessment of the situation, nevertheless he could have telephoned Dr H to discuss her reasons for transferring Mrs A to xx Hospital. Both experts had indicated that it would have been prudent for Dr G to have artificially ruptured the membranes as a minimum measure and this might have led to a much speedier delivery and an improved outcome.

6.5 **IT** was Mr Harborne's submission that Dr G was guilty of professional misconduct as his care and treatment of Mrs A had fallen substantially below the level of his peers, i.e. general practitioners with a diploma in obstetrics.

6.6 **FOR** the respondent practitioners, Mr Knowsley submitted that both were in a difficult position with little back up available to them, in particular, Dr H was lulled into a false sense of security by the specialist reports she received during Mrs A's pregnancy.

6.7 **FOR** Dr G Mr Knowsley indicated that he accepted that there were shortcomings in his care and treatment of Mrs A and he left it to the Tribunal to determine the level of misconduct.

6.8 **FOR** Dr H Mr Knowsley made no such concessions and it was his submission that Dr H did well to diagnose foetal distress and acted appropriately in immediately arranging for Mrs A's transfer to xx Hospital.

7. THE FINDINGS - DR H:

7.1 **DR** H was charged, pursuant to Section 93(1)(b) of the Act, that on or about 28 September 1990 at xx, in the course of her management of A failed to recognise the significance and therefore to act on the deteriorating Gestational Proteinuric Hypertension. At the hearing some

discussion arose to a possible amendment of the charge to specifically refer to the events of 29 September 1990 however Mr Knowsley, quite properly in the Tribunal's view, accepted that the charges intended to encompass the totality of Mrs A's care on 28 and 29 September 1990.

7.2 **WHAT** went wrong? It was Dr H's evidence that the reason why Mrs A was referred to the specialist obstetrician was her previous heart condition. The repeat visits to the obstetrician apparently occurred only because it was usual to repeat visits if a patient had been referred to a specialist early in the pregnancy. Dr H's treatment of Mrs A evidences no particular concerns for either Mrs A or her baby in the sense that any 'proactive' treatment was initiated, or any management plan put in place, notwithstanding either Mrs A's admission to hospital before oedema in July 1990; her persistent raised BP; or the proteinurea traces recorded at antenatal visits.

7.3 **MRS** A's treatment by both Dr H and subsequently by Dr G is characterised by an absence of any sense of urgency, or indeed any real awareness of the potential risks either to Mrs A or to her baby.

7.4 **RIGHTLY** or wrongly, Dr H was clearly influenced by the specialist obstetrician's reports of "all well" and, with the benefit of hindsight, was lulled into a false sense of security. However, in the Tribunal's view, whilst that might excuse her conduct of Mrs A's pregnancy up to 28 September 1990, at least at that visit Dr H ought to have been alert to the warning signs which were clearly evident in Mrs A's, by then, full term pregnancy.

7.5 **EVIDENCE** of the absence of any sense of risk for Mrs A, or perhaps most significantly for her baby, on the part of Dr H is demonstrated by the fact that Dr H saw Mrs A on a Friday afternoon, at a time when there were no laboratory facilities available, nor any facilities available at xx if events took a turn for the worse over the weekend. Dr H treated Mrs A's consultation on the Friday afternoon as a routine antenatal visit and merely noted that she would see Mrs A again one week later.

7.6 **ALTHOUGH** Dr H said in evidence that she had second thoughts about this overnight and she intended to recall Mrs A on Monday, on Saturday when she was advised by xx Hospital that Mrs A had been admitted in labour, and that her BP was raised to 160/100 with ++ proteinurea, her response does not indicate any suggestion that her overnight thoughts resulted in any heightened sense of risk or danger on her part notwithstanding an evident deterioration in Mrs A's clinical signs overnight.

7.7 **DR** H did not contact xx Hospital to ensure that Mrs A had arrived safely or to inquire into whose care she had been placed. Notwithstanding her own diagnosis of "foetal distress" at 11 am, there is no evidence that Dr H communicated any sense of immediacy or urgency (or even this diagnosis) either to Mr or Mrs A; the midwife who accompanied Mrs A to xx Hospital; the ambulance service, or to xx Hospital.

7.8 **SADLY**, both Mr and Mrs A were left only with the impression that Mrs A was being sent to xx for further monitoring and because she would have better facilities available for her in xx should further action prove necessary. The fact that they were not given any explanation or details as to the potential seriousness of Mrs A's condition, or PET generally, or that their baby

was in distress, meant that they were unable to assist Dr G, who received Mrs A without any records or notes, and they were thus completely in the hands of the practitioners and nurses caring for Mrs A.

7.9 **IT** is the Tribunal's decision that the care and treatment given to Mrs A by Dr H was deficient in that the lack of information or any management plan meant that neither Mr or Mrs A were put in a position where they could have been alerted to the potential risk for their child. C A was, for all practical purposes, left to her own devices and the signs which were signalled to, and recognised by, both doctors were ignored. As a result, C was tragically born asphyxiated and brain damaged with permanent consequences for her and her family.

7.10 **IT** is the Tribunal's finding that Dr H failed to put in place any sufficient management plan and failed to plan for Mrs A's continuing care either as a result of her examination of Mrs A on 28 September 1990, or on 29 September 1990 after Mrs A presented at xx Hospital in labour.

7.11 **THE** Tribunal is of the view that, at minimum, Dr H's management of Mrs A should have included her contacting xx Hospital to inquire into whose care she was placed and to speak directly to that doctor. Dr H appears simply to have assumed that the midwife who accompanied Mrs A to xx Hospital would have passed on the relevant information to the doctor and nursing staff taking over her care. It is the Tribunal's finding that a reasonable and prudent practitioner, with obstetrical experience, ought to have recognised the significance of the relatively "soft" clinical signs and acted accordingly. Dr H did not recognise the stage at which intervention in the interests of the child was required. It appears to the Tribunal that Dr H, whilst she possessed technical expertise, did not bring to bear any, or any sufficient, clinical judgement in the sense of

applying the clinical information she obtained to a total clinical context and to the formulation of a plan for the management of her patient.

7.12 **ACCORDINGLY**, the Tribunal finds that the charge against Dr H is upheld at a level of conduct unbecoming a medical practitioner which reflects adversely on the practitioner's fitness to practise medicine.

8.0 FINDINGS - DR G:

8.1 **DR** G fairly conceded shortcomings and the Tribunal considers that concession properly made. Dr G, as a general practitioner with a diploma in obstetrics should have been able to recognise the CTG tracing for what it was. At a minimum, Dr G should have artificially ruptured membranes when he saw Mrs A at 1400 hours. The Tribunal accepts Dr Court's evidence that, given the combination of clinical indicators - proteinurea, raised BP and the CTG abnormalities - ARM was mandatory.

8.2 **IT** was not beyond the competence of a reasonable and prudent general practitioner, with an additional obstetrical qualification, to have recognised and assessed Mrs A's situation and, if that had been done, it seems clear that an urgent Caesarean section would have occurred. An ARM, in the circumstances which presented, was not a difficult or demanding task in terms of time or expertise. Additionally, whether or not Dr G was in possession of Mrs A's records when he initially examined her, he was responsible for making his own assessment of her situation on the basis of the clinical facts he ascertained and identified at the time. The CTG showed clear abnormalities and an ARM was indicated even if only to support, or discount, Dr G's assessment

that the CTG abnormalities were most likely caused by the sedation given to Mrs A earlier in the day.

8.3 **THE** Tribunal also accepts the expert evidence that Dr G was placed in a difficult position in that he was the on-call general practitioner covering xx and xx, and in the absence of the xx Hospital's only specialist obstetrician. Nevertheless, Dr G did possess the additional qualification of diploma in obstetrics and apparently did not consider it necessary to seek any assistance or advice from a specialist obstetrician available either at xx or xx Hospitals. Neither did Dr G apparently think it necessary to contact Dr H, Mrs A's primary care giver and the practitioner responsible for transferring Mrs A into his care.

8.4 **THE** Tribunal finds that Dr G, in the course of his management of A:

(1) Failed to recognise the significance of the abnormal CTG trace.

(2) Significantly delayed in initiating steps to deliver the baby after its initial assessment of the patient.

Accordingly the Tribunal finds that the charge is upheld and constitutes professional misconduct on the part of Dr G.

9. PENALTY

9.1 **THE** charges having been upheld, the Tribunal invites submissions from counsel as to penalties. The timetable for making submissions will be as follows:

9.1.1 **COUNSEL** for the CAC should file submissions with the Secretary and serve a copy on counsel for the respondent not later than 24 October 1997 (10 working days from the date of Counsel for the CAC's return to New Zealand from overseas.

9.1.2 **IN** turn counsel for the respondent should file submissions in reply with the Secretary and serve a copy on counsel for the CAC not later than 10 working days from receipt of the CAC counsel's submissions.

9.2 **THE** Tribunal wishes counsel to know that, given that both respondent doctors are no longer practising obstetrics, the Tribunal is minded to make orders that the names of the respondent doctors not be published and invites counsel to address this aspect in their further submissions.

DATED at Auckland this 12th day of September 1997

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W N Brandon

Chairperson

Medical Practitioners Disciplinary Tribunal