MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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NB: DOCTOR'S NAME IS NOT FOR PUBLICATION

DECISION NO: 122/00/56C

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

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

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Dr G S Douglas, Mr R W Jones, Mr G Searancke, Dr L F Wilson (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers Stenographer)

Hearing held at Rotorua Monday 29 and Tuesday 30 May 2000

APPEARANCES: Mr M F McClelland and Ms J Elliot for a Complaints Assessment Committee ("the CAC")

Mr H Waalkens and Ms K Garvey for Dr P.

1. THE CHARGE:

THE Complaints Assessment Committee pursuant to section 93(1)(b) of the Medical Practitioners Act 1995 ("the Act") charges that Dr P , Medical Practitioner of xx on or about the 19th day of July 1994:

A. Erred in clinical judgement by not performing a scalp pH at an earlier stage when it was apparent that delivery of the unborn baby was not imminent and a CTG trace was abnormal.

B. Erred in his judgement in commencing syntocinon infusion to Ms Waenga rather than facilitation delivery.

C. Erred in not monitoring the baby's foetal heart beat during the twenty-two minutes prior to delivery of the baby.

Being conduct unbecoming a medical practitioner, that conduct reflects adversely on that practitioner's ability to practise medicine.

1.1 **AT** the conclusion of the case for the CAC, and prior to the opening of the case for Dr P, the charge was amended with the consent of both parties:

The Complaints Assessment Committee pursuant to section 93(1)(b) of the Medical Practitioners Act 1995 charges that Dr P, medical practitioner of xx on or about the 19th day of July 1994 erred in his clinical management of the labour of Mrs Waenga and the delivery of Adam Waenga, in that he:

A. Erred in clinical judgement by not performing a scalp pH at an earlier stage when it was apparent that delivery of the unborn baby was not imminent and a CTG trace was abnormal.

B. Erred in his judgement in commencing syntocinon infusion to Ms Waenga rather than facilitation delivery.

C. Erred in not monitoring the baby's foetal heart beat during the twenty-two minutes prior to delivery of the baby.

Being conduct unbecoming a medical practitioner, that conduct reflects adversely on that practitioner's ability to practise medicine.

2. FACTUAL BACKGROUND:

2.1 **THE** charge arises in the context of Dr P's care of Mrs Tracey Waenga during her labour, and the delivery of her son, Adam Waenga, at X Hospital on 19 and 20 July 1994. Dr P is a xx, and at all relevant times was responsible for Mrs Waenga's care and treatment, and for the safe delivery of her baby.

2.2 **THE** subject pregnancy was Mrs Waenga's second pregnancy. Her first child was born by Caesarean section in 1991 as a result of a persistent footling breech presentation.

When she became pregnant with her second child, Mrs Waenga wanted to avoid another Caesarean section, and hoped to have her baby born naturally.

2.3 **HER** GP advised her that if she wanted to have a trial of labour she would have to have her baby at X Hospital as her local hospital was not equipped to do Caesarean sections, or to manage 'trial of labour' following a previous Caesarean section, or cope with 'difficult' deliveries.

2.4 **MRS** Waenga decided to consult a xx to ensure that the same doctor who looked after her during pregnancy would also deliver her baby. Dr P …, and accordingly Mrs Waenga was referred to him for ante-natal and intra-partum care.

2.5 **DR** P first saw Mrs Waenga when she was 34 weeks pregnant. During that first consultation Dr P explained to Mrs Waenga the risks for women undergoing a trial of labour after a previous Caesarean section and the known risk that the uterus could rupture at the site of the Caesarean operation scar. This was the only risk which Dr P advised to her.

2.6 **IT** was agreed between them that Mrs Waenga would go to term in the hope that she would go into labour naturally. If she did not, then Dr P would induce labour at 42 weeks. Mrs Waenga did not go into labour by herself and, on 18 July 1994, her labour was induced by the administration of 2 mg of prostaglandin E2 gel.

2.7 **THIS** dosage was the subject of some discussion at the hearing as it appears that the protocols at National Womens Hospital and Wellington Hospital are to administer 1mg only when inducing a multiparous woman because the uterine response in such women can be unpredictable. It would appear also that there is reputable clinical literature supporting the lower dosage for multiparous women.

2.8 **AS** a preliminary point, the issue as to whether or not Mrs Waenga should have treated as a multiparous woman (more than one pregnancy) or a nulliparous woman (first pregnancy), because this was her first *labour*, was controversial, and there was a divergence of views among the practitioners giving evidence.

2.9 **NO** pre-induction cardiotocograph (CTG) recordings were made, and the midwife who inserted the prostaglandin was unable to feel the cervix, with the result that no 'baseline' recordings for the fetal heartbeat and no accurate assessment of the cervical state prior to the onset of labour, or spontaneous uterine activity, were available. About one hour after induction the first CTG was applied for approximately one hour.

2.10 **AT** around 8.30 am, and with permission obtained from Dr P by the midwife, Mr and Mrs Waenga went into town to do some shopping for approximately three hours. On her return CTG was recommenced at 1145 hours. This was normal and discontinued at 12 noon and no CTG was done for another 2 hours and 15 mins.

2.11 **DR** P reviewed Mrs Waenga's progress during the day, and the CTG was applied intermittently. The CTG was recommenced at 1415hrs and discontinued at 1610hrs by

which time contractions had increased. Because it showed some late decelerations this CTG trace was faxed to Dr P who was operating at another hospital.

2.12 **DR** P visited Mrs Waenga at 1755hrs and told her that labour was progressing well and that he would call later. At 2200hrs Dr P was again contacted by the midwife and called in. He visited Mrs Waenga at around 2245hrs. At this time he examined her and noted that the cervix was 3cm dilated and well applied. An IV line was inserted and pethidine was administered for pain relief.

2.13 **AT** 2300hrs there was a changeover of midwives and Midwife X took over Mrs Waenga's care. At Mrs Waenga's request, an epidural was inserted at approximately 2350hrs. At 0030hrs (partogram record) or 0055hrs (patient record), Dr P ruptured the membranes and the amniotic fluid was found to be clear. The fetal scalp electrode was then attached.

2.14 **DURING** the period 0055hrs to 0215hrs the fetal CTG continued to show intermittent traces of variable decelerations, increased fetal heart rate and falling baseline heart rate. At 0200hrs Dr P was telephoned at his home by Midwife x who was apparently concerned about the CTG. He came into the hospital and examined Mrs Waenga. He carried out a vaginal examination and recorded *"Called as above at 0200hrs due to concerns re CTG. Trace shows variable dips with good beat to beat throughout. Observed closely as VE revealed anterior rim only."* The partogram for 0215hrs records that dilatation was 9+cms and the fetal head had descended to +2.

2.15 **DR** P remained in the hospital from that point in time and kept an eye on Mrs Waenga's progress. At 0240hrs, "*some blood loss pv*", was noted by Midwife x. At 0250hrs Mrs Waenga's notes record "*Deep Type II decelerations to 60 BPM for one minute before recovery to baseline of 120BPM. Dr P aware*."

2.16 **AT** 0310hrs Mrs Waenga's contractions apparently stopped. The epidural infusion was stopped and Dr P was advised. He ordered syntocinon infusion be commenced at a rate of 3mls per hour. His notes made after the delivery of Adam Waenga record that the cervix was fully dilated at +3.

2.17 **DR** *P* stated in evidence that the baby's head was not on view at this stage. In his experience, a cessation in uterine activity late in the second stage is not infrequently encountered, he was satisfied there was no malpresentation or cephelopelvic disproportion.

2.18 **AT** 0315hrs Mrs Waenga's notes made by Midwife X record "*Syntocinon commenced at 3mls per hour. Variable decelerations continue to 110bpm for 60 seconds with improved baseline variability and reactivity between. Vomited 200mls. Blood loss pv"*.

2.19 **THE** syntocinon infusion was increased to 6mls per hour at 0330hrs and variable decelerations to 90bpm for 60 seconds were recorded. The notes also record that Dr P was present at this time. In his notes made after Adam Waenga's delivery, Dr P states

that he made the decision to deliver baby at this time (0330hrs). Dr P fairly conceded that this time was a "*guesstimate*", made after the event.

2.20 **IN** his notes, Dr P also recorded: "*Epidural top up given - No N.B. forceps available - wrong poles for bed and No help as only 2M/W on duty.*" Midwife X recorded that the syntocinon infusion was increased to 9mls per hour, but this was disputed by Dr P. He suggested that the dosage was not increased beyond 6 mls per hour.

2.21 **VARIABLE** deep decelerations continued, with no contractions at all. The exact time at which the fetal scalp monitor was removed was unclear from the evidence. It may have been as long as 22 minutes prior to delivery (as alleged), or it may have been less than 10 minutes prior to delivery.

2.22 **MRS** Waenga's notes made by Midwife X also record some moderate blood loss pv, and a complaint of shoulder pain by Mrs Waenga at 0350hrs. When the decision to expedite delivery was made, Midwife X sought and obtained assistance from Midwife Y, the other midwife on duty. It was Midwife Y who attended to obtaining the correct forceps and stirrups for delivery. The on-duty paediatric registrar was also summoned to the delivery suite.

2.23 **ADAM** Waenga was born at 0405hrs. He was flaccid and unresponsive and the paediatric specialist, Dr Z, was immediately summoned. Adam was resuscitated and taken to the Special Care Baby Unit for intensive care. He was subsequently transferred to Waikato Hospital for more specialised care than was available at X Hospital.

2.24 **IMMEDIATELY** after Adam's delivery, Dr P diagnosed a rupture of the uterus and Mrs Waenga was taken to the operating theatre for emergency surgery. When the ruptured uterus was diagnosed at delivery, Dr P assumed that the rupture was a dehiscence of the scar from Mrs Waenga's previous caesarean section. However, at surgery an extremely rare large posterior rupture of the uterus which extended through to the cervix into the posterior vaginal fornix was discovered. For all practical purposes, the site of the uterine rupture is not relevant in the context of the charge.

2.25 **DR** P was able to carry out a successful repair of the uterus and Mrs Waenga made a good recovery. Adam Waenga remained on a ventilator at Waikato Hospital for eight days until successfully weaned and independent breathing, assisted by oxygen, was established and he was transferred back to X Hospital. He remained in hospital until 20 August 1994.

2.26 **AS** a result of the trauma suffered at his birth, Adam Waenga is severely brain injured. He is an epileptic, he must be tube fed, and is a profoundly deaf spastic quadriplegic. He needs frequent suctioning and requires oxygen 24 hours a day. He is also prone to infections, and can rapidly become seriously ill.

3. EVIDENCE FOR THE CAC:

3.1 **THE** CAC called five witnesses; Mr Tukaki Waenga and Mrs Tracey Waenga; Mrs Garmonsway, a friend of Mr and Mrs Waenga who provided support to Mrs Waenga during her labour; Midwife Y, and Professor Peter Richard Stone of Auckland.

Mrs Tracey Waenga

3.2 **MRS** Waenga gave evidence of her pregnancy, labour and delivery. Her evidence, supported by that of her husband, was that at no time during the course of her pregnancy and labour, were her or her husband given any information or other reason to have concerns for the safety of their baby.

3.3 **MRS** Waenga was satisfied that, having been made aware of the risk of uterine rupture as a result of her previous delivery by caesarean section, she was being looked after by a xx who was very capable. She was completely trusting in his ability and had total faith in Dr P. Her pregnancy was normal and, when she did not go into labour naturally, she went into hospital for an induction, completely confident that she had xx care, that she was being delivered in a big hospital, and that nothing could go wrong.

3.4 **DURING** her labour, Mrs Waenga was aware that the CTG trace was faxed to Dr P around 3.15pm, for him to comment on. She was told this was just because the midwives liked to keep the xx informed. Mrs Waenga was not told of any concerns on the part of the midwife regarding some late decelerations evident in the CTG.

3.5 **WHEN** Dr P examined Mrs Waenga at around 5.55pm, he seemed to be happy with the tracings. Similarly, when he reviewed Mrs Waenga at around 10.45pm, he seemed happy with the way labour was progressing. Some pethidine for pain relief was administered shortly after 11.00pm, and at midnight Mrs Waenga requested and was given an epidural. She was moved into the delivery suite at this time.

3.6 **MRS** Waenga was effectively unaware of much that was happening around her from this time. She saw Dr P again at approximately 1.00 am when her membranes were ruptured and the FSE was attached to baby's head . She knew that he was being kept informed about her progress, and felt that if he was not concerned about anything, then she did not need to worry. As far as she was aware, her labour was progressing normally and there was nothing to be concerned about.

3.7 **AT** no time did Mrs Waenga recall either Midwife X, who came on duty at 11.00 pm, or Dr P, giving her or her husband any indication that there were features of the CTG which were causing concern. At around 3.00am, when labour suddenly ceased, Mrs Waenga recalled that Dr P was called; that he looked at the CTG and started her on syntocinon. She did not recall any other checks being made.

3.8 **AT** around 3.30 am, when Mrs Waenga felt severe shoulder pain, she recalled that Midwife X heard her complaints of pain, and that Dr P was present beside her bed. She believed that the pain was from her arthritis, and from the strain of her labour. Mrs Waenga recalls that around 3.45am Dr P asked for the FSE to be removed, and that things started happening very quickly. Mrs Waenga recalled hearing Dr P commenting that *"we had better hurry and get this baby out"*. Mrs Waenga certainly felt that things were not right at this stage. It was a busy time and everyone seemed flustered.

3.9 **WHEN** Adam was born he appeared to be lifeless and very blue. Dr P told Mrs Waenga that her uterus had ruptured and that she must have urgent surgery and possibly a hysterectomy.

Mr Tukaki Waenga

3.10 **MR** Waenga's evidence corroborated his wife's. He was present throughout and he also was unaware of any cause for concern during the course of his wife's labour. He was aware that the midwifes were keeping Dr P informed as to the progress of his wife's labour, and the CTG tracings. However, he believed that all of this was routine.

3.11 **LIKE** Mrs Waenga, he believed that Dr P was present when his wife complained of pain in her shoulders around the time that her labour stopped. It was soon after this that Dr P asked the midwife to call for help, and that his voice seemed louder and more urgent. Mr Waenga estimated that it took a few minutes to locate the stirrups and Neville Barnes forceps. Asked to be more precise, he suggested that it took two minutes to get both of these items.

3.12 **HE** recalled a *"huge amount of blood"*, perhaps two litres, followed Adam as he was lifted out. Adam looked to him to be blue and dead, and his wife looked like she was dying. He helped to push his wife to the theatre. While his wife was in theatre, he went to check on his son. He was told that he was seriously ill and was being closely monitored.

Mrs Garmonsway

3.13 **MRS** Garmonsway was present as Mrs Waenga's support person from approximately 4.00pm to 12.30am. She gave evidence that it was her impression that Dr P seemed in a hurry when he visited Mrs Waenga at around 5.55pm. She also gave evidence that progress of labour seemed slow, and contractions were irregular.

3.14 **MRS** Garmonsway was curious about the CTG and asked what the midwife was checking. She was told that the baby's heartbeat was being monitored, and that the baby's heartbeat was a little slow in returning to a normal beat, but that Dr P was happy with the way labour was progressing.

3.15 **AFTER** Midwife X came on duty and the epidural was commenced, Mrs Garmonsway again asked about the baby's heartbeat. Midwife X told her she had some concerns about the dipping of heartbeats and that she had contacted Dr P to ask him to come in and check the CTG.

3.16 **WHEN** Dr P arrived, Mrs Garmonsway again thought that he appeared rushed, and that he spoke abruptly. He told them that the baby was not going to born until the morning and they should try to relax and get some rest. Mrs Garmonsway decided to go home and to let Mrs Waenga rest, and left around 1.30am.

Midwife Y

3.17 **MIDWIFE Y** was on night duty on 18/19 July 1994. She was not directly involved in monitoring Mrs Waenga's labour, and Mr Waalkens made objection to parts of the evidence contained in her statement of evidence on the basis that it was hearsay. In the absence of Midwife X, who returned to the United Kingdom immediately after the subject events, Midwife Y's was the only evidence given from the midwives' perspective.

3.18 **IT** was Midwife Y's evidence that it was her impression at the time that "… *[Midwife X] was clearly worried, she was really concerned about the fetal heart rate, hence ringing Dr P."*

3.19 **SHE** was present at the delivery of Adam Waenga, and it was she who assisted at the delivery by going to get the right equipment, and administering the epidural infusion. Subsequently, Midwife Y objected to what she regarded as implied criticism of the midwives contained in Dr P's notes.

3.20 **IN** particular, Midwife Y, who worked as a midwife at X Hospital for some 33 years, told the Tribunal that there were always only two midwives on night duty at the time of Mrs Waenga's delivery. She confirmed Mr Waenga's evidence that it would have taken her less than a minute (certainly no more than a minute) to get the correct stirrups, and she did not recall any delay getting the Neville Barnes forceps from the delivery suite next door. It was Midwife Y's view that, due to the small area of the delivery suite, she could have gone all around it "*in a minute*".

3.21 **MIDWIFE Y** recalled that "*we were all surprised that the baby was so limp and flaccid and in such a poor condition*." As Dr P delivered the placenta and was checking the previous caesarean scar, Midwife Y recalled that he said to her "*it's dehisced*", meaning "*it's ruptured*". Midwife Y telephoned theatre to let them know what had happened and that Mrs Waenga was on her way for an emergency laporotomy.

3.22 **SUBSEQUENTLY**, Midwife Y was told that there would be debriefing meeting regarding Adam's birth. She was asked to comment as Midwife *X* had left New Zealand (the duty of 18/19 July 1994 was her last). She prepared a letter, which she sent, but was unable to attend the meeting herself. She no longer had a copy of the letter she had written.

Professor Stone

3.23 **PROFESSOR** Stone is Professor of Maternal Fetal Medicine and Clinical Director of the Maternal Fetal Medicine Service at National Womens Hospital in the Department of Obstetrics and Gynaecology and the University of Auckland. Professor Stone has 22 years experience in Obstetrics and Gynaecology.

3.24 **PROFESSOR** Stone reviewed all of the documentary evidence that is available regarding Mrs Waenga's pregnancy, labour and delivery in the context of the two adverse outcomes; Adam Waenga's cerebral palsy of the spastic quadriplegia type, and Mrs Waenga's uterine rupture in labour.

3.25 **IT** was Professor Stone's evidence that both of these outcomes are rare events. Dehiscence of a previous caesarean scar is of low incidence; around 0.8%, but there is a 2 to 4-fold increased risk of scar dehiscence when labour is induced. The type of uterine rupture suffered by Mrs Waenga is extremely rare. However, the signs and symptoms of both types of uterine rupture are the same.

3.26 **THE** issues therefore, in Professor Stone's view, for analysing the facts of this case relate not to the very rare adverse outcomes, which are difficult to predict, but to the recognition

of the risks of induction, in particular in a patient with a previous caesarean section, and therefore the monitoring of the fetal and maternal welfare throughout the induction, labour and delivery process.

3.27 **THE** first issue, and a point of difference between Professor Stone and the witnesses called for Dr P, was whether or not Mrs Waenga should have treated as if she was a nulliparous woman, rather than a multiparous. Professor Stone advocated the former. As such, caution must be exercised in induction and acceleration of labour.

3.28 **PROFESSOR** Stone was also concerned that no base recordings, including a CTG, had been made prior to the administration of prostaglandin gel. It is Professor Stone's view that pre-prostaglandin CTG should be done on all patients. In light of a statement in the admission notes that the uterus was irritable, it would have been prudent to have recorded the spontaneous uterine activity as a guide to prostaglandin gel dosage.

3.29 **OBTAINING** base recordings would have been prudent also because protocols available at other hospitals, National Womens and Wellington for example, stipulate a 1mg dosage for nulliparous women and women undergoing a trial of labour who have had a previous caesarean section.

3.30 **PROFESSOR** Stone was also concerned at the quality of the CTG trace due to the presence of a large amount of artefact (electronic noise) in the recording, and of the intermittent nature of the recordings during the day. In the presence of increasing uterine

activity, and a previous caesarean section scar, Professor Stone would recommend continuous fetal monitoring.

3.31 **THE** quality of the CTG recording was so poor that it made the CTG trace difficult to interpret, and attempts should have been made by the midwife, and Dr P, to ascertain whether not it was a machine problem, or a fetal problem as fetal arrhythmia can cause a poor recording.

3.32 **PROFESSOR** Stone noted with particular concern the large variable accelerations and increased heart rate occurring at around 0200hrs, which he described as "*non reassuring heart rate patterns.*" In relation to the variable decelerations evident on the CTG trace, Professor Stone expressed the view that their significance depends to some extent on the clinical context and it is important to remember that CTG is a test, it cannot be viewed in isolation.

3.33 **VARIABLE** decelerations are commonly seen in labour, and "*they are best thought of as all decelerations that cannot be clearly categorised as early or late decelerations and they may or may not be associated with hypoxia. They may also be seen with cord compression, as may early decelerations, and they can be seen with changes in fetal behavioural state, though except in early labour, behavioural state changes are unusual once labour is established*".

3.34 **IN** Professor Stone's opinion, in the presence of what may well be a falling baseline or large variable decelerations the prudent obstetrician would consider a serious acute

problem such as scar dehiscence or a cord problem. Possible reasons for this situation should be considered and a management plan put in place.

3.35 **IT** was Professor Stone's opinion that the large swings in the fetal heart rate prior to the cessation of the recording could be consistent with a uterine scar dehiscence and the evidence is that changes in the fetal heart rate are the most consistent indicator of uterine scar dehiscence.

3.36 **THE** partogram indicated rapid progress to full dilatation and also descent of the head to +3. At this point, the baby has passed the ischial spines and the baby's head is in the pelvic outlet, in normal circumstances, the baby may be delivered vaginally. At 0310, labour stopped and the syntocinon infusion was commenced.

3.37 **THE** cessation of labour at this point was, in Professor Stone's opinion, a situation requiring extreme caution in the presence of a uterine scar. Cessation of labour may be a sign of uterine rupture. Other signs of uterine rupture include blood loss pv and fetal distress indicated by changes in the fetal heart rate, the latter being the most consistent finding in labour related to scar rupture. In his view, sudden cessation of labour in a multiparous woman is a consistent and well-established sign of uterine rupture. Mrs Waenga's definition as a multiparous woman was not up for debate, and, he stated, "… *all of the evidence is that it almost, not entirely, unheard of to rupture or be able to rupture a nulliparous uterus, but a multiparous uterus whether or not women have laboured can rupture. ... I genuinely believe that is a fact which was understood or held by virtually all my colleagues.*"

3.38 **IN** such circumstances, commencing the syntocinon infusion rather than expediting delivery, would be questionable, particularly where the patient could be regarded as multiparous and therefore delay was unlikely to be due to inefficient uterine action. In a multiparous patient second stage delay would not conventionally be managed at this time by instituting syntocinon.

3.39 **PROFESSOR** Stone went on to consider all of these general matters in the context of each of the Particulars of the charge.

4. EVIDENCE FOR THE RESPONDENT:

4.1 **THE** witnesses for the respondent were Dr P, Dr J A Westgate, a specialist obstetrician and gynaecologist of Auckland, and Dr A J Haslam, a specialist obstetrician and gynaecologist of Hamilton.

Dr P

4.2 **DR P** confirmed the factual evidence already set out in this Decision. It was clear from the evidence of all of the witnesses that matters of fact (with the exception of the time at which some events occurred) were not disputed by any of them. The central issue for consideration in this hearing was the interpretation of the factual material, in particular the CTG trace, and the clinical records made by Dr P and Midwife *X* some time after the final stages of labour and Adam Waenga's delivery, and Dr P's overall management of Mrs Waenga's labour.

4.3 **DR** P confirmed that the dosage of 2mg prostaglandin was common practice at X Hospital. Dr P was not aware of any protocols or guidelines in place at X in 1994, similar to those in place in some other hospitals. He confirmed that he had reviewed Mrs Waenga during her labour, including the CTG traces sent to him by facsimile and otherwise referred to him by the midwives.

4.4 **HE** confirmed that he was summoned by the midwives on each occasion he saw Mrs Waenga during the 18th of July 1994, and that he was summoned by Midwife *X* at 0200hrs on 19 July 1994 when she expressed concerns regarding the fetal heart rate pattern. Dr P reviewed the record in full and was satisfied that there were variable decelerations. He performed a vaginal examination and confirmed the presence of a thin anterior rim of cervix only.

4.5 **DR** P noted that there was no meconium in the liquor. In cross-examination, he agreed that in the period from 0055-0215hrs, the CTG trace was not normal, and between 0140 and 0215hrs he agreed that "*possibly*" there were "*non-reassuring, possibly pathological"* events in the CTG. But by 0215hrs Dr P considered that the trace pattern had improved with excellent beat to beat variation and the normal return to baseline. He felt that these features "*were reassuring and that the baby was not anoxic. As the second stage was imminent, I remained in the Delivery Suite and observed the fetal heart rate pattern frequently. There was an excellent pattern of contractions, the epidural was decreased and Mrs Waenga began to push. She did so effectively and there was excellent descent of the fetal head."*

4.6 **AT** this stage, Dr P expected that delivery would occur within the next 60 to 90 minutes, and he chose to observe the rest of the trace. Again, in cross-examination, Dr P agreed that the CTG record at 0246hrs constituted "*a bad sign*" but he "*continued to watch*." He was aware of some blood loss reported at 0240hrs, but the amount of blood did not concern him. He was also aware of the prolonged deceleration at 0246hrs, and he agreed with Dr Westgate's description of this as a "*severe variable deceleration*".

4.7 **AT** 0300hrs the contractions became "*less frequent*". He again examined Mrs Waenga and found the cervix fully dilated with the presenting part of the baby at +3. Again, he concluded that the fetal heart rate pattern was satisfactory.

4.8 **HE** was not aware of the shoulder tip pain apparently reported by Mrs Waenga. If he had been, he would have been very concerned about this as he agreed with Professor Stone that it is a significant clinical sign indicating diaphragmatic irritation.

4.9 **HE** agreed that, by 0310hrs, three signs of possible uterine scar rupture were present. However, because at the time he considered the fetal heart rate to be 'normal'; he had formed the view that the baby was not anoxic; the liquor was clear, and "*wishing to avoid the risks and consequences of an instrumental delivery*", he directed that an syntocinon (oxytocin) infusion be commenced.

4.10 **DR** P continued to observe Mrs Waenga's labour but by 0330-0345hrs (he was unable to be certain about the exact time) he became concerned by the lack of further progress and change in the fetal heart rate pattern, namely the loss of beat to beat variability. He

decided to expedite delivery. Notwithstanding the delays in locating the correct equipment, which he estimated at 10 to 15 minutes, he "*remained confident that Adam was in good health.*"

4.11 **THE** delivery was uncomplicated, and he was shocked to discover the poor condition of the baby. He immediately diagnosed that the uterus had ruptured. Events from that diagnosis have already been described.

Dr J A Westgate

4.12 **DR** Westgate has practised as a specialist obstetrician and gynaecologist with a particular interest and speciality in fetal physiology and fetal monitoring. Dr Westgate is the author of the NZ Guidelines for CTG interpretation commissioned by the then Royal NZ College of Obstetricians and Gynaecologists.

4.13 **DR** Westgate first reviewed the CTG trace from Mrs Waenga's labour without being told Dr P's name or any other details of the case. Dr Westgate's comments provided at that time were produced at the hearing and were subject to cross-examination by the CAC. In her evidence given at the hearing Dr Westgate told the Tribunal that since becoming aware that a uterine rupture occurred she is better able to understand the events and why Adam Waenga was born in such a poor condition. She did not wish to change any of her original comments.

4.14 **DR** Westgate confirmed that the CTG trace is of very poor quality and therefore difficult to interpret. In her original comments, Dr Westgate stated:

"The quality of the CTG recording is very poor, and this is worthy of note. It is very difficult to interpret the fetal heart rate (FHR) pattern; the old adage of "rubbish in, rubbish out" comes to mind. Sometimes a poor quality recording is caused by a fetal arrythmia which may have clinical significance.

…

The CTG from 0145 to 0210 is concerning and I would have considered delivery in the presence of other non-reassuring factors, e.g. thick meconium liquor.

…

There is no interpretable CTG from 0342 until delivery at 0405 (assuming the clocks are synchronous). The fetal heart may have been auscultated but I do not have this information. 22 minutes is a long time to lose contact with a baby, especially at this stage of labour and given that the preceding CTG was abnormal."

4.15 **IN** summary, in her evidence given at the hearing, Dr Westgate stated that the monitoring record confirms that contractions stopped at 0310hrs. As the contraction frequency decreased the fetal heart rate pattern showed signs of improvement and it is likely that Dr P would have been reassured by this improvement and thus allowed Mrs Waenga to continue in labour with close observation of the fetal heart rate.

4.16 **DR** Westgate confirmed that cessation of labour is listed as one of the signs of uterine rupture, although in the cases she has seen or reviewed this has not occurred. In relation to this, Dr Westgate told the Tribunal: "*In view of this, Dr P's decision to start syntocinon at 0310 is not entirely unreasonable but as Mrs Waenga was by then fully dilated with the head at station +3, an instrumental vaginal delivery would have been another option."*

4.17 **DR** Westgate was unable to tell when the uterine rupture occurred, but around 0311hrs the CTG shows a prolonged contraction lasting nearly 5 minutes. This might have been

artefact caused by other factors, but no such alternative explanation, such as a change in maternal position, is noted on the CTG: *"The baseline variability increased and the decelerations became larger, indicating that some acute event had occurred. …By 0340 there was clearly a further deterioration in the FHR pattern with a loss of FHR variability and frequent decelerations."*

4.18 **IT** was Dr Westgate' opinion that most, if not all of the damage suffered by Adam Waenga occurred during the 20 minutes or so prior to delivery and was caused by a complete separation of the placenta from the uterus.

4.19 **IN** cross-examination, Dr Westgate confirmed that she had known Dr P for several years as a professional colleague. In the course of cross-examination, Dr Westgate suggested that Dr P's account of what was in his mind at the time was not in fact what he was thinking at the time, and "*his response to questions put to him were not as I would have expected, due to the pressure of the occasion*."

Dr AJ Haslam

4.20 **DR** Haslam is a specialist obstetrician and gynaecologist practising in Hamilton. He had reviewed all of the available documentary material and Dr P's statement of evidence prepared for the Tribunal.

4.21 **HE** confirmed that the quality of the CTG trace was poor, and that, while facilities for measuring fetal scalp pH were available at X Hospital at the time, no such test had been

performed and therefore it was not possible to know what the baby's condition was in the leading up to delivery.

4.22 **IT** was Dr Haslam's interpretation of the record that, when contractions stopped at 0310hrs, the baby could have been delivered with forceps or Ventouse suction cup. The oxytoxin caused the resumption of contractions, as intended. It is likely that uterine rupture occurred in the half hour preceding delivery.

4.23 **DR** Haslam told the Tribunal that, while the fetal trace was neither reassuring nor normal in the time prior to the last half hour before delivery, "*neither was it frankly diagnostic of the baby in distress. There was no fetal monitoring record from after around 0342hrs*." As to the delay in locating the correct equipment, he was uncertain of how long this might have taken, and also how significant the delay while the right equipment was located might have been.

4.24 **THE** decision to commence the syntocinon infusion in the circumstances "*is a debatable point. I note that Dr P makes the point that Mrs Waenga had not laboured in her first pregnancy and thus could be considered akin to a prima gravid. However, she also had a caesarean section scar. Labour may stop because of absent or poor uterine activity but also in the presence of obstructions because of a large baby or malpresentation or position. It is important that the CTG did not in my opinion require delivery. … Certainly there is great benefit of hindsight in now identifying the benefit of the alternative management - that is to undertake operative delivery by use of forceps to Ventouse."*

4.25 **DR** Haslam concluded his evidence by telling the Tribunal of high regard in which Dr P is held by his colleagues, and of Dr P's reputation as a clinician *"who is known to work hard and faithfully for his community and he has also put a great deal of effort into his profession. His record is of a practitioner who certainly does more than his fair share of the workload."*

5. THE DECISION:

5.1 **HAVING** carefully considered all of the evidence presented to it, and the submissions made by both counsel, the Tribunal has determined that Dr P is guilty of the charge of conduct unbecoming and that reflects adversely on his fitness to practise, in terms of section 109 (1)(c) of the Act.

6. REASONS:

The Standard of Proof -

6.1 **IT** is well-established that the standard of proof in disciplinary proceedings is the civil standard, the balance of probabilities. It is equally well-established that the standard of proof will vary according to the gravity of the allegations and the level of the charge. All elements of the charge must be proved to a standard commensurate with the gravity of the facts to be proved: *Ongley v Medical Council of New Zealand* [1984] 4 NZAR 369, 375 - 376.

The Burden of Proof -

6.2 **THE** burden of proof is borne by the CAC.

Conduct Unbecoming That Reflects Adversely On A Practitioner's Fitness To Practise Medicine -

6.3 **THE** statement by Elias J (as she then was) in *B v Medical Council* (unreported) HC 11/96, 8/7/96, is by now very familiar. In that statement, Elias J formulated the test of what constitutes "*conduct unbecoming*" as follows:

"There is little authority on what comprises "conduct unbecoming". The classification requires an assessment of degree. But it needs to be recognised that conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards. That departure must be significant enough to attract sanction for the purposes of protecting the public. Such protection is the basis upon which registration under the Act, with its privileges, is available. I accept the submission … that a finding of conduct unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which it is unfair to impose. The question is not whether error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations. The threshold is inevitably one of degree …. The structure of the disciplinary processes set up by the Act, which rely in large part upon judgment by a practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standards applied by competent, ethical, and responsible practitioners. …"

6.4 **FROM** this statement three basic and essential principles emerge:

(a) The departure must be "*significant enough*" to attract sanction for the purposes of protecting the public.

(b) A finding of conduct unbecoming is not required in every case where error is shown.

(c) The question is not whether an error was made, but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations (in all the circumstances of the particular case).

6.5 **THE** 'rider' added to the charge of "conduct unbecoming" in the 1995 Act, has now been referred to in a number of decisions. In *CAC v Mantell*, DC Auckland, NP 4533/98, 7/5/99, Judge Doogue concluded:

"The text of the rider … makes it clear that all that the prosecution need to establish in a charge of conduct unbecoming [with the rider] is that the conduct reflects adversely on the practitioner's fitness to practise medicine. It does not require the prosecution to establish that the practitioner is unfit to practise medicine. … In order to satisfy the requirements of the rider, it is not necessary that the proven conduct should conclusively demonstrate that the practitioner is unfit to practise. 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 will reflect adversely on a practitioner's fitness to practise. ***It is a matter of degree*** *…*

[after referring to the judgment of Jeffries J in Ongley (1984) 4 NZAR 369,375]

… My conclusion to this point is that the proper subject for enquiry is the conduct of the practitioner. It seems to me that the Tribunal should not proceed further and attempt to put into the balance the personal circumstances and characteristics of individual practitioner in order to decide his/her fitness to practise. The section requires assessment of standards of conduct using a yardstick of fitness. ***It does not call for an assessment of individual practitioners fitness to practise****." (at p.16/17, A Complaints Assessment Committee v Mantell, NP4533/98, 7/5/99).*

6.6 **THE** 'assessment of degree' the Tribunal must make is therefore effectively unchanged from that described by Elias J in *B.*, by the addition of the 'rider'.

6.7 **IN** *Ongley v Medical Council of New Zealand* (supra), Jefferies J held that:

"The structure of the disciplinary processes set up by the Act which rely in large part upon the judgment of a practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standards applied by competent, ethical and responsible practitioners."

6.8 **THAT** is not to say that the Tribunal unhesitatingly adopts the opinions expressed by those practitioners who give evidence as 'experts', neither does it necessarily measure the practitioner's conduct against what other doctors might have done in similar circumstances. In any event, in circumstances such as the present where the practitioners who gave expert evidence were all very experienced and well-regarded specialist obstetricians, but

did not agree on a number of issues, the Tribunal must exercise its collective judgment and decide which evidence it prefers.

6.9 **IN** so doing, the Tribunal it not necessarily making any judgment as to the credibility of particular witnesses; all of the evidence is weighed in the collective judgment, in this case, of a specialist Tribunal comprising both medical practitioners and lay members. The test is objective; that is, the conduct under review is measured against the judgment of the practitioner's professional peers of acknowledged good repute and competency, "*bearing in mind the composition of the tribunals which examine the conduct; Ongley v Medical Council (supra).*

6.10 **THUS,** while the evidence of what other doctors would have done, or as to how they assess Dr P's management and conduct of Mrs Waenga's (and Adam Waenga's) care or of acceptable practice generally in the circumstances which presented in this case, is a useful guide, perhaps even the best guide, it will never be more than that.

6.11 **IN** the context of the 'assessment of degree' that the Tribunal must undertake in its deliberations on the charge, the recent decisions of the High Court of Australia in *Chappel v Hart* (1998) 72 ALJR 1344, and *Naxakis v Western General Hospital* (1999) 73 ALJR 782, are relevant. In both cases the Courts referred to so-called "common sense" test of causation. In *Rogers v Whitaker* (1992) CLR 479, approved in New Zealand in B, Gaudron J expressed the test this way:

"The matters to which reference has been made indicate that the evidence of medical practitioners is of very considerable significance in cases where negligence is alleged in diagnosis or treatment. However, even in cases of that kind, the nature of particular risks and their forseeability are not matters exclusively within the

province of medical knowledge or expertise. Indeed, and notwithstanding that these questions arise in a medical context, they are often matters of simple commonsense. And, at least in some situations, questions as to the reasonableness of particular precautionary measures are also matters of commonsense. Accordingly, even in the area of diagnosis and treatment there is, in my view, no legal basis for limiting liability in terms of the rule known as the "Bolam test" which is to the effect that a doctor is not guilty of negligence if he or she acts in accordance with a practice accepted as proper by a responsible body of doctors skilled in the relevant field of practice. That is not to deny that, having regard to the onus of proof, "the Bolam test" may be a convenient statement of the approach dictated by the state of the evidence in some cases. As such, it may have some utility as a rule-of-thumb in some jury cases, but it can serve no other useful function."

6.12 **IN** *Chappel v Hart* the 'common sense' test was approved by the full Bench of the High Court of Australia. In that case, all five Judges proceeded on the basis that questions of causation are questions of fact to be answered by applying common sense to the situation, the test recognised as superseding the bare 'but for' test in its decision in *March v I & M H Stramare Pty Ltd* (1991) 171 CLR 506.

6.13 **THAT** test was again approved in *Naxakis* (supra) in circumstances where the overwhelming body of evidence pointed to the conclusion that a neurosurgeon was not at fault in persisting with his diagnosis of traumatic subarachnoid haemorrhage -

"not one medical witness said that … he … would have ordered an angiogram [and] no-one suggested that the failure to order an angiogram was in any way open to criticism.… assuming there was some evidence that there were steps that could have been taken to exclude other causes, it was for the jury to form their own conclusion whether it was reasonable for one or more of the steps to be taken. It was not for the expert witnesses to say whether those steps were or were not reasonable."

6.14 **THIS** 'common sense' test, is consistent with the formulation of the 'assessment of degree' test referred to in *Ongley* (supra) and the cases which have followed. Such a test is also entirely consistent with the composition of the Tribunal comprising as it does a mix

of lay persons and doctors. In the face of conflicting evidence from expert witnesses, it is an especially practical and useful approach.

6.15 **SIMILARLY**, the issue as to whether or not the outcome might have been different had the practitioner's management of the patient's care been different, will not determine whether or not a charge is proven. The central issue for the Tribunal's inquiry is to ascertain whether or not the practitioner's conduct and management of the case (at the relevant time) constituted an acceptable discharge of his or her professional and clinical obligations. Only if the Tribunal identifies any such shortcomings or errors may it go on to determine if those shortcomings or errors are culpable, and warrant the sanction of a finding against the practitioner.

6.16 **ADOPTING** this approach, the Tribunal considered each of the Particulars of the charge, and then the charge in its totality.

6.17 **THE** Tribunal is satisfied, on the balance of probabilities, that:

(a) In deciding to commence the syntocinon infusion at approximately 0315hrs, in the face of the cessation of labour, some blood loss pv, and changes in the fetal heart rate, Dr P made an error of judgment in his management of Mrs Waenga's labour and the delivery of Adam Waenga;

(b) that Dr P's conduct in terms of his management of Mrs Waenga's labour, and the clinical decision he made, is conduct which constituted a departure from acceptable professional standards and was not an acceptable discharge of his professional obligations as a xx responsible for Mrs Waenga's care, and the safety of her baby;

(c) the decision to commence the syntocinon infusion at around 0315hrs, instead of expediting delivery of Mrs Waenga's baby, is a culpable error and warrants the sanction of an adverse finding against Dr P.

7. AMENDMENT TO THE CHARGE:

7.1 **HAVING** heard the case for the CAC, and particularly the evidence given by Professor Stone, the Tribunal came to the view that it was necessary for the Tribunal to consider each of the Particulars of the charge in the context of Dr P's overall management of Mrs Waenga's pregnancy, labour and delivery.

7.2 **IT** seemed to the Tribunal, that inevitably, the Particulars of the charge would be considered in this way; to consider each of them in isolation, in effect each as a discrete complaint, would be impractical and unrealistic, and it would be potentially unfair to Dr P if there was any misunderstanding about the basis upon which the evidence was received by the Tribunal and how it would have to proceed to consider each of the Particulars in its deliberations.

7.3 **IT** also seemed to the Tribunal that all of the expert evidence which, in the usual way, had been exchanged and circulated to the parties and the Tribunal members prior to the hearing, was advanced on the basis that the Tribunal had to consider the totality of Dr P's management and care of Mrs Waenga's pregnancy, labour and delivery. The Particulars in effect, were the specific aspects of the total episode of care that was the subject of the charge.

7.4 **IN** accordance with the provisions of Clause 5(3) and Clause14(1)of the First Schedule to the Act, and prior to the opening of the case for Dr P, the Tribunal advised both counsel that it was considering amending the charge to make it clear that the Particulars of the charge would be considered by the Tribunal in the context of Dr P's overall management of Mrs Waenga's pregnancy, labour and delivery, i.e. on the basis of all of the evidence presented to it.

7.5 **THE** Tribunal wished to give Dr P and Mr Waalkens an opportunity to consider the Tribunal's proposed amendment prior to opening the defence case in order to enable an application for an adjournment to be made in the event it was considered that Dr P might be embarrassed in his defence if the amendment was made.

7.6 **MR** McClelland, on behalf of the CAC raised no objection to the proposed amendment, and Mr Waalkens, after taking instructions from Dr P, also advised the Tribunal that Dr P gave his consent to the amendment being made. Accordingly, by consent, the charge was amended as set out in paragraph 1.2 above.

8. FINDINGS IN RELATION TO PARTICULARS:

Particular A: Dr P erred in clinical judgment by not performing a scalp pH at an earlier stage when it was apparent that delivery of the unborn baby was not imminent and a CTG trace was abnormal.

8.1 **THE** Tribunal was not satisfied that this Particular was established. In coming to this view, the Tribunal was influenced by its key finding that the significant and culpable error in the context of Dr P's management of Mrs Waenga's labour, was his decision to commence the syntocinon infusion at around 0315hrs, rather than expediting delivery. In relation to

this Particular, it accepts the evidence given by Professor Stone that, whilst a fetal blood sample sometime prior to the commencement of the oxitocin may have demonstrated that the fetus was hypoxic or acidemic, fetal blood sampling is used to ascertain whether or not a CTG is indeed indicating that this is the case. Only 2% of otherwise healthy term fetus' develop acidosis in normal labour.

8.2 **BUT** the CTG in this case was very abnormal with a falling baseline and bradycardia (slow heart beat <100 beats per minute) at around 0215hrs - 0300hrs. Fetal blood sampling at this time would only be done if it was intended to continue the labour and it was not considered that some acute event or events had caused the fetal heart patterns to be abnormal. At around 0205hrs the baseline had clearly fallen, and some explanation should have been investigated at that time.

8.3 **HOWEVER**, where there is the potential for an acute event, the use of fetal blood sampling may delay other, more appropriate actions (such as expediting delivery) because variable decelerations may be associated with a number of reasons, such as cord collapse or uterine scar dehiscence (a significant and known risk for Mrs Waenga); and if the reason for the decelerations is detected early, or delivery expedited, it is unlikely that the fetus would be hypoxic or acidemic at that stage.

8.4 **APPROPRIATE** management in this case, in the face of the known risk, and a trial of labour, would have been for Dr P to have proceeded to deliver Adam Waenga quickly.

8.5 **BOTH** of Dr Westgate and Dr Haslam, while they might have delayed delivery a little longer than Professor Stone suggested was appropriate, nevertheless conceded that the decision to administer syntocinon when labour stopped at 0310hrs, rather than expediting labour, was debatable.

8.6 **NO** evidence was lead as to the availability of fetal blood testing at X Hospital in 1994, particularly in the middle of the night when it might have been indicated in this case.

8.7 **HAVING** regard to all of the evidence presented by the expert witnesses, and taking a pragmatic and common sense approach, the Tribunal was satisfied that the appropriate course was to expedite delivery, rather than delay matters by obtaining a fetal blood sample. As a result of that finding, the Tribunal is satisfied that Particular A is not established.

Particular B: Erred in his judgment in commencing syntocinon infusion to Mrs Waenga rather than facilitation (sic) delivery.

8.8 **FOR** reasons set out above, the Tribunal is satisfied, on the balance of probabilities that Particular B is established and the Tribunal is satisfied that this error of judgment on the part of Dr P, in the circumstances of this case, is a culpable error in terms of warranting the sanction of adverse finding on the charge of conduct unbecoming a practitioner and that conduct reflects adversely on Dr P's fitness to practice. The Tribunal accepts Dr Haslam's caution that the Tribunal is being asked to adjudge Dr P's management of this case with the benefit of hindsight. However, in cases such as this, that is necessarily the case and the Tribunal approached its task with the need to be cautious in this regard in mind.

8.9 **THE** Tribunal accordingly proceeded to consider this Particular, and the relevant evidence available in the clinical records and other material produced to it, on the basis of the information which was available to Dr P at the relevant time. It has not attempted to guess what was in Dr P's mind at the time, but to view the evidence objectively. In that regard, it considers the suggestion by Dr Westgate that Dr P may not have accurately articulated to the Tribunal what he was thinking at the time, as stemming from professional courtesy or perhaps influenced by collegial sympathy.

8.10 **ON** the basis of the factual evidence presented to it, the Tribunal is satisfied that Dr P was, and is, an experienced and well-regarded x; he was aware of the risk of uterine rupture in a woman with a previous caesarean section scar, and indeed that was the only risk he discussed with Mrs Waenga in her first consultation with him, when she told him of her desire to deliver her baby naturally; and he was aware of the signs and sentinel events of uterine rupture.

8.11 **BY** 0310hrs, when labour stopped, three of the well-documented signs of possible uterine rupture were present; blood loss pv, an abnormal CTG (and the Tribunal accepts that by this stage the CTG was, as a matter of fact, at least "*non-reassuring*"), and the cessation of a relatively rapid and effective second stage of labour. There was of course the additional 'sign' of shoulder pain, suggesting bleeding into the peritoneal cavity, but the Tribunal accepts that Dr P does not recall that he was aware of this, and it was not proven that it was expressly brought to his attention.

8.12 **THE** Tribunal is satisfied that a prudent obstetrician, with Dr P's experience and expertise, should have expedited delivery at, or around, the time that labour stopped. The head was well-descended, the cervix was fully dilated, and delivery could have been safely undertaken at that point. The Tribunal is also satisfied that there is sufficient evidence to suggest that the midwives had indicated persistent concerns regarding the CTG throughout the afternoon and evening.

8.13 **NOTWITHSTANDING**, it does appear that on every occasion that Dr P visited Mrs Waenga during her labour it was as a result of his being called by the midwives. The Tribunal accepts that, after being called in at around 0200hrs, Dr P remained in the delivery suite, and was no doubt keeping an eye on Mrs Waenga's progress, and adopting a 'wait and see' approach.

8.14 **HOWEVER**, by 0315hrs, with the cessation of labour, some positive action on the part of Dr P was called for. In the face of a known risk, and a risk of such magnitude in terms of the potential outcome for both mother and baby, Dr P requested that the syntocinom infusion be commenced in attempt to re-start labour. The consequences of that decision were devastating for Mr and Mrs Waenga and, most tragically, for Adam Waenga. For whatever reason, Dr P appears to have ignored, or at least, simply failed adequately to take into account, the accumulation of sentinel events and thus the increased level of risk of uterine rupture, and jeopardy for his patients.

8.15 **IT** is also a matter of concern that, at no time, did Dr P discuss the progress of her labour, particularly in the context of a 'trial of labour' with either Mr or Mrs Waenga, except in the

most cursory way. Mrs Waenga had been warned that she was at risk as a result of the delivery of her first baby by caesarean section. Accordingly, she went to Dr P so that she could receive the care and advice of a xx. On her own admission, she had complete faith in him to take care of her and her baby.

8.16 **GIVEN** that he expressly warned her of the risk of uterine rupture at the outset, it was incumbent upon him to keep that risk uppermost in his mind, and to inform Mrs Waenga if there were any clinical indicators pointing to the possibility of that risk being realised in the course of the 'trial of labour', even if he thought that it might not, or might not actually, have eventuated. Given the disastrous consequences if uterine rupture was to occur, Dr P was, in the Tribunal's view, obliged to keep Mr and Mrs Waenga informed about the course of labour, and given them the opportunity to reconsider Mrs Waenga's desire to deliver naturally.

8.17 **AS** it was, in the absence of any information to the contrary, Mr and Mrs Waenga were lulled into a false sense of security and believed that they had nothing to be concerned about. Unfortunately for all concerned, there seems to have been a general lack of communication and dialogue occurring between Dr P and Mr and Mrs Waenga, and Dr P and the midwives.

Particular C: Erred in not monitoring the baby's foetal heart beat during the twenty two minutes prior to the delivery of the baby.

8.18 **THE** Tribunal is not satisfied that this Particular is established, principally because the timing recorded on the CTG trace, and the time of the sentinel events recorded in the clinical records, is inconsistent and imprecise. It is simply not possible now for the Tribunal

to determine, with a sufficient degree of certainty, the actual period between the cessation of the fetal heart monitoring and the delivery of Adam Waenga.

8.19 **DR** Westgate in her original comments, noted that contact with the baby was lost for 22 minutes. However the CTG trace itself is imprecise, and there appears to be some discrepancy between in the time/clock recordings on the CTG, and the clinical records. The Tribunal is satisfied that 'best practise', and the usual practise, is to remove the fetal scalp electrode immediately before delivery of the baby. It is possible, on the basis of the evidence, that this is what was intended by Dr P, but due to the need to obtain both the correct stirrups and the Neville Barnes forceps, there was some relatively short period of delay.

8.20 **THE** Tribunal considers that it is more likely than not that this period of delay was relatively short, perhaps 5 minutes. On the basis of the available evidence it could have been as long as 22 minutes, or as short as 3 or 4 minutes.

8.21 **IN** any event, the Tribunal is satisfied that the material period of delay, in terms of the outcome for Adam Waenga, was the delay in making the decision to expedite delivery, i.e. the period between 0310hrs and 0330-0345hrs. In terms of the estimates of the period of delay caused by the need to locate and provide the correct stirrups and the correct forceps, the Tribunal prefers the evidence of Mr Waenga and Midwife Y, and is satisfied, on the balance of probabilities, that this was a very short period, perhaps no longer than 3 - 4 minutes at most.

8.22 **BECAUSE** it has not been established that the period of time during which Adam's heart rate was not monitored was in fact as long as 22 minutes, the Tribunal is persuaded that Particular C is not established. In any event, it is clear that the CTG trace was non-reassuring for some time before it was stopped, it is unlikely that the CTG trace in the period immediately prior to delivery would have provided any information that Dr P and the delivery team were unaware of, i.e. that this was a baby in distress, albeit the actual degree of distress may not have been apparent until his birth.

8.23 **THE** Tribunal is satisfied that, in at least the last 10 minutes before the delivery, Dr P and the delivery team were moving as quickly as possible to deliver the baby, and it may be the case that the fetal monitoring was in fact continued up until this time. Dr P gave evidence that it is his usual practice to remove the FSE immediately before applying the forceps.

9. CONCLUSION:

9.1 **AS** stated above, and on the basis of all of the evidence presented to it, including the documentary evidence, professional papers, protocols and guidelines presented to it, the Tribunal is satisfied that Particular B is proven; Particulars A and C are not proven.

9.2 **HAVING** considered each of the Particulars individually, and in the context of Dr P's overall responsibility for Mrs Waenga's intra-partum care, the Tribunal then considered the charge in its totality. On that basis, the Tribunal's assessment of the 'degree' of the departure from acceptable standards by Dr P, identified by it in relation to Particular B, is such that it is satisfied that it does warrant the sanction of an adverse finding on the charge

laid against him, notwithstanding that the Tribunal has also determined that Particulars A and C are not proven.

9.3 **THEREFORE**, although the Tribunal's ultimate determination of the charge is made on the basis of its adverse finding in relation to Particular B only, given the seriousness of the finding of culpable error on the part of Dr P in relation to that Particular, the Tribunal is satisfied that Dr P's management of Mrs Waenga's labour and delivery did not constitute an acceptable discharge of his professional obligations as a xx with overall responsibility for Mrs Waenga's intra-partum care.

9.4 **ACCORDINGLY**, the charge is upheld and constitutes conduct unbecoming that reflects adversely on Dr P's fitness to practise.

9.5 **THE** Tribunal's decision is unanimous.

9.6 **THE** Tribunal also notes the concern expressed by Professor Stone that there was no evidence of any pre-induction CTG, and therefore no record of spontaneous uterine activity. Compounding matters from the outset, the midwife who inserted the prostaglandin gel was unable to feel the cervix with the result that an accurate assessment of the cervical state could not be made.

9.7 **NOTWITHSTANDING** that Mrs Waenga was a booked admission, her 'risk' status, and the reasons why she sought the care of a xx, her induction by insertion of prostaglandin

gel was left to a midwife, rather than being undertaken by Dr P himself, with the result that labour was commenced on the basis of incomplete information.

9.8 **THE** Tribunal records that the events which are the subject of this charge, at the date of the hearing, occurred some six years ago. Dr P told the Tribunal that this case has had a significant impact upon him, and the Tribunal has no doubt that is indeed the case. As a result of this case, he stated, he has an extremely low threshold of intervention for women who have had a previous caesarean section, and is probably, in the general scheme of things, over-cautious.

10. PENALTY:

10.1 **THE** charge having been upheld, the Tribunal invites submissions from Counsel as to penalty. The timetable for making submissions is as follows:

10.1.1 **THE** Complaints Assessment Committee should file submissions with the Secretary of the Tribunal and serve a copy on Counsel for the respondent not later than 14 working days from the date of receipt of this Decision.

10.1.2 **IN** turn counsel for the respondent should file submissions in reply with the Secretary and serve a copy on the Complaints Assessment Committee not later than 14 working days from receipt of the Complaints Assessment Committee's submissions.

10.2 **THE** Tribunal reminds counsel, and any other person whether a party to this proceeding or not, that the Tribunal has made orders that:

10.2.1 **THE** publication of the practitioner respondent's name or of any fact identifying him, including the name of his employer and his professional status as a xx, is prohibited until the commencement of the hearing of the charge laid against him by the CAC, or until further order of the Tribunal.

10.3 **ACCORDINGLY,** the Tribunal invites counsel to address the issue as to whether or not those orders ought to remain in place, or be discharged in their further submissions.

DATED at Auckland this 29th day of June 2000

.....

W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal