MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 163/01/70D

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 and 109 of the Act against **JEFFREY NORMAN HARRILD** medical practitioner of Masterton

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Ms S Cole, Dr M G Laney, Dr A M C McCoy, Dr B J Trenwith (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Masterton on Wednesday 20 June 2001

APPEARANCES: Ms K McDonald QC and Ms T Baker for the Director of Proceedings

Mr C J Hodson QC and Ms G Phipps for Dr J N Harrild.

The Charge

1. Pursuant to sections 102 and 109 of the Medical Practitioners Act ("the Act") the Director of Proceedings ("the Director") charged that Dr Harrild was guilty of professional misconduct.

2. The Charge was particularised as follows:

    1. Being unsure about the clinical picture Dr Harrild did not seek further appropriate obstetric advice.
    2. Misinterpreted the presenting clinical signs, more particularly Dr Harrild failed to appreciate the signs of fetal distress.
    3. Failed to correctly interpret the cardiotocograph tracing undertaken on the morning and afternoon of 2 October 1997 and the morning of 3 October 1997.
    4. Failed to effect immediate delivery by caesarean when the clinical signs indicated fetal compromise.
    5. Failed to communicate with his patient in a sensitive and supportive manner. More particularly Dr Harrild:
        (a) On 2 October 1997 did not warn his distressed patient that he would be suddenly banging her stomach with the scanner probe whilst undertaking an ultrasound on her.
        (b) On 3 October 1997 at 3.00 pm whilst undertaking an ultrasound Dr Harrild informed his patient and her husband that their baby had died in utero by saying "you're absolutely right, there is no heart beat."
    6. Failed to offer appropriate support and information to his patient and her husband when he advised them that their baby was dead. More particularly Dr Harrild:

(a) Spoke abruptly.

(b) Did not adequately inform them of their options for delivery and explain the process to be followed.

(c) Failed to offer suggestions for support and/or counselling.

7. The conduct alleged in paragraphs 1 to 6 amount to professional misconduct and paragraphs 1 to 4 inclusive either separately or cumulatively are particulars of that professional misconduct.

8. The conduct alleged in paragraphs 5 and 6 separately or cumulatively with any of particulars 1-4 amount to professional misconduct.

3. At the commencement of the hearing Counsel for the Director sought leave to withdraw Particular 1, and leave was granted.

4. Counsel for Dr Harrild, Mr C Hodson QC, advised the Tribunal that Dr Harrild admitted Particulars 2, 3 and 4. He denied Particulars 5 and 6 and he denied that any of the Particulars amounted to professional misconduct. Mr Hodson conceded that, in the alternative, the Tribunal might find Dr Harrild guilty of conduct unbecoming that reflected adversely on his fitness to practise medicine.

Factual background

5. The Charge against Dr Harrild arose out of his care of Mrs Amanda MacLeod at Masterton Hospital in October 1997.

6. In August 1997 Mrs MacLeod was referred to Dr Harrild, a specialist obstetrician and gynaecologist, by her GP, Dr Prior. It was Mrs MacLeod's first pregnancy and she was then aged 26 years. At the time, Mrs MacLeod's pregnancy was being managed by Dr Prior and an independent midwife, Shelagh Rayner. Dr Prior was concerned that Mrs MacLeod was large for her stage of pregnancy, and because she appeared to carrying an excess amount of amniotic fluid.

7. Dr Harrild carried out a scan and examined Mrs MacLeod. He was satisfied that there did not appear to be anything abnormal about her pregnancy, or her baby, but he ordered

her to cease working and to rest. He gave her a 'kick chart' to record fetal movements. The chart comprised a series of squares representing half-hour intervals. It covered the period from 9.00am to 9.00pm per day. Mrs MacLeod was to record baby's kicks, when she had recorded 10 kicks per day, she could stop recording the kicks for that day.

8. Dr Harrild told Mrs MacLeod that because she had scoliosis (a deviation of the spinal column) and had broken her pelvis in a car accident the previous year, it was likely that she would deliver her baby by caesarean section.

9. On 10 September 1997, Mrs MacLeod went back to Dr Harrild and he was satisfied that the excess amount of fluid appeared to have reduced, and that the pregnancy was proceeding appropriately. Mrs MacLeod continued to record fetal movements.

10. On 30 September 1997 Mrs MacLeod felt that her baby's movements had reduced, and she did not record the 10th kick until 9.00pm that night. She felt no movements during the night, and by 10.00am the following morning she was becoming concerned. Mrs MacLeod contacted Ms Rayner, who told her to go to Masterton Hospital to be monitored.

11. Ms Rayner commenced monitoring at 11.30am that day. Ms Rayner contacted Dr Prior and apparently asked him to come and see Mrs MacLeod straight away. He was not available to see Mrs MacLeod, but suggested that Ms Rayner contact Dr Harrild, which she did.

12. During the first monitor run, Mrs MacLeod felt three faint kicks. The baby's heart rate was around 160 beats per minute. Mrs MacLeod's was 120 beats per minute.

13. Dr Harrild arrived and examined Mrs MacLeod. He took her blood pressure and pulse and he arranged for her to be admitted . Mrs MacLeod felt no further movements that day.

14. Later in the day, around the time of the evening meal, another midwife, Ms Jenny Burt, performed another monitor run. After that run was completed she instructed Mrs MacLeod not to have anything to eat as she thought that Dr Harrild might want to deliver the baby by caesarean section. She contacted Dr Harrild and told him the results of the monitor run. In evidence she said that she considered that the recording was "*very flat*", and it indicated to her that the baby was in trouble.

15. Dr Harrild did not consider that immediate delivery was indicated, and Midwife Burt told Mrs MacLeod that Dr Harrild had viewed the monitor run and was not concerned.

16. Mrs MacLeod felt no movements during the night, and the monitor run on the morning of 2 October 1997 showed no change. By this stage Mr and Mrs MacLeod were becoming very anxious. Dr Harrild visited her that morning, and ordered blood tests and an ECG. He performed a further ultrasound scan. In the course of this scan Dr Harrild pushed or prodded Mrs MacLeod's abdomen in an attempt to startle the baby. He thought he saw the baby move as a result, but Mrs MacLeod did not think that the baby moved at all.

17. At tea time another monitor run was carried out, again by Midwife Burt, with a similar result to the previous evening. Midwife Burt again told Mrs MacLeod not to have dinner as she thought Dr Harrild would want to deliver the baby. However, about 6.30pm she returned to Mrs MacLeod and told her she could eat dinner as Dr Harrild had no plans to come in that evening.

18. At this time Midwife Burt brought a CTG trace from a 'healthy' baby, and showed Mr and Mrs MacLeod the difference between that trace and the trace obtained from their baby. The traces were markedly different. The trace from the MacLeod baby was flat, with no variability. Midwife Burt urged them to obtain a second opinion.

19. Mr and Mrs MacLeod contacted Ms Rayner to ask her advice. She told them that she trusted Dr Harrild's ability, and reassured them. Mr MacLeod asked one of the other midwives on duty to contact Dr Harrild and to ask him to come in and meet with them.

20. Dr Harrild arrived and he and the MacLeods and Midwife Hodder met in private. Dr Harrild told Mr and Mrs MacLeod that he thought that there was something wrong with their baby, but he did not know what it was. He said that he was waiting for blood test results, and that, in the meantime, the best place for the baby was where it was.

21. Mr MacLeod asked about the possibility of delivering the baby by caesarean section, but Dr Harrild warned of the risks such as difficulties under anaesthesia, and breathing difficulties for a baby born at 37 weeks. He said that he was not overly concerned with the CTG recordings.

22. On 3 October 1997, Mrs MacLeod thought she felt three kicks around 4.00am and another at 8.00am, however when Dr Harrild saw her that morning he told her that these movements 'didn't count' because they occurred before 9.00am. He asked a nurse to sit with Mrs MacLeod during the monitor run to feel for movements.

23. During the run the nurse thought she felt some movements, but Mrs MacLeod did not. Around 4.30 pm that day, Midwife Burt carried out another monitor run. She was unable to find a heartbeat, and fetched Dr Harrild. He took Mrs MacLeod for an ultrasound scan and, after pointing out the baby's head, arms and legs to Mr and Mrs MacLeod said, apparently to Midwife Burt, "*You're absolutely right. There is no heart beat*".

24. Mrs MacLeod did not realise the importance of this statement, and Mr MacLeod asked Dr Harrild if he meant that the baby had died. Dr Harrild replied, "*Well yes, I'm sorry*". After some moments, Dr Harrild pointed out the baby's heart and suggested that there might be some abnormality.

25. Mr MacLeod asked Dr Harrild what they should do. Dr Harrild advised against delivering the baby by caesarean, and said that Mrs MacLeod would most likely go into labour in a day or two. They should return to their home and if Mrs MacLeod did not go into labour, then she should return to the hospital and he would induce labour.

26. Dr Harrild then left the room. Midwife Burt also briefly left them alone, then returned and told them that they did not have to remain at Masterton Hospital, but could ask to be transferred to either Hutt Hospital or to Wellington Hospital. This they elected to do, and Dr Harrild was told that they did not want to continue under his care. Hutt Hospital was unable to admit Mrs MacLeod, and she could not be admitted to Wellington Hospital until the next day.

27. The MacLeod's therefore left the hospital and returned to their home some 64 kms from Masterton. Their respective families live in the South Island, and they were not offered any comfort, support or counselling by Dr Harrild. Mrs MacLeod vividly described feeling 'stunned' and bereft. She described her feelings of disbelief, and her hope that when she got to Wellington Hospital they would be told that a mistake had been made and that 'everything would be alright'.

28. Their baby daughter, Georgia MacLeod, was delivered stillborn at Wellington Hospital on 6 October 1997.

Evidence for the Director of Proceedings

29. Evidence was given to the Tribunal by Mr and Mrs MacLeod and Midwife Burt.

Evidence for Dr Harrild

30. In light of the admissions made by Dr Harrild, and by agreement between the parties, only Dr Harrild gave evidence on his own behalf.

The law

31. Dr Harrild was charged with professional misconduct, the middle of the range of professional disciplinary findings available to the Tribunal under s.110 of the Act. The test for professional misconduct is well-established. The most commonly cited formulation being that of Jefferies J *in Ongley v Medical Council of New Zealand*[1984] 4 NZAR 369:

"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would reasonably be regarded by his colleagues as constituting

professional misconduct? With proper diffidence it is suggested that 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 composition of the tribunals which examine the conduct. Instead of using synonyms for the two words the focus is on the given conduct which is judged by the application to it of reputable, experienced medical minds supported by a layperson at the committee stage."

32. In *B v The Medical Council* (High Court, Auckland, 11/96, 8/7/96), and in the context of a charge of conduct unbecoming, Elias J stated:

"In the case of diagnosis or treatment, conduct which falls short of the mark will be assessed substantially by reference to usual practice of comparable practitioners. In the case of adequacy of communication of information to the patient, however, wider considerations are relevant. In particular, the communication must be such as to adequately inform the patient, taking into account the patient's capacity to understand it and the purposes for which the information is relevant. What needs to be communicated may depend upon whether the information is provided pursuant to the patient's general right to know about his or her condition, or whether it is required to inform the patient's own conduct in matters such as consent to medical procedures, or co-operation with investigational treatment. These seem to me to be considerations which are relevant in assessing the conduct of a medical practitioner. Those standards to be met are, as already indicated, a question of degree; the practitioner is not a guarantor of the effectiveness of communication any more than he or she is a guarantor of the effectiveness of treatment. I accept that the burden of proof is on the balance of probabilities. Assessment of the probabilities rightly takes into account the significance of imposition of disciplinary sanction. I accept that the court must be satisfied on the balance of probabilities that the conduct of the practitioner is deserving of discipline."

33. As has been stated on previous occasions, the relevant principles which can be distilled from these statements are:

(a) A finding of professional misconduct or conduct unbecoming is not required in every case where a mistake is made or an error proven.

(b) 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).

(c) The departure from acceptable standards and/or the failure to fulfill professional obligations must be "*significant enough*" to attract sanction for the purposes of protecting the public.

34. On the basis of both *B* (supra) and *Ongley* (supra), both decisions given in the professional disciplinary context and on appeal from specialist tribunals, the question as to whether Dr Harrild's conduct is conduct which is culpable, i.e. is conduct warranting an adverse finding, is a question to be determined by this Tribunal. This applies notwithstanding any admissions made in relation to certain or all of the Particulars of the charge, and notwithstanding that any or all of the Particulars of a charge may be proven.

The Standard of Proof -

35. The standard of proof in disciplinary proceedings is the civil standard, the balance of probabilities. 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 -

36. The burden of proof is borne by the CAC.

The decision

37. Having carefully considered all of the evidence presented to it and the very helpful submissions made by both counsel, and having had the opportunity to assess the credibility of each of the witnesses, the Tribunal is satisfied that Particulars 2 to 4 inclusive should be determined separately from Particulars 5 and 6, such alternative being available to the Tribunal by virtue of Particulars 7 and 8 of the Charge.

38. The Tribunal was satisfied that the Particulars 2 to 6 inclusive did not cumulatively constitute professional misconduct. Accordingly, in relation to Particulars 2 to 4 inclusive, Dr Harrild is guilty of professional misconduct in terms of section 109(1)(c) of the Act; and in relation to Particular 6, Dr Harrild is guilty of conduct unbecoming that reflects adversely on his fitness to practise.

39. The Tribunal is satisfied that Particular 5 does not warrant the sanction of an adverse finding against Dr Harrild.

Reasons for decision

Particulars 2 - 4 of the Charge:

Dr Harrild misinterpreted the presenting clinical signs and failed to appreciate signs of fetal distress;
Dr Harrild failed to correctly interpret the CTG tracing undertaken on the morning and afternoon of 2 October 1997 and the morning of 3 October 1997;

He failed to effect immediate delivery by caesarean section when the clinical signs indicated fetal compromise.

Particular 7 of the Charge alleged that either separately of cumulatively with Particulars 5 and 6, Particulars 1 - 4 amount to professional misconduct on the part of Dr Harrild.

40. As a result of Dr Harrild's admission of these Particulars, the Tribunal's only task was to determine culpability, i.e. to determine first, if Dr Harrild's conduct constituted a professional disciplinary offence and, secondly, to determine if it reached the threshold of professional misconduct.

41. The central issue for the Tribunal was to ascertain whether or not Dr Harrild's conduct and management of the case (at the relevant time) constituted an acceptable discharge of his professional and clinical obligations. Only if the Tribunal identifies any such shortcomings or errors of clinical judgment (or, as in this case, they are admitted) may it go on to determine if those shortcomings or errors are culpable, and warrant the sanction of a finding against the practitioner. It is therefore the case that an error of judgment, or 'falling short', on the part of a doctor does not inevitably, attract sanction.

42. On the basis of both *B* (supra) and *Ongley* (supra), the question as to whether Dr Harrild's conduct is culpable, i.e. is conduct warranting an adverse finding, is a question squarely for determination by this Tribunal. Whether or not a practitioner is guilty of professional misconduct, is an objective test and is to be determined by the Tribunal. It involves an 'assessment of degree' on the part of the Tribunal.

43. In this regard, it is usually the case that the Tribunal is presented with evidence from other practitioners, generally senior, experienced practitioners with a high level of expertise in the relevant area of practice, against which the conduct under scrutiny may be measured.

Having said that, it is equally the case that while the evidence of expert witnesses is generally a useful guide, perhaps even the best guide, it is no more than that, and is weighed against the judgment of this Tribunal, comprising as it does a mix of lay persons and medical practitioners.

44. In this present case however, no such evidence was available to the Tribunal and Mr Hodson resisted the admission of any evidence, factual and clinical, relating to the particulars which were admitted by Dr Harrild. For a number of reasons this made the Tribunal's task of determining culpability very difficult. First, while it is true that one member of the Tribunal, Dr Laney, had relevant specialist expertise to contribute, the Tribunal's practice is always to ensure that its consideration of the evidence given, particularly its reasons for determinations made, is as open and transparent as possible.

45. While accepting that it is a specialist Tribunal comprising members who collectively have a great deal of experience and expertise to contribute to the task at hand, nonetheless the Tribunal does not, and is not permitted to, take into account information or advice not received in public in the hearing and/or canvassed with the relevant witness or witnesses. Therefore the Tribunal cannot operate in an 'evidential void'; it must be able to consider the charge, as particularised, in its proper factual, legal and circumstantial context. It would be unfair and improper to do otherwise.

46. For these reasons therefore, the Tribunal tends to err on the side of caution and to adopt a liberal approach to the admissibility of evidence. It gains support for this approach from the provisions of clause 6 of the First Schedule to the Act, which permits the Tribunal to receive as evidence "*…any statement, document, information, or matter that may in its opinion assist it to deal effectively with the matters before it whether or not it would be admissible in a court of law.*"

47. Thus, save for evidence which, for any reason, it may be unfair to admit, the Tribunal tends to allow all evidence presented to be admitted, subject to objection. This approach seems to be the most fair and sensible approach, especially if the evidence has been exchanged prior to the hearing and the parties have had an opportunity to be forewarned as to

content. It is also generally the case that all relevant documents, records and reports are included in the Bundle of Documents prepared by agreement between the parties and provided to the Tribunal in advance of the hearing. The weight which any of the evidence might ultimately be given is a matter for the Tribunal.

48. Secondly, while the Tribunal endeavours to appoint at least one member with expertise and experience in the respondent practitioner's area of medial practice, this is not always possible, nor is the Tribunal required to do so.

49. Finally, the views of each of the Tribunal members carry equal weight; none ought to be more persuasive, or determinative, than any other. All of the members have relevant experience and expertise to contribute and, as a specialist tribunal, its decisions reflect the collective judgment of all of the members appointed to hear a charge, not just those held or expressed by any of the members possessing relevant specialist expertise or knowledge: refer *MPDT v Parry*, unreported, AP49/01, HC (Auckland) 11/5/01, per Priestley J - the opinions of specialist members or medical members of the Tribunal are not accorded any greater weight or respect than the views expressed by any other member of the Tribunal.

50. However, in this present case, the members were satisfied that the CTG and monitoring data obtained from Georgia MacLeod was significantly abnormal. Certainly, Midwife Burt recognised this from the outset. However it appears that none of the other midwives who were monitoring Mrs MacLeod appear to have shared her concerns and were content to leave matters to Dr Harrild. The Tribunal concurs with Midwife Burt's assessment that the CTG was 'very flat', with no 'beat to beat variability'; it should have alerted Dr Harrild to the need to take prompt, appropriate action. If he was reluctant to deliver Mrs MacLeod by caeserean section at Masterton Hospital because of her prematurity, then transfer to a tertiary hospital, such as Wellington, should have been considered.

51. The Tribunal is satisfied that Dr Harrild's decision to 'wait and see' was a serious error of judgment on his behalf. In terms of degree, the Tribunal considered that the conduct alleged in Particulars 2 to 4, and admitted by Dr Harrild, amounted to a more serious departure from relevant acceptable standards than that alleged in Particulars 5 and 6. In

effect, Particulars 7 and 8 of the Charge permitted the Tribunal to treat the Charge as comprising two separate components.

52. Having considered all of the evidence presented to it, and for the reasons contained herein, the Tribunal decided that it was appropriate to deal with the Charge in that way and the Tribunal determined that, separately, Particulars 2 to 4 of the Charge amount to professional misconduct

Particular 5: Dr Harrild failed to communicate with Mrs MacLeod in a sensitive and supportive manner. More particularly, (a) he did not warn her that he would suddenly bang on her abdomen whilst undertaking an ultrasound examination, and (b), on 3 October 1997 whilst undertaking an ultrasound examination he informed Mr & Mrs MacLeod that their baby had died in utero by saying "you're absolutely right, there is no heartbeat."

Particular 5(a)

53. In relation to Particular 5 (a), the Tribunal is not satisfied that this allegation is proven to the requisite standard of proof. Clearly, in the course of carrying out ultrasound examinations on Mrs MacLeod, Dr Harrild did push, prod or even bang, on her abdomen in an attempt to startle, or stimulate, the baby into movement. Mrs MacLeod gave evidence that he had done this on previous occasions, and when he examined her on 2 October 1997. Mrs MacLeod understood the purpose of 'banging' on her abdomen.

54. Dr Harrild believes that he does warn patients if he is going to push or prod the baby to stimulate movement. He gave evidence that it was his customary practice to warn the patient that he was going to push or prod the baby. He did not accept that he 'bangs' on the patient's abdomen, and his practice now is to wait until he has received an indication from the patient that she has heard him and is aware of what he is going to do.

55. Mrs MacLeod also variously described the stimulus as a push or prod or bang. She said that she was startled by it, and that she was concerned for the safety of her baby. Having observed Dr Harrild give his evidence, and in response to Ms McDonald's cross-examination, the Tribunal gained the impression that he is quietly spoken, almost reticent, in his demeanour. It is possible that, particularly when concentrating on the task at hand, he

speaks quietly and he might not always make his intention clear to the patient. He might also be unaware that his patient has not heard what he has said.

56. In the circumstances, the Tribunal is not satisfied that it is proven, on the balance of probabilities, either that Dr Harrild failed to warn Mrs MacLeod that he was about to attempt to stimulate the baby, or, if he did fail to warn her, that he 'banged' on the baby, rather than merely prodded or pushed on Mrs MacLeod's abdomen.

57. Accordingly, the Tribunal is not satisfied that, either separately or cumulatively, the allegation contained in Particular 5 is proven, or warrants the sanction of a professional disciplinary finding.

Particular 5(b)

58. As to Particular 5 (b), the Tribunal is satisfied that the allegation is established, and that, when he undertook the ultrasound examination after Midwife Burt advised him that she was unable to find a heartbeat on her examination, Dr Harrild confirmed this *to her* by way of the alleged comment.

59. In response to a question from the Tribunal, Dr Harrild accepted that more was required from him. However, it also seemed clear to the Tribunal that Dr Harrild was himself shocked by the finding, and the consequences for Mr and Mrs MacLeod.

60. Although there were previous occasions on which he had had to advise a patient that her baby had died *in utero*, these had occurred in the context of a request for a specialist consultation rather than in a patient under his care. Although he was not Mrs MacLeod's lead maternity carer, he had been responsible for her care since her admission two days previously.

61. However, as stated above, not every error of judgment or mistake will be culpable, and warrant the sanction of an adverse finding against the practitioner. Whilst the Tribunal is satisfied that Dr Harrild should have coped with the situation better, or more professionally, it is not satisfied that his failure to do so amounts to a professional disciplinary offence.

62. Further, the Tribunal considers that the failure and/or omission on the part of Dr Harrild alleged in Particular 5 is, in substance, encompassed in the allegations contained in Particular 6.

63. Accordingly, Particular 5 is not established.

Particular 6: Dr Harrild failed to offer appropriate support and information to Mr and Mrs MacLeod when he advised them that their baby was dead. In particular, he spoke abruptly; did not adequately inform them of their options for delivery and explain the process to be followed; and he failed to offer suggestions for support and/or counselling.

Particular 8: That separately or cumulatively with the other particulars, Particulars 5 and 6 amount to professional misconduct.

64. In response to the allegations made in Particular 6, Dr Harrild gave evidence that after he advised Mr and Mrs MacLeod that their baby was dead, he left the hospital and returned to his home, which was located very close to the hospital - 'about two minutes away'. He intended to return to see them either later that evening, or the next morning. He said that he had told Mrs MacLeod that she could remain in the hospital, or return to her home and wait for labour to commence spontaneously. He reassured her that there was no rush about making a decision.

65. The reason for his suggestion that Mrs MacLeod might want to go home was because he was aware that sometimes it is distressing for patients whose baby has died to remain in hospital where the presence of newborn babies and other pregnant women may only add to their distress. He was concerned that being around mothers delivering well babies would be upsetting for Mrs MacLeod.

66. It was also his expectation that patients, like Mr and Mrs MacLeod, who are shocked or who have just received bad news, do not immediately take in all of the information being given to them. It was his intention to allow some time for what had happened to 'sink in', and then return a short time later to fully discuss options with them. Such options would include arranging counselling and support.

67. He also expected that Midwife Burt, who remained with them and who had spent a good deal of time with them, would assist them in the interim period, which he thought was appropriate as patients generally have a closer relationship with the midwife than with the specialist who spends less time with them.

68. However, he had only been at home a short time when he was telephoned by Midwife Burt and told that his services were no longer required because Mrs MacLeod wished to transfer to Hutt Hospital. When Hutt Hospital was unable to admit her, he contacted Wellington Hospital and arranged for her to be admitted there. He said that he did not understand that she was leaving Masterton Hospital that evening to return to her home before travelling to Wellington the next day.

69. In all the circumstances, the Tribunal does not consider that Dr Harrild's conduct at the time was manifestly inadequate or unprofessional. By his own admission, he was himself shocked by what had occurred, and he could have communicated better with Mr and Mrs MacLeod. However, any intention to return to them to offer support, counselling or more information was foreclosed by their decision, taken largely on Midwife Burt's advice, to refuse to have anything more to do with Dr Harrild.

70. By her own admission, Midwife Burt had little time for Dr Harrild. She considered him to be rude and unpleasant. Their relationship was not one of mutual confidence or professional respect. Midwife Burt had been expressing concerns about Dr Harrild's management of Mrs MacLeod's care from the time of her admission. This extended to her obtaining a CTG from another baby and showing it to the MacLeods in order to highlight the difference between their baby's CTG, and "*a healthy baby's*".

71. She also urged them to seek a second opinion, and to ask Dr Harrild to deliver their baby by caeserean. The Tribunal does not intend to imply any criticism of Midwife Burt who, because of her concerns, took on the role of advocate for both Mrs MacLeod and her baby.

72. Unfortunately as things turned out, her concerns appear not to have been shared by any of the other midwives, particularly those to whom Midwife Burt showed the MacLeod baby's CTG in an attempt to elicit support for her view that the CTG required Dr Harrild to intervene and deliver the MacLeod baby by caeserean section.

73. In fairness to both of Midwife Burt and Dr Harrild, it must also be borne in mind that neither of them were Mrs MacLeod's primary carers. Her Lead Maternity Carer was her GP, Dr Prior, and she also had an independent midwife, Ms Rayner. However, Dr Prior was apparently either not available or unwilling to interfere with Dr Harrild's assessment of the case, and Midwife Rayner reassured Mr and Mrs MacLeod that she trusted Dr Harrild's ability to properly manage her care indicating that both of them had confidence in Dr Harrild's ability to provide an appropriate standard of specialist care.

74. However, Dr Harrild accepted that as the specialist in charge of her care at Masterton Hospital he was ultimately responsible for Mrs MacLeod's well-being, and on that basis, the Tribunal is satisfied that Particular 6 is established. The Tribunal also decided that, as provided for in Particular 8 of the Charge, Particular 6 should be considered separately to Particulars 2 - 4.

75. The Tribunal does not consider that the allegations contained in Particular 6 amount to the same level of seriousness as those contained in Particulars 2 - 4. At the end of the day, and in the context of the range of penalties available to it pursuant to s.110 of the Act, the Tribunal must make an 'assessment of degree'.

76. Having found that Particular 6 is established, and that the allegations warrant sanction, but at a lower level than those contained in Particulars 2 - 4, the Tribunal is satisfied that Particular 8, in effect, comprises a separate charge and amounts to conduct unbecoming that reflects adversely on Dr Harrild's fitness to practise.

Conclusions

77. In the context of determining culpability, the Tribunal took into account a number of factors which it considered to be relevant considerations both in the context of the Tribunal's determination of Dr Harrild's culpability, and its ultimate determination as to penalty. The

Tribunal came to the view that these factors are also relevant to the extent that the Tribunal considers they may have contributed to Dr Harrild's serious lapse in judgment in this case, bearing in mind that Dr Harrild has been a specialist practitioner for more than 20 years and this is the first time he has been charged with a professional disciplinary offence. Accordingly, the Tribunal records that it took into account the following:

(a) Dr Harrild did adopt a bona fide 'wait and see' approach. In the course of the three days during which he let this approach run he did continue to monitor Mrs MacLeod and her baby; he carried out tests, and he consulted with other specialists, including Dr Jeremy Tuohy a specialist obstetrician at Hutt Hospital. This is not a case where the doctor purported to adopt a 'wait and see' approach but in fact 'did nothing'.

(b) The Tribunal was concerned to ascertain from Mr MacLeod that he and Mrs MacLeod had apparently been told by the pathologist who carried out the postmortem that had Georgia been delivered at the first sign of fetal distress she would have been safely delivered. On the basis of the written postmortem report, that is plainly incorrect. However, neither Mr or Mrs MacLeod have ever been shown the written report and were unaware of its contents.

(c) For completeness therefore, the Tribunal records that the pathologist reported that, on the basis of the postmortem findings, "*It is not certain that the child would … have survived if delivery had been expedited at the time of admission …*".

(d) Further, while Dr Harrild admitted that his management of Mrs MacLeod's labour was deficient, and that he made an error of judgment, the Tribunal is satisfied that the deficiencies in his clinical judgment and expertise that have been identified in this case do not raise concerns regarding his clinical judgment *per se*.

(e) Dr Harrild has served the Wairarapa region for over 20 years and, having had the opportunity to observe him, and to hear him give evidence at the hearing, the Tribunal came to the view that he is a caring and diligent practitioner who, when he realised that Mrs MacLeod's baby had died *in utero*, was, quite simply, overwhelmed.

(f) It is clear from Dr Harrild's evidence, and the information he provided to the Director of Proceedings in the course of her investigation, that he has practised under an exhausting, almost intolerable, burden of work and expectations, for many years. For seven years he was the only obstetrician and gynaecologist working in the Wairarapa. In 1997 when the events giving rise to this charge arose, there was one other O & G specialist at Masterton, but he preferred to practise on his own, and left soon afterwards.

(g) Furthermore, in 1997 Dr Harrild was practising without the benefit of a well-managed, efficient and well-resourced maternity unit. He agreed with Midwife Burt's assessment that the maternity unit at Masterton Hospital was "*dysfunctional*". Equipment was aged and the quality of the information that was obtained on ultrasound examination for example was compromised; there were staffing issues, and personal and/or professional conflicts of one sort or another between members of the nursing staff and practitioners.

(h) This is not a case of a practitioner who became isolated in a provincial centre and/or who deliberately failed to keep his skills up to date because he did not participate in ongoing professional and collegiate education. That he was apparently unable to engage in College and other professional activities as much as he would have preferred, or to undertake other professional education on a regular basis, was not due to any disinterest, professional indifference or laziness on his part.

(i) As best as he was able, he did participate in College activities, but his opportunities to do so were limited. It was difficult to attract a locum to the Wairarapa, and, if Dr Harrild left the area to attend a conference or for study leave, that would have meant that there was no obstetrician and gynaecologist available in the Wairarapa to maintain his service and to provide emergency care.

(j) Even with another specialist practising in the area, unless the two worked in practice together and shared patient care, it was still necessary to obtain locum cover if Dr Harrild wanted to leave the area, even for a short time. In addition, other

practitioners' needs for holidays, sick leave, or study leave had to be provided for. In the face of such demands, there was no possibility that Dr Harrild's professional, or personal, needs could be given any sort of priority.

(k) Dr Harrild did not refer to these matters by way of excuse, but the Tribunal is satisfied that it was appropriate to consider this case in its entire factual context and in the context of the professional environment in which it arose.

78. The Tribunal is satisfied that all of these factors contributed to the events at issue in this hearing. It was reassured to learn from Dr Harrild that, since 1997 and as a result of reviews of the events giving rise to this charge undertaken by Masterton Hospital and others, a number of changes have been instigated, both at Masterton Hospital and by Dr Harrild in his own practice, and the situation is much improved.

79. In addition to institutional changes, including the arrival of two other O & G specialists in the area which provided the opportunity for a more collegiate practice at Masterton Hospital, Dr Harrild has taken steps to improve his own practice. Unfortunately, Dr Harrild reports that there are again only two specialists available in the area.

80. However, neither the outcome for Mr and Mrs MacLeod, or subsequent events, are determinative for present purposes; it is the practitioner's conduct at the relevant time which is the subject of the Tribunal's scrutiny. The focus of the Tribunal's inquiry is the degree to which the practitioner's conduct fell short of acceptable, professional standards. In this case, the Tribunal is satisfied that Dr Harrild's conduct fell significantly below the standards reasonably expected of a specialist obstetrician, and constitutes professional misconduct.

Orders

81. The Charge of professional misconduct laid against Dr Harrild in relation to Particulars 2 - 4 is established and Dr Harrild is guilty of professional misconduct.

82. In relation to that part of Charge laid against Dr Harrild in Particulars 5 and 6, Particular 5 is not established, and Particular 6 is established and amounts to conduct unbecoming that reflects adversely on Dr Harrild's fitness to practise medicine.

83. The Director of Proceedings is to file submissions on penalty within 14 days of the date of this Decision.

84. Submissions on penalty on behalf of Dr Harrild are to be filed within 14 days thereafter.

DATED at Wellington this 4th day of July 2001

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W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal