MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 177/01/77D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against **KATHERINE MARYANNE MCKENZIE** medical practitioner of Auckland

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Professor W Gillett, Dr L Henneveld, Mrs H White,

Dr L F Wilson (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Auckland on Thursday 30, Friday 31 August and Saturday 22 September 2001

APPEARANCES: Mr M F McClelland for the Director of Proceedings

Ms H Winkelmann and Mr N Beadle for Dr K M McKenzie.

The Charge

1. The Director of Proceedings for the Health and Disability Commissioner, acting pursuant to sections 102 and 109 of the Medical Practitioners Act 1995 ("the Act"), charges that Dr McKenzie is guilty of professional misconduct. The charge alleges that, on or about 16 July 1996 whilst providing medical services to her patient, Mrs A, Dr McKenzie failed to act as a responsible obstetric registrar and failed to adequately assess or monitor her patient during her labour in that:

   (a) Dr McKenzie failed to take responsibility and fulfil the role expected of a registrar when supervising junior staff.

   (b) Upon being advised of Mrs A's admission and her previous history Dr McKenzie failed to personally assess the patient.

   (c) Having identified high risk factors for Mrs A, Dr McKenzie failed to notify the consultant on duty and discuss with him the management plan.

   (d) Dr McKenzie failed to ensure that the fetal heart rate was appropriately monitored.

   (e) Dr McKenzie failed to review the CTG tracings.

   (f) Upon identifying the high risk factors, Dr McKenzie failed to have a consultant perform an artificial rupture of membranes/get consultant to perform artificial rupture.

(g) Upon being informed that there was thick meconium liquor following an artificially ruptured membrane, failed to personally assess the patient.

(h) Upon being informed of the results of the vaginal examination failed to prepare for imminent delivery and failed personally to assess the patient.

(i) Upon being informed of a request for an epidural by the patient Dr McKenzie failed to assess her.

2. Dr McKenzie denied the charge.

Factual background

3. In December 1995 Dr McKenzie was appointed as a Registrar at National Womens Hospital (NWH) in Auckland. Dr McKenzie had been Acting Registrar for three months prior to her promotion and, at the time of her appointment as a Registrar, had about two and a half years experience in obstetrics and gynaecology as a Senior House Officer (SHO). In June 1996, Dr McKenzie transferred to the NWH's "Blue Team" and commenced her duties in that position on 10 June 1996.

4. The Blue Team at NWH is the team to which high risk patients are usually allocated. Prior to taking up her appointment to Blue Team, Dr McKenzie met with the medical staff co-ordinator in the HR Department at NWH. Because Dr McKenzie was relatively inexperienced as a Registrar and had been rostered on night duty for the first four days of her appointment, she was concerned to ascertain the level of backup in Blue Team that would be available to her.

5. Dr McKenzie was told that there were other more experienced registrars in the Team who would be supportive, as well as the consultant and also there was a new House Surgeon (SHO), Dr Saba Abdul Karim who had also recently been appointed to Blue Team.

6. Dr McKenzie was told that Dr Karim was a very experienced doctor and in fact had more obstetrics and gynaecology experience than her own and, given her experience, Dr Karim would be considered for a registrar's position in the next intake.

7. Dr Karim obtained her medical qualifications in Iraq. It now appears that the information that was available about Dr Karim's qualifications and experience was scanty at best. In her application for employment as a SHO at NWH Dr Karim states that she obtained her medical degree from a university in Baghdad in June 1986 and was employed as a chief resident/resident (obstetrics and gynaecology) in hospitals in Iraq from January 1990 to November 1995.

8. In May 1996 Dr Karim was granted probationary registration in New Zealand having passed the General NZ Regulations Examination (NZREX). As a probationary registrant she was required to work only in the hospital named in her registration certificate, and under close supervision by nominated supervisor. It appears that as at 16 July 1996, Dr Karim had practised under supervision in New Zealand for approximately 5-6 weeks and had been with the Blue Team for about 3 weeks. Dr Karim provided references in support of her application for employment at NWH but there was no evidence that anyone had checked Dr Karim's qualifications, experience, references or referees.

9. In the course of investigating Mrs A's complaint both of the Director of Proceedings and/or the Health and Disability Commissioner tried to locate Dr Karim, even to the extent of employing a private investigator, without success and apparently the authorities have no record of Dr Karim having entered or left New Zealand.

10. Mrs A presented at NWH at approximately 9.30am on 16 July 1996. Mrs A had received her ante-natal care at Waitakere Hospital and she was admitted to NWH under the care of the Blue Team as this team handles the maternal fetal medicine service, referrals from independent providers and referrals from other institutions. At any time, the team comprises a consultant, a registrar and a SHO.

11. In July 1996 Mrs A was 42 years old and pregnant with her seventh child. Her first four children were born in Samoa, apparently uneventfully. Her fifth child was delivered at NWH at term. With this delivery Mrs A suffered a post-partum haemorrhage and, in 1994, her sixth child was born by emergency caesarean section due to severe fetal distress. On this occasion, Mrs A again suffered a post-partum haemorrhage more severe than previously.

12. Accordingly, for her seventh pregnancy Mrs A was referred for specialist obstetric care at the Waitakere ante-natal clinic. At Waitakere Hospital Mrs A received her ante-natal care from Dr Naidoo (also a specialist obstetrician and gynaecologist). He recommended that she should have a cesarean section delivery due to her previous history. However Mrs A wanted to have a normal delivery if possible and accordingly the plan for this pregnancy was that shared care would be undertaken with her general practitioner, delivery would be at NWH and that a trial of labour would be undertaken. Mrs A's last ante-natal visit was on 15 July 1996. At that time, Dr Naidoo reported the CTG recording made at that visit as being satisfactory and he arranged to see her in a week's time.

13. Mrs A's pregnancy was a high risk pregnancy. She was a large woman, had had six previous deliveries and therefore was a grande multigravida, she was aged 42 and had had two previous post-partum haemorrhages and a pregnancy complicated by severe fetal distress. She was also past her due date, 10 July 1996. Given these factors, Mrs A required close monitoring and supervision to ensure the safe delivery of her baby. The extent of the risk for Mrs A and her baby was the subject of conflicting evidence at the hearing however, she was admitted to the care of the Blue Team, the team that is responsible for the most high risk patients cared for by the obstetric services offered at NWH.

14. NWH has published Guidelines for Obstetric Care (1995 ed) which, in relation to women who have had a previous cesarean section delivery, provide:

"On admission to delivery suite:

- *assessment by the Registrar on duty;*
- *discussion with Consultant on duty regarding his management plan. This plan should be documented in the patient's clinical notes;*
- *group, save and I.V. access."*

15. At the time of her admission Mrs A's ante-natal records were still at Waitakere Hospital and these were urgently requested and apparently delivered to NWH later in the morning. Mrs A was admitted at 9.30am by a midwife Ms Anne Killeen. Ms Killeen was a very experienced midwife. She graduated as a general and obstetric nurse in 1965 and had

worked as a midwife at NWH since 1986. Although Mr and Mrs A and Dr McKenzie remember the sequence of events differently, it appears most likely that Dr McKenzie and Dr Karim saw Mrs A shortly after her admission (probably between 9.39 – 9.47am). Mrs A was seen again by Dr Karim at 10.05am and then formally admitted by Dr Karim at 10.20am.

16. During the course of Mrs A's labour after admission there was no continuous fetal heart monitoring. The CTG recording indicates that in all there were five observations of the fetal heart rate made over a 2 hour 25 minute period. All of the recordings indicate an abnormal fetal heart rate. Ms Killeen gave evidence that she had also listened to the fetal heart rate by auscultation regularly throughout Mrs A's labour.

17. At 13.55 Dr Karim performed a vaginal examination and ARM. "Thick Meconium" was recorded and a fetal scalp electrode was applied. Dr McKenzie was informed at least that "meconium stained liquor" was seen, and a paediatrician was also informed.

18. At 1439 hrs the fetal heart rate dropped to 60, and then 50 BPM. Dr McKenzie was informed and at 1442 hrs she performed a vaginal examination. Both the paediatrician and the consultant on duty, Dr Souter, were called and Baby A was born at 1454 hrs in very poor condition with no heartbeat. Baby A died on 26 July 1996 as a result of severe ischaemic hypoxic injury which was likely to have occurred in labour.

Evidence for the Director

19. Evidence for the Director was given by Mr and Mrs A; Dr Peter Renou, a specialist obstetrician and gynaecologist from Australia and Dr Rob Buist, a consultant obstetrician and gynaecologist from NWH.

Evidence for Dr McKenzie

20. Evidence for Dr McKenzie was given by Dr McKenzie; Dr Jennifer Ann Westgate, an Associate Professor in obstetrics and gynaecology at Auckland University; Dr Jacqueline Smalldridge, consultant obstetrician and gynaecologist, Middlemore Hospital, Auckland,

Dr Smalldridge is also a training supervisor for the RANZ College of Obstetricians and Gynaecologists.

Other evidence

21. During the hearing the Tribunal became concerned that there were matters of fact in respect of which Mr and Mrs A and Dr McKenzie gave conflicting evidence. The Tribunal was satisfied that all of the witnesses were truthful witnesses, however one or other of them must have been mistaken as to the chronology of the events of 16 July 1996, and some of the other facts and circumstances described in evidence.

22. It was also of concern to the Tribunal that neither of the other participants in the events giving rise to the charge (Dr Karim and Ms Killeen) were being called as witnesses to give their accounts of all of the facts and circumstances otherwise canvassed in the evidence and entered into the record as documentary evidence. Dr Karim could not be called because her whereabouts are unknown, and Ms Killeen was not being called as a witness by either of the Director or Dr McKenzie's advisers.

23. The Director of Proceedings advised that Ms Killeen's conduct in this case was still under investigation and, later in the hearing, advised that Ms Killeen was also to be charged with a professional disciplinary offence.

24. Ultimately, the Tribunal decided that it should issue a witness summons requiring Ms Killeen to appear in the Tribunal. It arranged for Ms Killeen to receive legal advice and to be represented at the hearing by an Auckland barrister, Ms Kate Davenport. The Tribunal wishes to record its thanks to Ms Killeen and Ms Davenport for their co-operation in responding to the witness summons and for assisting the Tribunal by giving evidence and answering questions put to Ms Killeen by the Tribunal members.

The law

25. Dr McKenzie 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 oft-cited formulation being that of *Jefferies J Ongley v Medical Council of New Zealand* [1994] 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 of 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."

26. In *B v The Medical Council* (High Court, Auckland, 11/96, 8/7/96), and in the contest 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. …These standards to be met are, as already indicated, a question of degree; … 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."

27. The relevant principles applicable in this present case are:

(a) A finding of professional misconduct or conduct unbecoming that reflects adversely on the practitioner's fitness to practise 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.

28. On the basis of *B* (supra) and *Ongley* (supra), both decisions given in the professional disciplinary context and on appeal from this Tribunal's predecessors, the question as to whether Dr McKenzie's conduct is conduct which is culpable, i.e. is conduct warranting sanction, is a question to be determined by this Tribunal bearing in mind that it is well established that not every error, or error of judgment on the part of a practitioner, will be culpable, or warrant the sanction of an adverse professional disciplinary finding. Whether or not a practitioner is guilty of professional misconduct is an objective test and is a question squarely for determination by this Tribunal.

29. The Tribunal has also kept in mind that while the evidence of expert witnesses is a useful guide, perhaps even the best guide, it is no more than that and must be weighed against the judgement of this Tribunal, comprising as it does a mix of lay persons and medical practitioners.

The standard of proof

30. The standard of proof in disciplinary proceedings is the civil standard, the balance of probability. The standard of proof will vary according to the gravity of the allegations founding the charge and the standard of proof may vary within a single case, such as this, where the credibility of the witnesses on factual matters may be an issue of certain matters of fact and circumstance.

31. 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* (supra).

The burden of proof

32. The burden of proof is borne by the Director.

The decision

33. The Tribunal Members have, as always, carefully considered all of the evidence presented to it and the very helpful submissions made by both Counsel. Having had the opportunity to assess the credibility of each of the key witnesses, the Tribunal has determined that Dr McKenzie is not guilty of professional conduct in terms of section 109(1)(c) of the Act. The Tribunal also considered whether or not it should amend the charge to the lessor offence of conduct unbecoming and that conduct reflects adversely on Dr McKenzie's fitness to practice medicine, and determined that an amendment was not warranted.

34. The Tribunal's decision is a decision of the majority of the members of the Tribunal. For reasons which will also be given, the chairperson of the Tribunal, Mrs Brandon, departs from the majority decision, and would have found Dr McKenzie guilty of conduct unbecoming that reflects adversely on Dr McKenzie's fitness to practise.

Reasons for decision (Majority)

Particular 1 – [that Dr McKenzie] failed to take responsibility and fulfill the role expected of a Registrar when supervising her junior staff

35. The Tribunal is satisfied that, Particular 1 is established. This finding is unanimous, however the majority of the Tribunal members do not consider that Dr McKenzie's conduct in this regard falls so far short of acceptable standards as to warrant the sanction of an adverse professional disciplinary finding.

36. The Tribunal is satisfied that Dr McKenzie did accompany Dr Karim 'to assess' Mrs A when she was initially admitted into the delivery unit. Dr McKenzie introduced Dr Karim to Mrs A, and put in place a management plan for her labour. She asked Dr Karim to report at 3 hourly intervals throughout the course of Mrs A's labour.

37. The Tribunal is also satisfied that it was Dr McKenzie's expectation that the fetal heart rate would be continuously monitored and that Dr Karim and/or Ms Killeen would report any concerns to her.

38. The Tribunal is also satisfied that Dr McKenzie did believe that both Dr Karim and Ms Killeen were very experienced practitioners, and that Mrs A could safely be left under their direct supervision and management. Further, Dr McKenzie did actively keep herself informed about the progress of Mrs A's labour throughout the day.

39. It was Dr McKenzie's evidence that she had been told that Dr Karim was a very experienced doctor and in fact had more obstetrics and gynaecology experience than she did. She was also informed that Dr Karim would be considered for a registrar's position in the next intake. Although she did not work directly with Dr Karim in the sense of working alongside her prior to 16 July 1996, she formed the impression that Dr Karim was a very confident and experienced doctor. She had asked Dr Karim about her experience and had been told that Dr Karim was used to working essentially as a consultant and was not used to working 'like this', which Dr McKenzie took to mean reporting to another doctor.

40. On a number of occasions Dr McKenzie had asked Dr Karim whether she was comfortable in carrying out certain procedures, such as a vaginal examination and putting on a scalp clip. On every occasion Dr Karim had responded confidently that she was. Dr McKenzie therefore believed that what she was asking her to do in the context of managing Mrs A's case was well within Dr Karim's capability. In summary, Dr McKenzie "*had no cause for concern about her ability to assess a patient, or that she would have any difficulty in assessing a CTG*".

41. It was Dr Westgate's evidence that the tasks Dr McKenzie assigned to Dr Karim and Ms Killeen should have been well within the competence both of a doctor with over 5 years obstetrics and gynaecology experience who is soon to be appointed to a registrar post (Dr Karim) and of an experienced midwife. It was entirely reasonable for Dr McKenzie to believe that Dr Karim was very experienced in obstetrics and gynaecology and to

conclude that she should have been able to perform the tasks assigned to her appropriately.

42. It was also Dr Westgate's evidence that:

"Specialists and registrars rarely stay in a delivery room through a whole labour, but rather rely on the midwifes who do, to detect abnormalities in any of these parameters and notify them immediately. This happens every day (several times a day, in fact) in delivery suites throughout this country. At National Womens the caesarean section rate is in excess of 20% and management of women who are labouring with a previous scar is common and should be within the scope of an experienced NWH delivery suite midwife.

Dr McKenzie had worked with Ms Killeen in the last 2 years and regarded her as an experienced midwife. …it should have been within Ms Killeen's ability to care for Mrs A during her labour….

From what she was told of Dr Karim's experience, her own limited personal experience and the absence of adverse comments from colleagues it was entirely reasonable for [Dr McKenzie] to believe that Dr Karim was very experienced in obstetrics and gynaecology…".

43. The majority of the Tribunal accepts this evidence. It equally accepts that the outcome in this case highlights two problems:

- that the system used for teaching junior staff is potentially dangerous – junior or at least inexperienced, practitioners 'don't know what they don't know'. Those practitioners charged with supervising inexperienced or junior staff need to be diligent at the outset of the teaching relationship about the need for close supervision and regular checking; and

- it is extremely difficult to adjudicate on events 5 years after they have occurred.

44. A further difficulty which is highlighted in this case is the increasing concern on the part of the medical professional about the qualifications and skill of foreign trained doctors. Most of the evidence in this regard was given by Dr Westgate. She gave evidence that whilst New Zealand practitioners have found that overseas trained doctors who trained or who have worked in the United Kingdom or South Africa have very similar experience and

skills to New Zealand trained specialists, many practitioners involved in supervising overseas trained doctors have more recently come to the view that they were initially somewhat naive about the level of training and skills acquired by specialists trained in other overseas countries, particularly in the Middle and Eastern European countries, Iraq and Iran and the Indian sub-continent.

45. It was Dr Westgate's evidence that:

> *"In the last 3 to 4 years, I have come to appreciate that specialist status in some countries is obtained by passing exams with limited patient contact and practical experience. In New Zealand, registrars are appointed after at least 18 months practical experience in obstetrics and gynaecology and we expect a certain level of skill and expertise. Unfortunately, some overseas trained doctors and senior obstetrics and gynaecology trainees from some overseas countries do not have this level of skill.*
>
> *For example, when I started working at North Shore Hospital in 1999, one of the registrars was an Indian woman who had already done 3 to 4 years of obstetrics and gynaecology training at registrar level. However, we soon discovered that her clinical abilities were so limited that she was removed from the on-call roster, demoted to house officer status and her contract was not renewed when it ended. I am also aware of a Bulgarian doctor who was an obstetrics and gynaecology specialist in his country and a fairly senior academic who also had to be removed from the on-call roster during his first registrar post due to concerns at his lack of clinical ability. His first 'in-hospital clinical assessment' had to be abandoned because the specialist examiner had to counsel each woman he saw because he gave such bad clinical advice about their condition and management.*
>
> *Therefore, although the stated experience of some overseas trained doctors may suggest that they have comparable training and skills to doctors trained in New Zealand, that is not always the case. Whilst I know this now, it was not widely known in the mid 1990's when large numbers of overseas trained doctors started to arrived in New Zealand".*

46. Dr Westgate also went on to report that she had really only formalised the difficulties in relation to overseas trained doctors in her own mind this year. In the context of this case, where Dr McKenzie explained that it was common practice for her as a house surgeon to admit the patient (with the midwife), to do a CTG, blood pressure etc and discuss the case with the registrar, the registrar would assess the patient and know what the risk factors were, but would rely on the house surgeon to report on the procedures carried out on admission.

47. If the midwife or house surgeon expressed any concerns the registrar would become involved but he or she would otherwise often leave the house surgeon and midwife to deliver. As a house surgeon, if Dr McKenzie was ever in doubt it was her practice to ask for a registrar's opinion. She told the Tribunal:

> "*That was also the approach of my contemporaries and there was no ignominy in seeking assistance. That was how we learned. That was not only our practise, but also what was expected of us. My experience was that a basic level of competence on the part of the house surgeons was assumed by the registrars and this was understood by the house surgeons*".

48. However, it was Dr Westgate's observation that many overseas doctors have great difficulty in seeking assistance, possibly because it may be viewed as a sign of weakness. Many overseas trained doctors have trained in highly competitive environments, some are senior doctors or come from powerful and important families in their own country and find it embarrassing to admit they need assistance, especially to a younger New Zealand colleague, and others lack the insight that their skills are limited. Dr Westgate said that:

> "*… whatever the reason, this fundamental difference and the understanding of the model of supervision means I have had to significantly alter the way in which I interact with some overseas trained doctors*".

49. In summary, it was Dr Westgate's evidence that Dr McKenzie's supervision of her junior staff was acceptable practice.

50. However, Dr Buist described the NWH system as "*essentially that found in all clinical units that have grown out of the British Medical School/teaching hospital system*". It was his evidence that:

> "*… the nature of obstetrics has resulted in far greater initial involvement of registrars and consultants in initial management (certainly of cases with any degree of complexity) than in many other specialties. The usual practice at NWH is that women transferred from outside institutions or independent providers are referred directly to the registrar on duty. Registrars may delegate tasks to SHOs that may include initial assessment of patients. That delegation is based on their knowledge and interpretation of the SHO's experience and ability. Nonetheless we would expect a registrar to have personally assessed any patient referred from outside NWH with significant obstetric risk factors and to have notified the consultant of the case.*"

51. Both Dr Buist and Dr Westgate gave evidence of the increasing role of midwives in the New Zealand context. The Tribunal was advised that it is current practice for midwives to expect that referrals and reports from them to the medical staff will occur at registrar level or higher. There apparently is a midwifery viewpoint that SHOs have a level of expertise in maternity that is consistent with that of a student midwife and therefore should function in delivery units only in a learning role.

52. Dr Buist gave evidence that, at NWH, "*we would expect a registrar to:*

(a) accept and act upon requests to attend women by the midwifery staff;

(b) supervise the functioning of the SHO, delegating them tasks consistent with their experience and expertise;

(c) liaise closely with the specialist regarding high risk cases and situations;

(d) inform the specialist of any women they are taking to the operating room;

(e) request the specialist attend at any time they feel it appropriate for them to do so."

53. Dr Buist also referred to the NWH's Guidelines for Obstetric Care (1995 edition) which states:

"For women with a previous caesarean section, The National Women's Hospital Guidelines for Obstetric Care (1995 edition) states:

On admission to delivery suite:

- *assessment by the registrar on duty*
- *discussion with consultant on duty regarding his management plan. This plan should be documented in the patient's clinical notes*
- *Group, save and IV access."*

54. Dr Renou, a consultant obstetrician and gynaecologist called by the Director to present independent expert evidence, considered that a registrar's delegation of tasks to an SHO must be based on their knowledge and interpretation of the SHO's experience and ability. In this latter regard, it would seem to be a matter of commonsense that any professional person, bearing responsibilities (especially responsibilities as serious as those Dr McKenzie

was required to discharge in relation to Mrs A and her baby) must be both cautious and diligent in delegating those responsibilities to more junior practitioners.

55. This is especially the case when the person to whom responsibility is delegated is not well-known to the delegator, and the delegator has had no opportunity to personally assess the expertise, experience and judgment of the delegatee. Further, as registrar, and given that Dr Karim had probationary registration only, Dr McKenzie was Dr Karim's supervisor. In relation to this issue, the minority member accepts and adopts the Director's submissions set out in paragraphs 65 to 68 inclusive, herein.

56. It is also relevant that in the context of Dr McKenzie's delegation to Dr Karim in particular, she knew that Dr Karim's training and experience was very different to her own and she had no means of ascertaining the correctness of the information she had been given about Dr Karim's abilities except by personally observing her 'in action'. Her only opportunity to do this would have been by closely supervising her, especially in the initial stages of their professional relationship.

57. The Tribunal also considered it relevant that Dr McKenzie did not report Mrs A's admission to the unit to her consultant, Dr McPherson, and discuss her management plan for Mrs A's labour with him, as required by the guidelines. The Tribunal acknowledges, that as a matter of general practice, the guidelines may not have been strictly adhered to by all registrars on all occasions.

58. However, if a registrar elects to depart from the guidelines then they must equally assume a greater responsibility in terms of their obligation to the patient. It was the minority member's view that a more junior doctor, such as a registrar, can't have it both ways; if they elect not to adhere to the guidelines then they assume a greater obligation toward the patient in terms of their own responsibilities.

59. In terms of the applicable law, much was made of Dr McKenzie's inexperience as a registrar. However, the law requires that a practitioner who is inexperienced or who is just learning a particular task or skills must come up to the standards of the reasonably competent and experienced person. It is a consequence of the rule that a practitioner will

be judged according to 'the ordinary skill of a practitioner carrying out the subject task', that the standard of care expected of the reasonable practitioner is objective, not subjective. The rule takes no account of the particular idiosyncrasies or weaknesses of the subject practitioner.

60. This principle applies with as much force to an inexperienced doctor as it does to, say, an inexperienced motorist. In *Jones v Manchester Corporation* [1952] 2 All ER 125, a patient died from an excessive dose of anaesthetic administered by an anaesthetist who had only been qualified for five months. The Court of Appeal made it clear that it was not defence to an action by a patient to say that the anaesthetist did not have sufficient experience to undertake the task, or to say that the surgeon in charge was also to blame.

61. The issue arose in *Wiltshire v Essex Area Health Authority* [1986] 2 All ER 801 in which a premature baby in a special care baby unit received excess oxygen due to an error in monitoring its supply of oxygen. An inexperienced doctor had inserted a catheter into a vein rather than an artery. This in itself was not a negligent error. However, on checking the position of the catheter by means of an x-ray, the doctor had failed to spot that the catheter was mispositioned. He did ask a senior registrar in the unit to check the x-ray but the registrar also failed to notice the mistake. The majority held that the notion of a duty tailored to the particular practitioner, rather than to the act which he elects to perform, had no place in the law of tort.

62. The effect of applying a subjective test would be that the standard of care that a patient would be entitled to expect would depend upon the level of experience of the particular doctor who happened to treat him. A professional person who assumed the performance of a task must bring to it the appropriate care and skill, although the standard of care should be related, not to the individual, but to the post which he or she occupies.

63. It followed that the standard was not just of that of the averagely competent and well-informed junior houseman (or whatever the position of the doctor), but of a person who holds such a post in a unit offering a highly specialised service, while recognising that different posts make different demands; inexperience was not a defence to an action for professional negligence. The duty arises by virtue of the fact that the practitioner has

undertaken to perform a particular act or procedure, and by doing so professes that he has the competence to perform it with skill and care.

64. In submissions, Mr McClelland referred to this Tribunal's observations in the *Phipps* Decision (156/99/43C) which related to events in Dunedin Hospital in 1994. In that Decision the Tribunal determined (p12):

"While this will vary with the ability and maturity of these doctors and how well we know their attributes and our confidence in them the responsibility and consequences of delegation is ours.

…when they express concern or are dealing with problems beyond their experience or ability. Any request by a junior for assistance must be attended immediately."

65. It was Mr McClelland's submission that while tasks may be delegated to an SHO where appropriate, actual responsibility can never be delegated, nor can the consequences of delegation be avoided. In this regard, it was the Director's submission that:

"Responsibility for a delegated task must always lie with the delegator; a delegator can never absolve him or herself of the responsibility through delegation, nor of the consequences of that delegation. This is commonsense. If it were possible for the delegator to absolve him or herself of responsibility through delegation then there is no point in having a hierarchal system. The inevitable result would be that all responsibility would be passed down or delegated to the person or persons at the bottom of the hierarchal ladder."

66. It was submitted that this was precisely what occurred in this case. In her defence Dr McKenzie argued that she was entitled to rely entirely and absolutely on the SHO, Dr Karim; that through delegation Mrs A became Dr Karim's responsibility; and she should not be held responsible for the consequences of the delegation if Dr Karim (and the midwife) failed to tell her or report accurately on what was happening. In other words, said Mr McClelland, the thrust of Dr McKenzie's defence was that "*it is Dr Karim's (or the midwife's) fault, not [Dr McKenzie's] mine and I should not be held accountable for the consequences of my delegation to her*".

67. For the Director, Mr McClelland submitted:

"While such an argument may have an initial appeal, its fundamental flaw is sadly and graphically demonstrated in this case where the SHO, to whom all responsibility was delegated by Dr McKenzie, was either incompetent, inexperienced, lacked judgment or simply incapable of identifying situations which were outside her level of skill or experience. Despite glaringly obvious indications throughout Mrs A's labour and from the time of her admission that things were not right, Dr Karim apparently did not recognise these indications as such and therefore saw no need to seek help from the person responsible for supervising her. And because Dr McKenzie had seen fit to dispense with the need to supervise and monitor Dr Karim these indications continued for some 5½hours totally undetected. Had Dr Karim been properly supervised or supervised at all by Dr McKenzie then the warning signs should have been detected.

The Tribunal must ask itself whether, in such a high risk labour, it was appropriate for Dr McKenzie to not only delegate to Dr Karim full responsibility for the management of Mrs A's labour, but also at the same time to absolve herself of all responsibility for supervising and monitoring the SHO for whom she remained directly responsible. If the common sense test is applied then the answer must be "No". As acknowledged by the Tribunal in ***Phipps****, supervision is an essential part of delegation within the hierarchal system. If the requirement for effective and actual supervision is no longer recognised or somehow watered down then one of the essential "checks" within the system will be lost. A system based on delegation without supervision and responsibility will not work to the benefit of the patients and the community.*

For the hierarchal system to work there must be appropriate delegation of tasks. As was noted by both Dr Renou and Dr Buist, a Registrar's delegation of tasks to a SHO must be based on their knowledge and interpretation of the SHO's experience and ability. This is precisely what the Protocol as endorsed by the Tribunal in ***Phipps*** *was referring to when noting that the degree of supervision will vary with the ability and maturity of the doctors being supervised, and how well those delegating know their attributes and how much confidence they have in them.*"

68. Having taken all of these submissions, and the relevant evidence, into account, the majority of the Tribunal members did not accept these submissions and were satisfied that Dr McKenzie should not be held liable in circumstances where all of the information she was given reassured her that Mrs A's labour was being appropriately managed by an experienced doctor, and very experienced midwife.

69. The majority accepted Dr McKenzie's evidence that she had made herself available throughout the day; that she had 'checked in' three hourly as arranged and that she did discuss the progress of Mrs A's labour with Dr Karim and Ms Killeen at regular intervals throughout the day, and considered that this conduct and management of Mrs A's labour

constituted an acceptable discharge of her obligations and responsibility as the registrar directly responsible for Mrs A's care, taking into account her own level of expertise and experience supervising junior doctors.

70. In particular, it was the view of the medical practitioner members of the Tribunal that more junior doctors, such as registrars, are not formally taught how to supervise junior staff. The system of teaching such skills is *ad hoc* and, as doctors are promoted they take on their increasingly senior roles according to how they, in turn, were treated. In this regard, role models are crucial. If a more junior doctor has good role models in this regard then they are likely to demonstrate a high level of skill in supervising more junior staff.

71. In all the circumstances, the majority of the Tribunal members were satisfied that while Particular 1 was established, and that Dr McKenzie did make an error of judgment in failing to supervise Dr Karim in particular, more closely, her failings in this regard did not constitute a professional disciplinary offence. The minority member departs from the majority in relation to these findings.

Particular 2: Upon being advised of the patients' admission and her previous history [Dr McKenzie] failed to personally assess her.

72. The majority of the Tribunal members were satisfied that this Particular is not established. The Tribunal is satisfied that Mr and Mrs A were mistaken in their evidence about the time at which Dr McKenzie visited Mrs A after she was admitted. As stated above, the Tribunal has no doubt whatsoever that Mr and Mrs A were truthful witnesses, however the CTG trace which records that the CTG was commenced at "*9.39*" and then immediately ceased and recommenced at '*9.47*' is consistent with both Dr McKenzie's and Ms Killeen's account of Dr Karim and Dr McKenzie arriving in Mrs A's room as Ms Killeen was admitting her, and as Ms Killeen attached the CTG monitor. Ms Killeen confirmed that she had attached the monitor, but did not start the recording until after Drs McKenzie and Karim left.

73. The majority of the Tribunal is therefore satisfied that Dr McKenzie did *"personally assess*" Mrs A on admission and that Particular 2 is not established. However the Tribunal also records that Mrs A's records from her previous pregnancies were not

available when she was admitted on 16 July 1996, but her records were requested and they did arrive at the unit later in the morning.

74. However, Dr McKenzie did not review those records, and it appears that neither Dr Karim nor Ms Killeen reviewed and/or reported in that regard to Dr McKenzie. In this regard, the system of transferring records between locations when the patient's antenatal care is provided at a location some distance from the delivery unit, is unsatisfactory and, to the extent that possibly crucial information was not obtained and/or reviewed by Dr McKenzie, it is unsafe.

75. In evidence, it became apparent that the CTG recording made at her antenatal visit the previous day might have indicated that her baby was already compromised. Because Mrs A's antenatal record was not at NWH when she arrived in labour, and the records were not delivered to Dr McKenzie (or requested by her) for review when they arrived at the hospital (and also because she failed to ensure that the CTG monitoring was continuous), Dr McKenzie did not have crucial information which might have enabled a better outcome for Baby A.

76. The minority member also departs from the majority in relation to this Particular and would have found it established. It is the view of the minority member that, given the presence of risk factors and Mrs A's history of poor delivery outcomes, her labour needed to be closely and carefully managed, and Dr McKenzie both had, and assumed, primary responsibility for ensuring that was done.

Particular 3: Having identified high risk factors for [Mrs A] failed to notify the consultant on duty and discuss with him the management plan.

77. The majority of the Tribunal members are satisfied that, while Dr McKenzie did not formally notify the consultant on duty (then Dr McPherson) of Mrs A's admission, and discuss with him the management plan she agreed with Dr Karim, this omission does not constitute a professional disciplinary offence.

78. In relation to this Particular, the majority of the Tribunal members concur with the evidence given by Dr Westgate that, in 1996, a significant proportion of consultants would not have expected a registrar of Dr McKenzie's experience and competence to refer a case such as this one to them, so long as the CTG was satisfactory and Mrs A was to be continuously monitored and reviewed by competent staff at suitable intervals. That is, in Dr Westgate's experience, referral of all women in labour with a previous caesarean to a consultant was not an invariable practice in New Zealand in 1996, notwithstanding the stipulations contained in the NWH Guidelines.

79. On the basis of the evidence presented to it, it seems that Dr McPherson was aware of Mrs A's admission (most likely from Dr Karim) and he was content to leave the management of her labour in Dr McKenzie's hands, subject to any advice or information that Mrs A's labour was not progressing satisfactorily.

80. On 16 July 1997 it was necessary for Dr McPherson to leave the unit and, prior to his departure, he consulted with Dr Souter and updated him on the status and condition of all of the patients who were in the unit at the time. In other words, there was a formal hand-over by Dr McPherson to Dr Souter. It was also Dr McKenzie's understanding that between 1230-1300 hours Dr Karim discussed Mrs A's case with Dr McPherson and that he was happy with the plan that had been made at the outset, but told Dr Karim to do an ARM.

81. In light of this evidence, the majority of the Tribunal members were satisfied that this particular was not established, with Mrs Brandon departing again from the majority view.

Particular 4: [Dr McKenzie] failed to ensure that the fetal heart-rate was appropriately monitored, and

Particular 5: [Dr McKenzie] failed to review the CTG tracings.

82. The majority of the Tribunal members were also satisfied that these particulars were not established, largely for the same reasons given in relation to Particular 1 – that when she initially assessed Mrs A the CTG monitor was attached and Dr McKenzie reasonably

expected that the CTG recording would be commenced and maintained in accordance with the management plan she agreed with Dr Karim.

83. In the absence of any advice to the contrary from either Dr Karim or Ms Killeen, Dr McKenzie could not have known that the CTG monitoring was carried out only intermittently, rather than continuously. On that basis, the allegation that Dr McKenzie failed in her professional obligations owed to Mrs A, is not proven.

84. The majority of the Tribunal members were satisfied that, in the absence of any advice to the contrary, Dr McKenzie was not reasonably required to check the monitoring, either as to its content or its frequency and she should not be held liable for the decisions on the part of Dr Karim and Ms Killeen to depart from the usual and accepted practice of ensuring that the patient was continuously monitored, and from the management plan instructed by Dr McKenzie.

85. Mrs Brandon also departs from the majority finding in relation to Particulars 4 and 5.

Particular 6: Upon identifying the high risk factors [Dr McKenzie] failed to have a consultant perform an artificial rupture of membranes/get consultant to perform artificial rupture.

86. The Tribunal is satisfied that this particular is not established and that the performance of an ARM is generally accepted as being within the competence of registrars, midwives and SHOs.

87. Dr Karim elected not to perform an ARM as she considered that the presenting part of the baby was very high and she did not feel it was safe to perform an ARM. She advised Dr McKenzie accordingly, and Dr McKenzie agreed under those circumstances that this was a reasonable decision.

88. She instructed Dr Karim to re-examine the patient in three hours and if Mrs A's waters had not broken by then, then an ARM would be performed. As far as Dr McKenzie was aware, all appeared to be going to plan.

89. Dr Renou gave evidence that it is his general practice to perform an ARM early in the labour. However, the Tribunal is satisfied that this is a matter that largely depends on an individual practitioner's personal preferences and experience Dr McKenzie's management of Mrs A's labour was consistent with accepted standards and practice, and was therefore not deficient in this regard.

90. Accordingly, Particular 6 is not established. This finding is unanimous.

Particular 7: Upon being informed that there was thick [meconium liquor] following an artificially ruptured membrane, [Dr McKenzie] failed to personally assess the patient.

91. The Tribunal is satisfied that Particular 7 is not established.

92. There was a significant degree of conflict in the evidence given in relation to this issue. Whilst Mrs A's clinical record made by Ms Killeen at the time (1355) records: "*ARM thick meconium ...*" and, at 1448 hours, Dr McKenzie recorded "*Called urgently ... fetal heart not recordable ... V/E – 9cm ... ST -3 to -4 ... LOT ... Thick meconium ...*" it could not be established to the requisite degree of proof that Dr McKenzie was "*informed that there was thick meconium liquor following an artificially ruptured membrane ...*".

93. Ms Killeen was questioned on this point when she gave evidence. She told the Tribunal that:

> *"I can't recall verbatim what I said on the phone when I reported the findings, but I think it would be unlikely that I would write it in two places ... and not report it as such."*

94. Dr Renou gave evidence that it is his practice, if he is told that there is meconium stained liquor, to ask for further information, for example, "*is the meconium thick or thin*"?

95. However, Dr Westgate gave evidence that it is her experience in Auckland, with the largest Pacific Island population in the world, that as a racial group, Pacific Island women are significantly more likely to have meconium in the liquor than any other racial group (25% incidence). While the presence of thick meconium places the foetus at a significantly

increased risk of pre-natal mortality, the mere presence of "*meconium*" per se would not necessarily have alerted Dr McKenzie to anything untoward.

96. Therefore, in the absence of any other indications that Mrs A's labour was not progressing normally, Dr McKenzie would not have been alerted to any need to personally assess Mrs A.

97. Given the conflicting factual evidence regarding what Dr McKenzie was told, the Tribunal is satisfied that Particular 7 is not proved to the requisite standard of proof and therefore this Particular is not established. This finding is unanimous.

Particular 8: Upon being informed of the results of the vaginal examination, [Dr McKenzie] failed to prepare to imminent delivery and failed personally to assess the patient.

AND

Particular 9: Upon being informed of a request for an epidural by the patient failed to assess the patient.

98. The Tribunal is not satisfied that either of these particulars are established. They are satisfied that Dr McKenzie did make herself available to deliver Mrs A's baby immediately that was indicated. Dr McKenzie gave evidence that she had been intending to carry out a caesarean section operation on another patient that afternoon, but had made arrangements for another doctor to undertake that procedure in order to stay close by and to take over from Dr Karim and Ms Killeen if required.

99. In this regard, the Tribunal is satisfied that Dr McKenzie's conduct in remaining in the vicinity and accessible to Dr Karim and Ms Killeen was appropriate. Also, given its finding in relation to Particular 7, it cannot be certain what information Dr McKenzie was given. If she was not given all of the information which would have mandated immediate delivery, she cannot be held liable for failing to do that.

100. Accordingly, while the Tribunal accepts that she did not personally attend and assess Mrs A's labour prior to being urgently summoned when the CTG indicated that the baby's

heartbeat had ceased, it is however, satisfied that she did remain in the vicinity and available to act promptly if summoned.

101. In relation to Particular 9, all of the evidence on this point was consistent; at the time Mrs A requested an epidural, delivery was imminent and an epidural would have been ineffective.

102. Accordingly, the Tribunal is satisfied that Particulars 8 and 9 are not established. These findings are unanimous.

Minority View (Mrs Brandon)

103. As stated above, the minority member, Mrs Brandon, departs from the views of the majority in relation to Particulars 1 – 5 only. In relation to Particular 1 – Mrs Brandon considers that Dr McKenzie's conduct in failing to adequately supervise Dr Karim was not an acceptable discharge of her professional obligations towards Mrs A. She is therefore satisfied that Dr McKenzie's failings in this regard are significant enough to warrant the sanction of an adverse professional disciplinary finding.

104. Whilst Mrs Brandon makes this finding on the basis of the evidence presented and the applicable law, she also wishes to record that she agrees with the Director's assessment that, to a large extent, Dr McKenzie's defence relied on discrediting Dr Renou; to a lesser extent, Dr Buist and, indeed, even foreign-trained doctors. It is Mrs Brandon's view that both the nature and extent of the attack on the evidence given by Dr Renou in particular, was misplaced and inappropriate.

105. Notwithstanding, the Director is correct to assert that, at the end of the day, it is not for the expert witnesses to determine whether professional standards have or have not been met in any particular case. Rather, that is entirely a matter for the Tribunal, and is a matter that must be determined on the basis of all of the evidence presented to it, and the applicable law.

In relation to Particulars 2-5

106. Mrs Brandon is also satisfied that these Particulars are also established and that Dr McKenzie's failings in this regard do constitute a professional disciplinary offence.

107. Mrs Brandon accepts the Director's submissions that, apart from briefly meeting with Mrs A at about 0945 hrs, Dr McKenzie had no further personal contact with Mrs A until she was urgently requested to attend at approximately 1440 hrs, and the nature and extent of her 'clinical' attendances was inadequate in the circumstances.

108. This is especially disturbing in the context of a patient with known risk factors admitted to a service (Blue Team, NWH) to which only high risk patients are usually allocated. Mrs Brandon does not accept Dr Westgate's evidence that Dr McKenzie's merely *considering* personally reviewing Mrs A without actually doing so, constituted an acceptable discharge of her professional obligations.

109. Mrs Brandon also considers that in determining this present Charge, it is relevant, fair and necessary to take into account similar cases, and the findings made by the Tribunal on other occasions. In the context of this case, Mrs Brandon considers that it is a relevant consideration that in a recent case the practitioner (albeit a specialist obstetrician) was found guilty of professional misconduct in circumstances where he failed to correctly interpret a continuous fetal heart recording. In this case, Dr McKenzie failed to look at the fetal heart recording at any time throughout the period of Mrs A's labour.

110. Even the most cursory inspection would have disclosed two salient facts: first, that the recording was not continuous and, secondly, that it indicated fetal distress. It hardly needs stating that it would not be in the interests of patient safety if it were the case that if a practitioner acts and gets its wrong, he or she may attract sanction, but if they do nothing, they avoid liability.

111. Having determined that Particulars 1-5 are established, and warrant the sanction of an adverse finding, Mrs Brandon would have determined that, on a cumulative basis, Dr

McKenzie is guilty of conduct unbecoming and that reflects adversely on her fitness to practise.

112. In making this finding, Mrs Brandon wishes to record that this determination is made on the basis of Dr McKenzie's conduct on 16 July 1996, **not** in terms of her current practice. Dr McKenzie gave evidence that this case has caused her to reflect carefully upon her practice in 1996 and that she was, and remains, devastated by the death of Baby A and that not a day on duty in delivery suite passes without her thinking of her and her mother.

113. As is frequently observed in this Tribunal, Dr McKenzie has undergone a lengthy period of introspection and self-examination, to the extent that she has questioned whether she should continue in a career of obstetrics and genecology, or indeed medicine. Dr McKenzie has also changed her practice in a number of respects.

114. Dr McKenzie gave evidence to the Tribunal regarding her present practice of seeing every patient in the delivery unit at regular intervals, usually every two hours depending on what else is going on. It is immaterial whether the patient is a high risk patient or not, she sees them all and she is much less inclined to rely on what she is told, preferring to check herself.

115. In all respects, Dr McKenzie's professional practice since the tragic events giving rise to this charge, appears to be quite different. She is apparently highly regarded by her peers and her employer. It is likely she may be offered a consultant position in the near future. It has also obviously caused a great deal of hardship and stress to both Dr McKenzie and Mr and Mrs A that the process of investigating and laying this charge has extended over five years.

116. It is therefore the Tribunal's view that, on the basis of the evidence presented regarding Dr McKenzie's professional practice since 1996, Dr McKenzie is a competent, professional and diligent practitioner.

117. In view of the Tribunal's determination that Dr McKenzie is not guilty of the charge of professional misconduct, there are no issues as to costs or penalty.

DATED at Wellington this 9th day of November 2001

....

W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal