MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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PUBLICATION OF THE NAME OF THE DOCTOR AND ANY DETAILS WHICH MAY IDENTIFY THE DOCTOR IS PROHIBITED	**DECISION NO:**	268/03/108D
	IN THE MATTER	of the Medical Practitioners Act 1995
		-AND-
	IN THE MATTER	of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against, B medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chair)

Dr F E Bennett, Mrs J Courtney, Dr A A Ruakere, Dr J L Virtue (Members)

Ms K L Davies (Hearing Officer)

Mrs G Rogers (Stenographer)

Hearing held at Napier on Wednesday 8, Thursday 9 and Friday 10 October 2003

APPEARANCES: Mr M Heron for the Director of Proceedings; and

Mr H Waalkens and Ms C Garvey for Dr B

Introduction

1. Doctor B is a general medical practitioner in xx. On 5 June 2003 the Director of Proceedings laid a disciplinary charge against Dr B. The particulars of the charge are explained in paragraphs 4 and 5 of this decision.

2. The charge was heard in Napier on 8, 9 and 10 October 2003. The Tribunal endeavoured to reach a decision on the afternoon of 10 October before counsel for Dr B and the Director of Proceedings left Napier. The Tribunal was unable to reach its decision in relation to all particulars of the charge that afternoon. There have been regrettable delays which have precluded the Tribunal reconvening to determine the outcome of the charge. The Tribunal unreservedly apologises to Dr B and the family and friends of the late Ms A who have been waiting for the Tribunal's decision.

3. The Tribunal has now determined that two particulars of the charge (namely particulars 2 and 3) have been established as professional misconduct when considered cumulatively. The Director of Proceedings is invited to make submissions in relation to penalty and name suppression by 23 January. Counsel for Dr B should file his submissions on penalty and name suppression by 5 February 2004. If those dates cause difficulty for either counsel they may apply to the Tribunal for extensions of the timetable set by the Tribunal.

The Charge

4. The allegations relate to the way Dr B provided services to Ms A on 8 and 9 August 2001. There are four particulars to the charge, namely:

> *"1. At Ms A's second consultation in the afternoon of 8 August 2001 [Dr B] failed to:*
>
> *1.1 Undertake an adequate clinical assessment and/or clinical examination of ... A; and*
>
> *1.2 Ensure adequate investigations were undertaken to determine the cause of Ms A's clinical presentation;*
>
> *AND/OR*
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> *2. When consulted by Ms A by telephone on 9 August 2001 [Dr B] failed to arrange and/or undertake an adequate re-assessment of Ms A's clinical condition;*
>
> *AND/OR*
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> *3. On 9 August 2001, in the absence of an adequate clinical examination and/or re-assessment of Ms A's clinical condition [Dr B] prescribed a change of her medication by telephone;*
>
> *AND/OR*
>
> *4. Between 8 and 9 August 2001 [Dr B] failed to adequately document the clinical consultations with Ms A."*

5. The Director of Proceedings alleges the particulars of the charge either separately or cumulatively amount to professional misconduct.

Summary of the Evidence

6. Ms A was a high user of health services. She had a number of medical problems which caused her to attend upon doctors on a very regular basis. It is not necessary to traverse all of Ms A's medical history. Suffice to say that at the time of the events giving rise to the

charge Ms A was 50 years old and had suffered a wide variety of medical problems. Ms A passed away in the early hours of 10 August 2001.

7. On 7 August 2001 Ms A formally registered as a patient at "xx" in xx. She had however attended "xx" on approximately 140 dates during the 6½ years prior to her formally becoming a patient of "xx". Prior to transferring to "xx" Ms A had been a patient of another practice in xx. When Ms A transferred to xx she became a patient of Dr B.

8. Doctor B commenced working at "xx" in xx. She first saw Ms A on 25 May 2001 in relation to arthritic pain in her neck. Doctor B saw Ms A again on 19 July when she presented with lesions on an arm and shoulder.

9. On the morning of 8 August 2001 Ms A went to "xx". She lived near the practice. General estimates suggested it would take her no more than 7 minutes to walk to the practice.

10. Ms A saw Dr B who presented with pain in her rib area when breathing deeply. According to members of Ms A's family she was feeling very unwell. Her family said she was having trouble breathing and suffered from hot and cold sweats. When Ms A arrived at "xx" she was triaged by nursing staff. Doctor B conducted an examination and concluded that Ms A's lungs were clear on auscultation and that she was not suffering respiratory distress. Doctor B believed Ms A in all likelihood had pleurisy. Panadeine was prescribed together with Diazepam to help Ms A sleep.

11. Ms A returned home. Later, during the afternoon of 8 August she returned to "xx". Ms A was given a ride to the surgery by a friend who described her as moaning with pain, gasping for breath and holding her chest.

12. When Ms A returned to "xx" on 8 August she was again seen by Dr B after being triaged by nursing staff.

13. In her evidence Dr B said that Ms A had not been able to keep down the Panadeine which had been prescribed that morning. Doctor B believed that aside from having vomited as a

consequence of taking Panadeine Ms A was not in distress. Doctor B arranged for a nurse to administer Maxolon 10mg intramuscularly and requested that Ms A remain under observation in the nursing area of the surgery for 20 minutes. After having been observed for 20 minutes Dr B said Ms A could go home.

14. The evidence called by the Director of Proceedings was that on the morning of 9 August Ms A continued to be very unwell and complained of difficulties with her lungs. Ms A telephoned Dr B. There is a dispute about whether or not Ms A refused to return to the surgery. That issue is considered later in this decision. Suffice to say for present purposes Dr B changed Ms A's prescription by increasing the dose of Diazepam and also prescribing Tramadol. There was no dispute Dr B relied on her telephone assessment of Ms A when changing her patient's medication.

15. Later on 9 August Ms A's partner collected the medication which Dr B had prescribed. Ms A went to bed. Later she collapsed in the hallway when returning to her bedroom from the toilet. She got back into bed but during the early hours of 10 August she passed away.

16. A post mortem conducted on 13 August 2001 concluded that Ms A had died as a result of succumbing to pneumonia, in the upper lobe of her right lung.

Summary of Case for Director of Proceedings

17. It is convenient to summarise the evidence relied upon by the Director of Proceedings under the following headings:

    17.1 Observations of Ms A's family and friends;

    17.2 Facilities available at "xx";

    17.3 Expert opinions.

Observations of Ms A's family and friends

18. The Director of Proceedings adduced evidence from Ms C. She was a niece of Ms A. Ms C visited her Aunt on 8 August after Ms A's first visit to Dr B that day.

19. Ms C told the Tribunal that when she saw Ms A at about 10am on 8 August her Aunt:

> *"…had a lot of pain in her ribs, she was leaning over holding her ribs, making a 'aagh' noise … she was having hot and cold sweats, she was out of breath and she was clearly not right, she was finding it hard to breathe."*[1]

20. Ms C telephoned Ms A on 9 August at about 10am. According to Ms C her Aunt was:

> *"…making no sense whatsoever …she sounded out of breath and [she] had to ask her to repeat things three or four times."*[2]

Ms C said she told her Aunt to return to "xx" and that the response was Ms A's partner had also told her to return to "xx". Ms C knew her Aunt well and said she would have not hesitated to go to "xx" if she had been asked.

21. Mr D explained that he saw Ms A walking to "xx" on the afternoon of 8 August. He gave her a ride in his car and said Ms A:

> *"… managed to get into the car OK, but was moving with pain. She was making "aagh" noises and gasping for breath. She seemed to be in a lot of pain."*[3]

22. Ms A's partner, Mr E gave evidence. Mr E said he took Ms A home from "xx" on the afternoon of 8 August, and that although she was not feeling very well, Ms A slept "OK" that night.

23. Mr E told the Tribunal that the next day Ms A was able to walk but said that she felt as if her lung had collapsed. Mr E went to work. When he returned home he went and got Ms

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[1] Evidence of C paragraph 2
[2] Evidence of C paragraph 4
[3] Evidence of D paragraph 3

A's new medication from the Pharmacy. That evening Ms A went to bed but collapsed when returning to her bedroom from the toilet. Later that night he noticed his partner was not breathing. He telephoned an ambulance but unfortunately Ms A had passed away. Mr E said Ms A was fastidious about going to doctors and that she never missed a medical appointment. Mr E told the Tribunal that:

> *"Anything a doctor said [Ms A] had to do, she did it."*[4]

24. The Director of Proceedings also presented evidence from an employee of the Office of Health and Disability Commissioner who conducted inquiries into Dr B's treatment of Ms A. As part of those inquiries the Commissioner's office employee spoke to Mr A, the brother of Ms A. Unfortunately Mr A died on 3 August 2003. The Director of Proceedings produced file notes recording Mr A's comments to the Health and Disability Commissioner's office. Unfortunately because Mr A's evidence could not be tested the Tribunal has not been able to place weight on the file notes of his interview.

Facilities available at "xx"

25. The Director of Proceedings called Dr F, the General Manager of "xx". Dr F explained to the Tribunal that:

> *"Dr B elected not to obtain an x-ray of Ms A on 8 August. X-ray facilities [were] available at "xx" in [the] upstairs Radiology Department".*[5]

Doctor F thought Dr B's decision not to x-ray Ms A on 8 August was attributable solely to Dr B's own clinical judgment.

26. Dr F also explained that:

> *" 'xx' offered transport services for patients unable to get to the clinic on their own. ... If Ms A or her family members had expressed a desire for a home visit, this would have been arranged for them."*[6]

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[4] Evidence of E paragraph 9
[5] Evidence of F paragraph 5

27. In relation to the telephone consultation on 9 August Dr F said:

> *" 'xx' does not endorse the practice of giving consultation advice over the phone, as Dr B did on this occasion, and we certainly do not recommend the changing of prescriptions over the telephone without inviting the patient in for a consultation."*[7]

Expert Opinions

28. The Director of Proceedings called expert evidence from Dr Jeffrey Garrett, a respiratory physician at Middlemore Hospital in Auckland. Doctor Garrett is also Clinical Director of Medicine at Middlemore. Dr Garrett's opinion was partially based on the description of Ms A on 8 and 9 August as provided by her family and friends. Doctor Garrett thought their descriptions suggested Ms A suffered a lower respiratory tract infection and were entirely consistent with the post mortem findings of right upper lobe pneumonia. Doctor Garrett said in his evidence in chief:

> *"… a patient presenting with these symptoms would warrant further investigation with a chest x-ray and full blood count".*[8]

Doctor Garrett was critical of Dr B's decision to prescribe Tramadol on 9 August which he described as:

> *"…a second or third line pain relief medication [that] should not be used without careful thought and a thorough clinical assessment, particularly in a patient complaining of pleuritic pain."*[9]

29. The final witness called by the Director of Proceedings was Dr C Wright, a general practitioner in Lower Hutt. Doctor Wright has been a general practitioner since 1986. He is a Fellow of the Royal New Zealand College of General Practitioners.

30. Doctor Wright was "moderately" critical of the level of examination Dr B provided Ms A on her first visit to "xx" on 8 August. It is not necessary to repeat Dr Wright's concerns

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6 Evidence of F paragraph 7
7 Evidence of F paragraph 8
8 Evidence of J Garrett paragraph 4
9 Evidence of J Garrett paragraph 5

about the first consultation as the first visit was not the subject of the charge brought by the Director of Proceedings.

31. Doctor Wright was concerned about the level of care provided to Ms A on her second visit to "xx" on 8 August. Doctor Wright said:

> *"… it is always important to re-examine or re-consider the original diagnosis when a patient re-attends. However Ms A was given only symptomatic treatment of her vomiting without a re-assessment."*[10]

32. Doctor Wright told the Tribunal that it is common for doctors to conduct telephone consultations. He emphasised however that telephone consultations are fraught with difficulty. Doctor Wright was concerned Dr B had failed to recognise Ms A's vomiting on 9 August was due to a progressing illness. Doctor Wright thought that if Dr B failed to ask Ms A to return to the clinic on 9 August then her omission would be a serious departure from appropriate standards of care.

Summary of Evidence for Dr B

33. Doctor B explained that after qualifying xx from xx in xx she practised principally in xx before she and her husband decided to move to xx. Doctor B commenced working at "xx" on xx.

34. Although Dr B had access to Ms A's notes held by "xx" she had no opportunity to review those notes when she saw Ms A on the morning of 8 August 2001.

35. When Ms A presented on the morning of 8 August she was triaged by nursing staff. She said that nurses took Ms A's temperature, pulse rate and measured her oxygen saturation. The nurses practice was to write these details on a piece of paper or tell the doctor the results (but not enter them in the patient's notes). When Dr B saw Ms A she determined the patient's:

35.1 Lungs were clear on auscultation and that she was;

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[10] Evidence of C Wright paragraph 18

35.2 Not coughing or afebrile; or

35.3 In any respiratory distress.

Doctor B also observed Ms A was speaking full sentences (an indication the patient was not suffering respiratory distress). Doctor B's diagnosis was that Ms A was in all likelihood suffering pleurisy. Oral Panadeine was prescribed as were two Diazepam to help Ms A's sleep.

36. When Ms A returned to 'xx" later on 8 August she was again triaged by nursing staff. Doctor B said that Ms A did not tell her she had deteriorated in any way. Ms A's only concern since seeing Dr B earlier that day was that she had vomited. This was attributed to the Panadeine Ms A had taken. Doctor B said in her evidence in chief:

> *"Ms A was not in distress (respiratory or otherwise) in the surgery and she was not vomiting or coughing … and she was not leaning over as if in pain."*[11]

Doctor B explained she felt Ms A's forehead and that there was no indication of fever. Doctor B attributed Ms A's vomiting to the codeine in the Panadeine and accordingly asked a nurse to administer Maxolon 10mg intra-muscularly. Doctor B instructed that Ms A be observed for 20 minutes in the nursing bay area after the Maxolon had been administered. After the 20 minute observation period had passed Dr B was told by a nurse that Ms A had not deteriorated or vomited. Doctor B then told Ms A she could go home. Oral Maxolon was prescribed with the instruction that it be taken before Panadeine to prevent vomiting. So far as Dr B was concerned Ms A's condition had not changed since seeing her that morning (other than vomiting).

37. Doctor B told the Tribunal that when Ms A telephoned her on 9 August she said that she had not slept well the night before and that she was continuing to vomit. Doctor B formed the "impression" that Ms A was:

> *"…alert and orientated … speaking full sentences."*[12]

Doctor B said Ms A did not sound "winded" and she thought her patient had no difficulty breathing.

38. Doctor B told the Tribunal that she encouraged Ms A to return to the surgery but Ms A said:

> *"…she could not afford to."*[13]

Doctor B said she told Ms A not to worry about payment but that it became:

> *"…apparent that [Ms A] was not going to attend the surgery."*[14]

39. Doctor B decided to change Ms A's medication. She did so on the basis of the assessment she made while talking to her patient over the telephone. Doctor B said Ms A requested a repeat of the Diazepam prescribed the previous day because she had experienced difficulty sleeping. Ms A also told Dr B she had continued to vomit. Doctor B told the Tribunal that her assessment of Ms A on the morning of 9 August was:

> *"… unchanged and that she said she had vomited the medication and had trouble sleeping."*[15]

In these circumstances Dr B thought it appropriate to re-prescribe Diazepam (at a higher dose) and issue a prescription for Tramadol.

40. Doctor B rejected the Director of Proceedings' claim that she had failed to adequately document her clinical consultations with Ms A on 8 and 9 August 2001. She told the Tribunal that her notes accurately recorded the patient's presentation and symptoms. Doctor B accepted that her

> *"… notes could have been more thorough."*[16]

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[11] Evidence of B paragraph 21
[12] Evidence of B paragraph 31
[13] Evidence of B paragraph 33
[14] Evidence of B paragraph 33
[15] Evidence of B paragraph 40

but that when viewed in context her notes were adequate.

41. The notes made by Dr B on 8 and 9 August were made available to the Tribunal. They read:

"8 August 2001	*Dx: pleurisy*
8 August 2001	*Rx: 50 panadeine cap 2, Four times daily*
8 August 2001	*IMM: Maxolon injection – G – 22g, im. 20/60 wait* *Rx: 2 – Diazepam Tab 2mg – 1 tab in the evening* *Rx: 15 – Maxolon Tab 10 mg – 1 tab, Three times Daily as ne [needed]* *second visit can't keep med down because it causes her to vomit maxaalon 10mg im* *no vomiting*
8 August 2001	*pain with deep inspiration/recent cold* *phys alert 98% chest r lower lung tender to palp are lungs cta 1 panadiene*
9 August 2001	*vomitting up panadiene/not sleeping* *Rx: 5 – Diazepam tab 5mg – 1 tab, In the Evening* *Rx: 10 – Tramal 50mg Cap – 1-2 tabs two to Three times Da"* [daily]

42. Doctor B conveyed her genuine remorse over Ms A's death and that she had not diagnosed the fact her patient was suffering pneumonia. Doctor B said if she had thought:

> *"…Ms A was as unwell as transpired, [she] would not have hesitated in arranging her admission to hospital. … and that she … simply did not suspect that [Ms A] was suffering from anything other than pleuritic pain and certainly not pneumonia."*[17]

43. Doctor B called Dr Thomas Marshall as an expert witness. Doctor Marshall is one of New Zealand's most senior and respected general practitioners. His qualifications and credentials include Fellowship of the Royal New Zealand College of General Practitioners, Fellowship of the New Zealand Medical Association and an OBE for Services to

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[16] Evidence of B paragraph 44

[17] Evidence of B paragraph 50

Medicine and the Community. In addition to having practised medicine for more than 35 years Dr Marshall is also an Honorary Clinical Associate Professor in the Department of General Practice and Primary Healthcare at the University of Auckland Medical School.

44. In Dr Marshall's view Dr B could be excused for not conducting a full re-examination of Ms A when she presented on the second occasion on 8 August 2001. Doctor Marshall's reason for making this suggestion was that:

> *"Where a patient presents for a second time within a relatively short period of time and with a specific complaint (in this case vomiting related to the taking of Panadeine) this does not as a matter of course necessitate the practitioner conducting a full re-examination."*[18]

45. Doctor Marshall told the Tribunal that conducting a telephone consultation with a patient is a common occurrence in general practice, he added however:

> *"This is not an ideal practice … but it happens."*[19]

46. Doctor Marshall also thought it reasonable for Dr B to change Ms A's medication over the telephone in circumstances where the patient refused to go to the doctor's clinic.

47. Doctor Marshall thought that Dr B's notes were:

> *"…not as full as they ought to be".*[20]

but that in the circumstances of a busy practice they were excusable.

48. Overall, Dr Marshall thought Dr B acted reasonably in her treatment of Ms A. He told the Tribunal pneumonia is difficult to diagnose and that Dr B's observations of her patient:

> *"…were not highly suggestive of pneumonia"*[21]

and that Dr B should not be criticised for not prescribing antibiotics.

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[18] Evidence of T Marshall paragraph 11
[19] Evidence of T Marshall paragraph 17

Evaluation of Evidence

49. In assessing the accuracy of the evidence of witnesses of fact the Tribunal is mindful that the events under scrutiny occurred a little over 2 years ago. It is natural that with the passage of time memories fade and recollections can become distorted. The Tribunal is also aware that Ms A's death on 10 August 2001 was a great shock to her family, friends and Dr B. The tragic death of Ms A may well have affected the ability of some witnesses to fully recall the events of 8 and 9 August. In making these observations the Tribunal accepts every witness endeavoured to honestly and accurately recall the events they had observed. No witness deliberately attempted to distort the truth.

50. It is important to focus on an aspect of Dr B's evidence which is important in the determination of the second and third particulars of the charge.

51. In her evidence in chief Dr B referred to her telephone consultation with Ms A on 9 August and said:

> *"I am certain that I told Ms A that she should come back to the surgery to see me. However, said she could not afford to. I said that it did not matter: she knew that I had not charged her for the previous two visits on 8 August and I told her that I would not charge if she came in again. I cannot recall what Ms A's response was, but it was apparent that she was not going to attend the surgery".*[22]

52. Doctor B's suggestion Ms A was reluctant to attend "xx" on 9 August because of financial concerns did not accord with the descriptions given to the Tribunal of Ms A by her family and friends. The Tribunal was in no doubt Ms A would have not hesitated to go to a doctor if she was able. Doctor B was questioned on her understanding of the telephone conversation she had with Ms A on 9 August and acknowledged that Dr B had <u>interpreted</u> Ms A's responses to her as meaning that she was unable to go the surgery because of financial considerations.[23] The Tribunal is certain Dr B mis-interpreted what Ms A told her on the morning of 9 August. The Tribunal is very confident Ms A was too ill to attend "xx"

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[20] Evidence of T Marshall paragraph 25
[21] Evidence of T Marshall paragraph 29
[22] Evidence of B paragraph 33

without assistance and that Dr B failed to fully appreciate the true reasons why Ms A appeared unable to go to the surgery.

Legal Principles

Onus and standard of proof

53. The allegations levelled against Dr B are serious. Accordingly the onus placed upon the Director of Proceedings to establish the charge requires a high standard of proof. The requisite standard of proof in medical disciplinary cases was considered by Jeffries J in *Ongley v Medical Council of New Zealand*[24] where the High Court adopted the following passage from the judgment in *Re Evatt: ex parte New South Wales Bar Association*[25]

> *"The onus of proof is upon the Association but is according to the civil onus. Hence proof in these proceedings of misconduct has only to be made upon a balance of probabilities; Rejfek v McElroy.*[26] *Reference in the authorities to the clarity of the proof required where so serious a matter as the misconduct (as here alleged) of a member of the Bar is to be found, is an acknowledgement that the degree of satisfaction for which the civil standard of proof calls may vary according to the gravity of the fact to be proved".*

54. The same observations were made by a full bench of the High Court in *Gurusinghe v Medical Council of New Zealand*[27] where it was emphasized that the civil standard of proof must be tempered "having regard to the gravity of the allegations". This point was also made by Greig J in *M v Medical Council of New Zealand (No.2)*[28]:

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

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23 Transcript p.110 l. 10-12
24 (1984) 4 NZAR 369
25 (1967) 1 NSWLR 609
26 [1966] ALR 270
27 [1989] 1 NZLR 139 at 163
28 Unreported HC Wellington M 239/87 11 October 1990

55. In *Cullen v The Medical Council of New Zealand*[29] Blanchard J adopted the directions given by the legal assessor of the Medical Practitioners Disciplinary Committee on the standard required in medical disciplinary fora.

> *"The MPDC's legal assessor, Mr Gendall correctly described it in the directions which he gave the Committee:*
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> *'[The] standard of proof is the balance of probabilities. As I have told you on many occasions, ... where there is a serious charge of professional misconduct you have got to be sure. The degree of certainty or sureness in your mind is higher according to the seriousness of the charge, and I would venture to suggest it is not simply a case of finding a fact to be more probable than not, you have got to be sure in your own mind, satisfied that the evidence establishes the facts".*

56. In this case where the Tribunal has made a finding adverse to Dr B and has done so because the evidence satisfies the tests as to the onus and standard of proof set out in paragraphs 53 and 55 of this decision. Indeed, in relation to particulars 2 and 3 the Tribunal believes the evidence against Dr B is compelling.

<u>Professional Misconduct</u>

57. In recent years, those attempting to define professional misconduct have invariably commenced their analysis by reference to the judgment of Jefferies J in *Ongley v Medical Council of New Zealand*[30]. In that case his Honour formulated the test as a question:

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

58. In *Pillai v Messiter* [No.2][31] the New South Wales Court of Appeal signalled a slightly different approach to judging professional misconduct from the test articulated in *Ongley*.

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[29] Unreported HC Auckland 68/95, 20 March 1996

[30] supra.

[31] (1989) 16 NSWLR 197.

In that case the President of the New South Wales Court of Appeal considered the use of the word "misconduct" in the context of the phrase "misconduct in a professional respect". In his view, the test required more than mere negligence. At page 200 of the judgment Kirby P. stated:

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

59. In *B v The Medical Council*[32] Elias J said in relation to a charge of "conduct unbecoming" that:

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

Her honour then proceeded to state:

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

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

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

[32] Unreported HC Auckland , HC11/96, 8 July 1996

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

60. In *Staite v Psychologists Board*[33] Young J traversed recent decisions on the meaning of professional misconduct and concluded that the test articulated by Kirby P in *Pillai* was the appropriate test for New Zealand.

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

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

62. In *Tan v Accident Rehabilitation Insurance Commission*[34] Gendall and Durie JJ considered the legal test for "professional misconduct" in a medical setting That case related to a doctor's inappropriate claims for ACC payments. Their Honours referred to *Ongley* and *B v Medical Council of New Zealand.* Reference was also made in that judgment to *Pillai v Messiter* and the judgment of Young J in *Staite v Psychologists Registration Board.*

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

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

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[33] (1998) 18 FRNZ 18.

[34] (1999) NZAR 369

> *be especially the case if such claims are regularly made so as to disclose a pattern of behaviour".*

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

   - The first portion of the test involves an objective evaluation of the evidence and answer to the following question:

     Has the doctor so behaved in a professional capacity that the established acts and/or omissions under scrutiny would be reasonably regarded by the doctor's colleagues and representatives of the community as constituting professional misconduct?

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

65. The words "representatives of the community" in the first limb of the test are essential because today those who sit in judgment on doctors comprise three members of the medical profession, a lay representative and chairperson who must be a lawyer. The composition of the medical disciplinary body has altered since Jeffries J delivered his seminal decision in *Ongley*. The new statutory body must assess a doctor's conduct against the expectations of the profession and society. Sight must never be lost of the fact that in part, the Tribunal's role is one of setting standards and that in some cases the communities' expectations may require the Tribunal to be critical of the usual standards of the profession.[35]

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

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

67. In *McKenzie v MPDT*[36] Venning J endorsed the two question approach taken by this Tribunal when considering whether or not a doctor's acts/omissions constitute professional misconduct. The same judgment of the High Court cautioned against reliance in this country upon the recent judgment of the Privy Council in *Silver v General Medical Council*[37] In that judgment it was said the general Medical Council could take into account subjective factors relating to the circumstances in which a doctor practised when assessing whether or not the doctor should be held liable in respect of a disciplinary charge.

Conduct Unbecoming a Medical Practitioner

68. Mr Waalkens argued that if the Tribunal was minded to find Dr B liable then she should be found "guilty" of "conduct unbecoming" pursuant to s.109(1)(c) Medical Practitioner's Act 1995. Section 109(1)(c) of the Act refers to the offence of conduct unbecoming a medical practitioner which "reflects adversely on [their] fitness to practise medicine".

69. The Tribunal will briefly explain why it does not believe that it is appropriate to find Dr B guilty of conduct unbecoming a medical practitioner. By any objective assessment, Dr B's omissions in relation to the telephone consultation with Ms A on 9 August were such a serious departure from accepted standards that a finding of professional misconduct is warranted for the purpose of maintaining professional standards.

70. In deference to Mr Waalken's submissions, the Tribunal will also explain why it does not accept as a matter of legal principle his submission that a finding of conduct unbecoming is appropriate.

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[36] Unreported, High Court Auckland, CIV 2002-404-153-02, 12 June 2003, see also *F v MPDT* High Court Auckland, AP113/02, 20 November 2003, Frater J

[37] [2003] UK, PC33

71. The Tribunal acknowledges that conduct unbecoming was a "lesser form" of professional misconduct under the Medical Practitioners Act 1968.

72. The origins of the view that "conduct unbecoming" was a less serious version of "professional misconduct" under the 1968 Act can be traced back to comments made in Parliament when the Medical Practitioners Act 1968 was amended in 1979 to provide for the new disciplinary offence of conduct unbecoming a medical practitioner. The then Minister of Health, the Hon. E S F Holland said:

> *"The new clause 15B introduces a new charge of conduct unbecoming a medical practitioner, representing a complaint or charge of lesser seriousness than that of professional misconduct".*[38]

73. The view that "conduct unbecoming" was a less serious charge than "professional misconduct" also has its origins in the fact that when the Medical Practitioners Act 1968 was amended in 1979, Divisional Disciplinary Committees were empowered to hear charges of "conduct unbecoming a medical practitioner". The penalties which Divisional Disciplinary Committees could impose were confined to censure and costs. However, under the 1968 Act the Medical Practitioners Disciplinary Committee could hear charges of "conduct unbecoming a medical practitioner" as well as charges of "professional misconduct". As McGechan J pointed out in *Cullen v The Preliminary Proceedings Committee*[39] when the Medical Practitioners Disciplinary Committee heard a charge of conduct unbecoming a medical practitioner:

> *"The penalties for conduct unbecoming a practitioner and professional misconduct [were] exactly the same ... [and that] Parliament by the terms of the statute it passed envisaged the possibility of cases of 'conduct unbecoming a practitioner' so grave that the penalty imposed could equal the most serious available for professional misconduct".*

74. Aspects of the observations of McGechan J in *Cullen* are helpful in understanding the current statutory regime. Section 110 of the Act confers on the Tribunal exactly the same powers to penalise a doctor found guilty of "professional misconduct" as one who is found guilty of conduct unbecoming a medical practitioner.

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[38] New Zealand Parliamentary Debates Vol. 426 p.3524

[39] Unreported High Court Wellington AP 225/92, 15 August 1994

75. The legislative regime now in place portrays "conduct unbecoming a medical practitioner" as a disciplinary offence which parallels "professional misconduct". Parliament has created two categories of disciplinary offence in s.109(1)(b)and (c) of the Medical Practitioners Act 1995. The range of penalties for both offences is the same. If "conduct unbecoming" were still a less serious version of "professional misconduct" the range of penalties for both offences would not be identical. The language employed to describe the offence of "conduct unbecoming a medical practitioner" suggests that offence encompasses conduct by a doctor which falls outside the scope of a doctor's "professional" conduct. This interpretation is reinforced when account is taken of the way Parliament has now framed the charge of "conduct unbecoming a medical practitioner" to include the requirement the conduct must also "reflect adversely on the practitioner's fitness to practise medicine"[40]. The words "reflect adversely on the practitioner's fitness to practise medicine" suggest the conduct in question must be serious before a finding of "conduct unbecoming" should be made.

76. It is axiomatic that there must be a distinction between "professional misconduct" and "conduct unbecoming a medical practitioner". If there were no distinction s.109(1)(c) Medical Practitioners Act 1995 would be otiose. There is a distinction between "professional misconduct" and "conduct unbecoming a medical practitioner" but as McGechan J also noted in *Cullen*, the difference can at times "become a fine one". The distinction which does exist between "conduct unbecoming" and "professional misconduct" can be maintained by ensuring charges of "conduct unbecoming a medical practitioner" focus on allegations that extend beyond a doctor's "professional conduct". In this case the

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[40] The words "reflect adversely on the practitioner's fitness to practise medicine" have been commented upon in two District Court decisions: In *Complaints Assessment Committee v Mantell* (District Court Auckland, NP 4533/98, 7 May 1999) the Court said: *"The text of the rider in my view makes it clear that all that the prosecution need to establish in a charge of conduct unbecoming is that the conduct reflects adversely on the practitioner's fitness to practise medicine. It does not require the prosecution to establish that the conduct establishes that the practitioner is unfit to practise medicine. The focus of the enquiry is whether the conduct is of such a kind that it puts in issue whether or not the practitioner whose conduct it is, is a fit person to practise medicine... The conduct will need to be of a kind that is inconsistent with what might be expected from a practitioner who acts in compliance with the standards normally observed by those who are fit to practise medicine. But not every divergence from recognised standards will reflect adversely on a practitioner's fitness to practise. It is a matter of degree".*
In *W v Complaints Assessment Committee* (District Court Wellington, CMA 182/98, 5 May 1999) the Court said: *"It is to be borne in mind that what the Tribunal is to assess is whether the circumstances of the offence "reflect adversely" on fitness to practice. That is a phrase permitting of a scale of seriousness. At one end the reflection may be so adverse as to lead to a view that the practitioner should not practice at all. At the other end a relatively minor indiscretion may call for no more than an expression of disapproval by censure or by an order for costs".*

allegations focus on the way Dr B discharged her professional responsibilities to her patient, and accordingly it was appropriate she be charged with professional misconduct.

77. Mr Waalkens relied on *McKenzie v MPDT* in support of his submission. However, the High Court Judge did not refer to the Tribunal's interpretation of the meaning of conduct unbecoming in that decision, and there is nothing in that judgment which says the Tribunal's interpretation of sections 109(1)(b) and (c) of the Medical Practitioners Act is erroneous.

78. The Tribunal repeats, that even if its interpretation of the meaning of s.109(1)(c) is incorrect, it believes that Dr B's errors justify a finding of professional misconduct, even if it were possible to find a charge of conduct unbecoming a medical practitioner in the circumstances of this case.

Findings in relation to each particular of the charge

Particular One

During Ms A's second consultation in the afternoon of 8 August 2001 Dr B failed to:

> **1. Undertake an adequate clinical assessment and/or clinical examination of Ms A and/or**
>
> **2. Ensure adequate investigations were undertaken to determine the cause of Ms A's clinical presentation.**

79. The Tribunal has found in favour of Dr B in relation to this particular allegation. The Tribunal has some concerns about aspects of the way Dr B managed Ms A when she returned to "xx" on the afternoon of 8 August. However the Tribunal does not believe that any shortcomings that occurred that afternoon constituted a failure to adhere to the standards reasonably expected of a general practitioner in New Zealand.

80. The Tribunal was satisfied, after carefully evaluating Dr B's evidence that she carried out a reasonable examination of Ms A when she first saw her patient on the morning of 8 August. The Tribunal is also satisfied that Dr B considered the possibility Ms A may have been suffering pneumonia but was justified in opting for her diagnosis of pleurisy because:

> 80.1 Of the information which Dr B received from the triage nurses relating to Ms A's temperature, pulse, and oxygen saturations; and

80.2 Dr B's own clinical examination and assessment of Ms A.

81. It is not possible to determine precisely when Ms A returned to "xx" on the 8th August. In all likelihood it was later in the afternoon because her partner picked her up from the surgery and he normally worked until about 4.30pm. Dr B's suspicions should have been heightened when her patient returned complaining of vomiting. Again, however the Tribunal accepts Dr B did assess her patient and relied upon the triage nurses. Doctor B can be forgiven for not diagnosing pneumonia at that juncture because it can be a difficult condition to detect. The information which Dr B received that Ms A had vomited because of the effects of Panadeine was a reasonable assessment on the afternoon of 8 August.

Particular Two

When consulted by Ms A by telephone on 9 August Dr B failed to arrange and/or undertake an adequate re-assessment of Ms A's clinical condition.

82. It will be apparent from paragraph 52 of this decision the Tribunal believes Dr B erred when she failed to appreciate Ms A was unable to attend "xx" because of her incapacity. The Tribunal has accepted the evidence of Ms A's niece and partner who described Ms A's condition on the morning of 9 August as having deteriorated from the previous day. Doctor B appreciated when she spoke to Ms A on 9 August that her patient's condition had not improved. On the contrary, Ms A had continued to vomit. This should have caused Dr B to reconsider her earlier diagnosis. It was very imprudent of Dr B to make an assessment of her patient's condition on the basis of the telephone consultation. This was the third contact between Dr B and her patient within 24 hours. By no account had Ms A improved. In those circumstances it was incumbent upon Dr B to personally examine her patient, or arrange for her patient to be examined. Doctor B clearly failed to arrange and/or undertake an adequate re-assessment of her patient's clinical condition. Doctor B's omissions were compounded by her misunderstanding the reasons why Ms A was unable to personally attend "xx".

83. Doctor Marshall told the Tribunal that

> *"If a patient in Ms A's circumstances said to a doctor she could not go to the surgery then the doctor should make arrangements to*

> *personally visit the patient or arrange for the patient to be transported to the surgery or to a hospital by ambulance"*[41]

Doctor Marshall also said that if a patient in Ms A's circumstances said they could not attend the doctor's surgery then that would send a clear signal that the patient's condition had deteriorated from the previous day.

84. The Tribunal believes it important to stress to Dr B and to general practitioners that telephone diagnosis is potentially dangerous and should only be used when face to face consultation is impossible. In this case the dangers of conducting a telephone consultation were greatly increased because of the following factors:

    84.1 Ms A was a relatively new patient of Dr B. Doctor B had not appraised herself of her patient's extensive medical history and could not rely on any "inherent knowledge" that some general practitioners develop in relation to their patients.

    84.2 The telephone consultation on 9 August was the third contract Ms A had with Dr B in 24 hours. Ms A's condition had not improved. There were many indications Ms A's condition had in fact deteriorated.

    84.3 By relying on her assessments over the telephone Dr B denied herself the opportunity to comprehensively re-assess the differential diagnosis she made on 8 August.

Doctor B should have arranged for Ms A to have been taken to 'xx" using the practice's courtesy vehicle. Doctor F advised the Tribunal that a courtesy vehicle was available.

85. Doctor B's failure to properly interpret and respond to her patient's plight on the morning of 9 August was a serious error which passes the threshold of the first limb of the test of professional misconduct set out in paragraph 64 of this decision.

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[41] Transcript p.134 l. 19-26; p.135 l.3-5

Particular Three

On 9 August 2001, in the absence of an adequate clinical examination and/or re-assessment of Ms A's clinical condition, Dr B prescribed a change of medication by telephone.

86. The Tribunal also finds the Director of Proceedings has clearly established that the allegations in the third particular of the charge satisfy the first limb of the test of professional misconduct. It follows logically from the Tribunal's finding in relation to the second particular that Dr B should not have altered her patient's medication on the basis of her brief assessment of Ms A by telephone. It was incumbent upon Dr B to examine Ms A or arrange for her to be examined before altering her medication. Doctor B elected to provide symptomatic relief instead of re-assessing her previous day's diagnosis. The Tribunal found itself agreeing entirely with Dr Wright's criticism of Dr B for changing her patient's medication solely on the basis of her telephone consultation.[42]

87. The Tribunal believes Dr B's decision to change Ms A's medication solely on the basis of her assessment of her patient by way of telephone consultation was a serious departure from the standards reasonably expected of a general practitioner in New Zealand. The Tribunal notes however that general practitioners can prescribe for patients on the basis of telephone consultations when they know their diagnosis and proposed treatment are correct. In this case Dr B was not entitled to assume she knew what was wrong with Ms A on the 9th August and what treatment should be prescribed. In the circumstances of this case it was necessary for Ms A to be properly re-assessed.

Particular Four

Between 8 and 9 August 2001 Dr B failed to adequately document the clinical consultations with Ms A.

88. Doctor B's notes for the 8th and 9th August 2001 were very brief. The full notes are set out in paragraph 41 of this decision and need not be repeated.

89. Doctor B acknowledged that aspects of her notes were not adequate.[43]

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[42] Transcript p.62 l.17
[43] Transcript p.103 l.1-3

90. Although the Tribunal believes Dr B's records of her three consultations with Ms A were brief and in many respects inadequate her short comings in this regard do not meet the threshold of the first limb of the test of professional misconduct. The Tribunal accepts that the notes made by Dr B provided a brief but accurate record of Dr B's diagnosis and treatment plan. The notes could have been significantly improved if more detailed descriptions of Dr B's observations of her patient had been recorded, but nevertheless the notes barely pass the test of what could reasonably be expected of a general practitioner in New Zealand.

Cumulative Finding

91. The Tribunal believes the second and third particulars of the charge, when viewed separately, clearly satisfy the first limb of the test of professional misconduct. Doctor B's failure to properly assess and appreciate her patient's circumstances when conferring with her by telephone on the 9th August constituted a serious departure from the standards expected of a general practitioner in New Zealand. Doctor B's errors were compounded when she elected to change her patient's medication on the basis of the observations she made when talking to Ms A on the telephone.

92. The Tribunal has carefully evaluated the cumulative effects of Dr B's proven errors and omissions referred to in the second and third particulars of the charge and believes that when viewed cumulatively they justify a disciplinary finding against Dr B primarily to maintain professional standards and also to protect the public.

93. The Tribunal records that it accepts Dr B has in all other respects demonstrated that she is a conscientious and caring general practitioner and that a disciplinary finding against her will constitute a severe penalty.

94. The interim name suppression orders made by the District Court will continue until the Tribunal has had an opportunity to consider submissions on penalty and name suppression.

DATED at Wellington this 22nd day of December 2003.

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D B Collins QC

Chair

Medical Practitioners Disciplinary Tribunal