MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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NB: BY ORDER OF THE DISTRICT COURT PUBLICATION OF THE RESPONDENT'S NAME IS PROHIBITED	**DECISION NO:**	184/01/83C
	IN THE MATTER	of the Medical Practitioners Act 1995
		-AND-
	IN THE MATTER	of a charge laid by a Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against H medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Mrs J Courtney, Dr R W Jones, Dr C P Malpass, Dr F McGrath (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Auckland on Monday 5, Tuesday 6 and Wednesday 7 November 2001

APPEARANCES: Ms K G Davenport for the Complaints Assessment Committee ("the CAC")

Mr A H Waalkens for the respondent

The Charge

1. The Complaints Assessment Committee pursuant to section 93(1)(b) of the Medical Practitioners Act 1995 charged that H medical practitioner, of xx between 8 March 1995 and 18 March 1995 at xx ("xx"), in his management and treatment of the late A:

   (a) Failed to clinically assess the late A to an adequate standard;

   (b) Failed to review the medical notes of the late A;

   (c) Failed to keep adequate records of his assessment of the late A;

   (d) Failed to ensure adequate monitoring of the Vancomycin levels and renal function of the late A;

   (e) Failed, prior to his being absent from xx from 18 March 1995, to hand over the care of the late A in a proper manner by not adequately alerting the Ward Registrar and his Consultant/Colleague to the late A's condition,

   being professional misconduct.

Background to the charge being professional misconduct

2. On 21 December 1994 Mrs A fell in the lounge of her house, fracturing her left hip. At the time Mrs A was 83 years of age, she was described as being alert and healthy and she was living independently in her own home.

3. Mrs A was admitted to the Orthopaedic Unit at xx Hospital under the care of an orthopaedic consultant, Dr B, where she underwent surgery on her hip. The operative procedure was uncomplicated.

4. On 24 December 1994 Mrs A had an episode of severe central chest pain, however the pain subsequently settled and she appeared not to sustain any significant myocardial damage.

5. X-rays taken following her surgery revealed that the fixation on her femoral head had failed and it was decided that a total hip joint replacement was needed. Accordingly, on 6 January 1995, Dr B performed a total hip joint replacement on Mrs A's left hip. The procedure was performed without any significant complications.

6. While still in hospital Mrs A developed a urinary tract infection and a course of oral Triprin and Citravescent was commenced on 14 January 1995. She had some ongoing ooze from her wound which was treated with regular dressing changes.

7. Mrs A continued to mobilise reasonably well and she was transferred from xx Hospital to the rehabilitation ward at xx (xx) on 16 January 1995. While in that rehabilitation ward, Mrs A's wound was infected and she was given a further course of antibiotics.

8. Mrs A remained in the rehabilitation ward until 31 January 1995 when she was reviewed in the Orthopaedic Outpatient Clinic at the request of the xx geriatrician specialists. As a result of this review, she was re-admitted to xx Hospital for investigation of swelling in her surgical wound.

9. On re-admission to xx Hospital an ultrasound examination of her wound was carried out. An attempt to drain the wound was performed under ultrasound control and Mrs A was then started on a course of intravenous Augmentin.

10. By this time it was clear that the wound from her hip replacement was not healing as expected. The wound was oozing and Mrs A's temperature was raised. As a result of this ongoing wound infection, an exploration, irrigation and debridement of the hip wound was performed on 3 February 1995. It appears also to be the case that, from around this time, Mrs A's family were becoming increasingly concerned about her condition and attempted to talk to the medical staff responsible for her care.

11. Following the 3 February procedure the wound was left open and then re-explored and closed two days later. The wound subsequently healed satisfactorily. Intravenous antibiotics were stopped on 14 February and Mrs A was started on a course of oral Ceclor.

12. On 19 February 1995 Mrs A 'spiked' a high temperature and significant drainage from the wound was noted. Intravenous Flucloxacillin and Penicillin was commenced. As a result of these ongoing problems with her wound Dr B referred Mrs A to the respondent, Dr H, for a second opinion.

13. Dr H first saw Mrs A on 21 February 1995 to assess her continued management. At the time Dr H saw Mrs A she was still being cared for in xx Hospital's Orthopaedic Ward for acute patients.

14. Dr H commenced Mrs A on a course of Gentamicin, Amoxil and Flagyl in an attempt to clear up the persistent infection in her hip wound. On 22 February 1995 renal function tests and Gentamicin levels were performed. These revealed an elevated trough Gentamicin level and the Gentamicin dosage was changed from 8 hourly to 12 hourly. A subclavian central line to administer the antibiotics was inserted on 25 February 1995 under local anaesthetic.

15. On 27 February 1995 Mrs A was reviewed by the Infectious Diseases team. Because of the difficulty in isolating the organism which had caused the infection in Mrs A's hip wound the Infectious Diseases consultant who assessed her recommended that she was to be commenced on the antibiotics Vancomycin and Cefuroxime.

16. The need to measure the levels of Vancomycin in Mrs A's blood stream on a regular basis was recorded in her notes by Dr H and the Infectious Diseases team members who reviewed her again on 28 February 1995.

17. By the end of February, Mrs A continued to have an elevated temperature. The Vancomycin level checked on 2 March 1995 was recorded as '17'. The recommended level is less than 15. However, the Infectious Diseases team recommended that the Vancomycin dosages should be continued. The following day Mrs A developed a cough and Augmentin was also prescribed from 4 March 1995.

18. On 6 March 1995 Mrs A was again reviewed by the Infectious Diseases team. On this occasion, they expressed concerns about the advisability of transferring her back to xx at that time, which was being considered by the surgical team. However after discussion with the Registrar, the medical notes record that Dr H instructed that Mrs A was not to be transferred to a rehabilitative ward, Ward xx at xx, as was initially considered, but to Ward xx, an Orthopaedic Unit looking after elective patients so that she could remain under his care. Mrs A was duly transferred back to xx on 8 March 1995.

19. There is no record in the xx notes that confirms whether or not Dr H saw Mrs A after her re-admission to xx. Similarly, there is no record of her Vancomycin levels being measured or monitored as instructed, although she continued to receive the Vancomycin dosages suggested by the Infectious Diseases team.

20. Mrs A's notes record that she was 'seen by' a Registrar on 9 March 1995, and her notes also record that her wound was satisfactory. On 14 March Mrs A was seen by the Ward House Surgeon who noted she *was "... Comfortable [temp] afebrile Obs - stable ..."*. Mrs A was also seen by the Registrar on 14 March 1995. He attempted to insert a new

Hickman's Line but was not successful and a subclavian line was inserted under local anaesthetic on 16 March 1995.

21. Mrs A was again reviewed by the Registrar on 20 March 1995 after the nurses reported that her temperature had 'spiked'. However, Mrs A herself appeared to be mobilising well, her wound was healing satisfactorily and her ongoing management was unchanged.

22. Dr H went overseas on 18 March 1995 and Mrs A remained in xx. On 21 March 1995, Mrs A's family again raised concerns about her care and well-being with the nursing staff. An elevated JVP and chest signs consistent with congestive heart failure were detected by a House Surgeon on 23 March 1995 and significant and acute renal failure was evident. As a consequence, the Vancomycin medication was stopped immediately.

23. Dr H was notified of Mrs A's condition on his return to New Zealand, 27 March 1995. Over the next four days Mrs A's condition deteriorated and she died on 30 March 1995.

Evidence of the Complaints Assessment Committee

24. Evidence for the Complaints Assessment Committee was given by Mrs C and Mrs D, Mrs A's daughters; Mrs E, a registered nurse and Mrs A's grand-daughter; Professor James Horne, Professor of Surgery at the Wellington School of Medicine; and Dr Stephen Chambers, registered medical practitioner of Christchurch.

Evidence on behalf of Dr H

25. Evidence on behalf of Dr H was given by Mr H, registered medical practitioner of xx; Mr F, registered medical practitioner of xx; Mrs G, registered nurse and manager of xx Hospital; Mr H, registered medical practitioner of xx.

Submissions for the Complaints Assessment Committee

26. The CAC submitted that Dr H had responsibility for Mrs A's care while she was at xx Hospital and that he also assumed the responsibility for her ongoing care following her transfer to xx.

27. The CAC submitted that there was no evidence in the notes that Dr H had visited Mrs A in xx, nor of any other assessment of her condition made by him or at his direction. Additionally it was submitted that Mrs A's Vancomycin levels were not monitored by anyone at xx until her condition deteriorated on 23 March 1995.

28. The CAC's witnesses gave evidence that if visits to a patient had been made it was reasonable to expect that these would be recorded, most likely in the nursing notes.

29. The CAC asserted that Dr H had professional responsibility to ensure that he properly assessed Mrs A and to ensure that her Vancomycin levels in particular, were monitored appropriately. If this had been done, then he did not record those assessments nor did he monitor his junior staff to check if the Vancomycin levels were being monitored and/or any results.

30. It was further submitted by the CAC that Dr H as the consultant responsible for Mrs A's care was required to ensure that her management and care was handed over to another senior consultant when he went overseas or otherwise to ensure her continuity of care.

Submissions on behalf of Dr H

31. On behalf of Dr H, Mr Waalkens noted that the charge was confined to the specific period 8 March – 18 March 1995 and it was particularised in relation to his care and/or attendances (or lack thereof) at xx. Dr H gave evidence that he did do regular ward rounds at xx, but that there was no set routine for these and his practice was to visit the ward on his own, or with a nurse. Instructions about his patients' care were usually recorded in the Ward Round book only. The Ward Round book for the relevant period was not available and it was likely that it had been discarded and/or destroyed.

32. It was submitted for Dr H that Mrs A's notes showed that she was in a stable condition during the time to which the charge relates. She appeared to him to be stable and recovering, albeit slowly, from her surgery and the infection in her wound. Her wound was dry. The infection seemed to be under control. Her temperature was reasonable and there were no hints of anything untoward. Mrs A was also mobile.

33. Dr H told the Tribunal that he relied on his junior staff (at that time a competent Registrar and a House Surgeon) nurses and also the pharmacists, all who would have known about the importance of monitoring Vancomycin to ensure that Mrs A received appropriate care and monitoring.

34. Professor Horne gave evidence that it was reasonable to expect that if there had been any concerns raised about Mrs A's condition Dr H would have been told about them. However Dr H did not deny ultimate responsibility for her care.

The Law

Professional Misconduct

35. Dr H was charged with professional misconduct, the middle of the range of professional disciplinary findings available to the Tribunal under s110 of the Act. The test for professional misconduct is well established. The most oft-cited formulation contained in *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 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."

36. In *B v The Medical Council* (High Court, Auckland, 11/96, 8 July 1996), and in the context of a charge of conduct unbecoming, Elias J (as she then was) 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. …Those 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."

Conduct unbecoming that reflects adversely on a practitioner's fitness to practise medicine

37. Pursuant to Clause 14 of the First Schedule to the Act, the Tribunal has the power to amend the charge at any time during the hearing of the charge. It is therefore open to the Tribunal to find that the charge is proven at a lessor level than that charged.

38. In *B v The Medical Council of New Zealand* (High Court, Auckland Registry, HC 11/96, 8 July 1996) Elias J described the test of what constitutes "*conduct unbecoming*" in the following terms:

> *"There is little authority on what constitutes "conduct unbecoming". The classification requires assessment of degree. But it needs to be recognised that conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards. That departure must be significant enough to attract sanction for the purposes of protecting the public. Such protection is the basis upon which registration under the Act, with its privileges, is available. I accept the submission of Mr Waalkens that a finding of conduct unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which it is unfair to impose. The question is not whether error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations. The threshold is inevitably one of degree. Negligence may or may not (according to degree) be sufficient to constitute professional conduct (sic) or conduct unbecoming:…..The structure of the disciplinary processes set up by the Act, which rely in large part upon judgment by a practitioner's peers, emphasises that the best guide as to what is acceptable professional conduct is the standards applied by competent, ethical, and responsible practitioners. But the inclusion of lay representatives in the disciplinary process and the right of appeal to this court indicates that usual professional practice, while significant, may not always be determinative; the reasonableness of the standards applied must ultimately be for the court to determine, taking into account all the circumstances including not only practice but also patient interests and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards."*

39. A number of decisions have established, that it is not sufficient to show merely that a practitioner has been guilty of conduct unbecoming. It must also be proved that the conduct reflects adversely on the practitioner's fitness to practise medicine, being the

"rider" added to the charge of "conduct unbecoming" in the 1995 Act: *Complaints Assessment Committee v Mantell* (District Court, Auckland, NP4533/98, 7 May 1999).

40. In *Mantell*, the Court (Doogue J) concluded:

"The section requires assessment of standards of conduct using a yardstick of fitness. It does not call for an assessment of individual practitioner's fitness to practise."

41. In relation to section 109(1)(c), the Court stated:

"The text of the rider in my view makes it clear that all that the prosecution need to establish in a charge of conduct unbecoming is that the conduct reflects adversely on the practitioner's fitness to practise medicine…The focus of the enquiry is whether the conduct is of such a kind that it puts in issue whether or not the practitioner whose conduct it is, is a fit person to practise medicine…The conduct will need to be of a kind that is inconsistent with what might be expected from a practitioner who acts in compliance with the standards normally observed by those who are fit to practise medicine. But not every divergence from recognised standards will reflect adversely on a practitioner's fitness to practise. it is a matter of degree."

42. Those statements are consistent with the earlier case of *Ongley v Medical Council of New Zealand* [1984] 4 NZAR 369, in which the High Court (per Jefferies J) held that:

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

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

the Tribunal is distilled down to the issue of 'responsibility vs culpability'. Dr H did not deny responsibility, however he did contest the issue as to whether or not he was culpable in terms of a professional disciplinary offence.

44. 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 H'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, or omission 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 (or conduct unbecoming that reflects adversely on his fitness to practise) is an objective test and is ultimately to be determined by this Tribunal.

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

The standard of proof

46. 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.

47. 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

48. The burden of proof is borne by the Complaints Assessment Committee.

The Decision

49. The Tribunal has carefully considered all of the evidence presented to it and the very helpful submissions made by both counsel. The Tribunal has determined that Dr H is not guilty of professional misconduct in terms of s109(1)(c) of the Act.

50. However the Tribunal has determined that Dr H's conduct in the context of his management of Mrs A's care is conduct which falls short of acceptable standards of care and that it does warrant the sanction of an adverse finding but not at the level charged, professional misconduct. The Tribunal has therefore determined that Dr H is guilty of conduct unbecoming and that his conduct does reflect adversely on his fitness to practise medicine.

Reasons

51. In considering the issue as to whether or not Dr H's conduct was conduct which departs from acceptable professional standards, the Tribunal considered Dr H's conduct both as the medical practitioner who was responsible for Mrs A's care, and as a consultant supervising and training other, more junior, practitioners. As Dr H himself conceded, it was his name at the end of the bed, and he accepted "titular responsibility".

52. Mr Waalkens, on behalf of Dr H, submitted that before the Tribunal finds a practitioner guilty of a professional disciplinary offence, it must be satisfied that the practitioner is culpable in terms of the error or omission, or falling short of acceptable standards. In summary, Mr Waalkens' submission was that if the Tribunal determined that any of the junior staff in Dr H's team were guilty of an error or omission then the Tribunal could not 'sheet home' any such error or omission on the part of others to Dr H simply because he was the clinician ultimately responsible for Mrs A's care.

53. It was the thrust of Dr H's defence of the charge that he did do regular ward rounds and he observed nothing untoward in Mrs A's condition. There was no hint of any suggestion that Mrs A's Vancomycin levels were not being monitored nor was Dr H told, at any time, that there was anything about Mrs A's condition or care that was causing concern.

54. If he had been alerted to any change or anything untoward then he would have responded and that this may have included reference to the patient notes, but he did not perceive any need to do that and he was not given any indication of any need to review or revise Mrs A's care or medication.

55. Mr Waalkens submitted that it would be grossly unfair to personalise the failure to adequately monitor Mrs A's Vancomycin levels, especially in the context of the 'responsibility vs culpability dichotomy'; that there were others involved in Mrs A's care, such as the registrar and house surgeon, nurses, and pharmacists, who could reasonably have been expected to have been monitoring the Vancomycin levels. *"Other than in terms of adequate monitoring"*, Mr Waalkens submitted, *"all of the evidence demonstrates the reasonableness of Dr H expecting that [monitoring of the Vancomycin levels] would occur and expecting that he would be told if there were any problems. That's not an excuse but a statement of reality. Its all very well and good, with an infected hip, to say he should have supervised this, but being realistic you could well understand why he wouldn't do that when particularly he had a competent registrar like xx*".

56. Professor Horne gave evidence that, in terms of who is ultimately responsible for making sure that clinical cares, such as monitoring, are done "*clearly the consultant is ultimately responsible for everything, but in [terms of] what is common practice, and I believe it is almost always appropriate, the day to day monitoring of patients' progress is done by the junior staff with oversight from the consultant. As I have said before, one hopes one doesn't pick up on things that haven't been done, but occasionally that happens*".

57. Mr Waalkens, in his submissions to the Tribunal, relied substantially on the findings of the Appellant Court Judge in *Lake v Medical Council of New Zealand* {1998) HC 123/96, High Court, Auckland, per Smellie J. In *Lake*, the Court determined that *"Dr Lake's error of judgement is one which on the evidence, would have been shared by the majority of specialists in her field. There is room for the view, therefore, that it was a mistake only clearly seen with the benefit of hindsight. It was not, in my judgement, the kind of conduct, given all the circumstances and in particular the*

appellant's otherwise exemplary record, which should attract the label "unbecoming". Furthermore the major cause of the tragic outcome was a series of defaults at the Hospital over which the appellant had no control in respect of which no charges were laid, particularly against the registrar on duty on the 8th…."

58. Dr Lake had been found guilty of conduct unbecoming by this Tribunal's predecessor, the Medical Practitioners Disciplinary Committee, and the Medical Council. However, the High Court Judge upheld Dr Lake's appeal largely on the basis of his findings in relation to the nature of Dr Lake's error, there was "*room for the view, therefore that it was a mistake only clearly seen with the benefit of hindsight*" and because that by far the major responsibility for the adverse outcome was not hers.

59. However, this Tribunal also finds it relevant that Smellie J concluded on the basis of the evidence presented in the appeal, that Dr Lake "*was reasonably entitled to expect that her pink form would be taken seriously and that close monitoring would occur*", and that "*the Council's reference to 'a poor level of post-induction monitoring' supports the view that the fault was with the Hospital staff. I have no hesitation in saying that what happened at the Hospital between 11.00pm on 7th and the caesarean birth on 8th fell below acceptable standards. Those defaults cannot properly or fairly be laid at Dr Lake's door*."

60. It is the Tribunal's view that there are relatively subtle, but significant, differences between the *Lake* case, and this present case. In Dr Lake's case, Dr Lake did take action to ensure that appropriate monitoring of her patient's condition would occur. It was largely for that reason that the appellant court held that Dr Lake could not be blamed for the subsequent failures on the part of others to respond appropriately.

61. In this present case, there is simply no evidence of any similar action on the part of Dr H beyond an expectation that his registrar and/or the house surgeon and/or anyone else involved in Mrs A's care would recognise the need to monitor her Vancomycin levels, and ensure that was done.

62. There is no evidence of any active oversight or supervision on the part of Dr H beyond his bare instruction that Mrs A should be transferred to Ward xx rather than Ward xx so that he could continue her care there.

63. Dr H's defence also relied substantially on the fact that he is an orthopaedic consultant, and in this context his conduct and practices in relation to ward rounds and the supervision of junior staff are consistent with those of his peers.

64. In relation to this issue, the Tribunal refers to Elias J's statement in *B v The Medical Council of New Zealand* (supra) that *"the inclusion of lay representatives in the disciplinary process and the right of appeal to this Court indicates that usual professional practice, while significant, may not always be determinative; the reasonableness of the standard supplied must ultimately be for the Court to determine, taking into account all of the circumstances including not only practice but also patient interest and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process is in part one of setting standards"*.

65. And also in *Ongley* (supra) that the test as to whether the practitioner's conduct is "*acceptable professional conduct*" is objective and ultimately for the Tribunal to determine. In this regard, the Tribunal considers that there is a distinction between the standards which it, objectively, considers are "acceptable" and the standards which may be "accepted" by some members of the profession.

66. Taking all of these factors into account, the Tribunal is satisfied that Dr H did not exercise sufficient oversight, either in terms of his junior staff or Mrs A's care and treatment generally, notwithstanding that some other consultants might conduct their practices in a similar fashion. It is Dr H's failure to adequately carry out his professional obligations and responsibility to oversee Mrs A's care that the Tribunal considers falls significantly short of acceptable standards i.e. standards which the Tribunal considers are "acceptable" taking into account the evidence given to the Tribunal by other medical practitioners; the clinical context of Mrs A's care, the principal purpose of the Act pursuant to which this Tribunal is established and the role of the Tribunal in identifying and, if appropriate, setting standards.

67. For this failure, the Tribunal considers that Dr H has both responsibility and culpability notwithstanding that his conduct in this regard might have been consistent with some of his colleagues at the time. The Tribunal is satisfied that Dr H had responsibilities and obligations towards Mrs A over and above his responsibility as a competent orthopaedic surgeon. It appears to the Tribunal that Dr H's focus in terms of his management of Mrs A's care was relatively narrow and, in terms of her clinical care, it was confined to her orthopaedic problems.

68. However Mrs A also had significant medical problems. All of the signs were that she had a number of co-morbidities and that her condition required careful medical management. In this regard, it was appropriate for Dr H to involve the Infectious Diseases team at xx Hospital, however having done so, he elected to put their advice to one side and he retained ultimate responsibility for the totality of her care.

69. Taking all of these factors into account therefore, the Tribunal was satisfied that Dr H retained responsibility for Mrs A's care at all times. His failure to adequately ensure that she was receiving all of the care and monitoring she required, is conduct that fell significantly below the standards of a reasonably competent consultant practitioner. The departures from acceptable professional standards identified by the Tribunal are, in its view, significant enough to warrant sanction.

70. In respect of each of the particulars of the charge, the Tribunal finds as follows:

Particular 1 – [that Dr H] failed to clinically assess the late A to an adequate standard

71. The Tribunal finds that the assessment of Mrs A's condition at the relevant time, as evidenced in her medical records, was relatively cursory, and confined to her orthopaedic condition. This finding relates both to the failure to ensure that she was adequately assessed and appropriate instructions given for her care at the time of her transfer to xx on 8 March 1995, and to the absence of any evidence of ongoing assessment and monitoring while she was at xx. Such assessments as were carried out were not holistic, nor were they to an adequate standard in that Dr H failed to recognise (during the period 8-18

March 1995) that there was little or no monitoring of Mrs A's general medical condition being carried out.

72. Dr H told the Tribunal that he visited Mrs A on a number of occasions but that he did not review her notes. He carried out his assessments of her condition by using the charts available at the end of her bed, and by talking to the nurses who accompanied him on his visits. On that basis, any assessments he made were manifestly inadequate in that the fluid balance charts retained in Mrs A's patient record contain information that is either non-existent or so sparse as to be useless for all practical and clinical purposes.

73. If Dr H did look at these charts and rely on them, then he should have been alerted to the need to make further enquiry regarding Mrs A's care and condition.

74. It appears to the Tribunal that Dr H failed to respond either to the absence of adequate information in the fluid balance charts and/or the temperature charts and/or where recordings were made, to what the recordings were indicating about Mrs A's condition.

75. The Tribunal is therefore satisfied on the basis of the evidence, that between 8 March and 18 March 1995 Dr H did fail to clinically assess Mrs A to an adequate standard and Particular 1 is established.

Particular 2 – [that Dr H] failed to review the medical notes of the late A

76. For the reasons set out above, and because Dr H conceded that he did not review Mrs A's patient notes or look at her chart after she was admitted to Ward xx, the Tribunal is satisfied that Particular 2 is established.

Particular 3 – [that Dr H] failed to keep adequate records of his assessment of the late A

77. The Tribunal is satisfied that, in the absence of any records of his assessment of Mrs A's being made by Dr H between 8 March and 18 March 1995 this Particular is also established. The Tribunal has taken into account Dr H's evidence that records of his visits to Mrs A, and of any instructions he gave regarding her care, would have been made in the Ward Round book only. However, apart from that record (which is now not available)

there is **no** record of **any** assessment being made by Dr H during the relevant period. The Tribunal's task (by virtue of the wording of the Particular) is to determine not only whether or not any records at all were made by Dr H, or on his instructions, but also their adequacy.

78. Clearly, on the basis of the failure to monitor Mrs A's Vancomycin levels, and to adequately record basic clinical information, not only of Dr H's assessments of and/or visits to Mrs A, his records were plainly inadequate in that they failed to ensure that she received the care and treatment she required.

79. As this Tribunal has determined on previous occasions the task of making and retaining adequate records, in part to ensure continuity of care, is an essential part of the proper management of the patient's care.

80. The Tribunal is satisfied that Dr H did fail to keep an adequate record of his assessments of Mrs A, and his failure to do so undoubtedly contributed to the absence of any continuity of care, both across the team, and in relation to her transfer from xx Hospital to xx.

Particular 4 – [that Dr H] failed to ensure adequate monitoring of the Vancomycin levels and renal function of the late A

81. This Particular was admitted by Dr H and is therefore also established. In light of Dr H's admissions, and for the reasons already given, the Tribunal has dealt with this Particular cumulatively with the other Particulars that it is satisfied are also established.

Particular 5 – [that Dr H] failed, prior to his being absent from xx from 18 March 1995, to hand over the care of the late A in a proper manner by not adequately alerting the Ward Registrar and his Consultant/Colleague to the late A's condition.

82. It is the Tribunal's view that Dr H's failure to ensure that Mrs A's transfer and admission to xx was adequately documented, and his other failings identified in relation to Particulars 1 to 4, resulted in the inadequacies and shortcomings in the care that occurred at xx. His absence from xx from 18 March 1995 does not of itself, warrant an adverse finding against Dr H.

83. It is also relevant in terms of Particular 5 that there was no evidence as to any protocols or practices being in place at xx to ensure that patients were cared for by the ward registrars or consultant colleagues in the absence of the consultant or other practitioner responsible for their care. All of the evidence indicates that Dr H's conduct in this regard was consistent with the practice of other consultants caring for patients at xx.

84. Taking all of these factors into account, the Tribunal is satisfied that, prior to his being absent from xx on 18 March 1995, Dr H failed to hand over Mrs A's care either formally or informally, however the Tribunal is not satisfied that any shortcomings in this regard on Dr H's part warrant the sanction of an adverse disciplinary finding.

85. Accordingly, the Tribunal has determined that Particular 5 is not established in terms of warranting sanction.

Conclusion

86. For the reasons set out above, the Tribunal is satisfied that the charge against Dr H is proven and that his conduct in relation to Particulars 1 to 4 of the charge is conduct that departs significantly from acceptable professional standards. The Tribunal is unanimous in determining that Dr H's conduct was not an acceptable discharge of his professional obligations owed to Mrs A, or to her family.

87. However, the Tribunal is not satisfied that the charge is proven at the level of professional misconduct, that is, Dr H's conduct does not depart so significantly from accepted standards to warrant a finding at that level.

88. The Tribunal's assessment in this regard is, ultimately, a matter of degree. In the context of determining this charge, the Tribunal has carefully reconsidered the judgement of Elias J in *B v The Medical Council* (supra) on the basis of the evidence presented in this case, and bearing in mind the findings in that case and the other cases referred to by counsel, in particular *Lake's* case, the Tribunal is satisfied that, on a cumulative basis, Dr H is guilty of conduct unbecoming a medical practitioner, and his conduct reflects adversely on his fitness to practise medicine.

Penalty

89. The Tribunal seeks submissions from Counsel as to appropriate penalty. Counsel for the Complaints Assessment Committee is to file submissions with the Secretary of the Tribunal and serve a copy on Counsel for Dr H no later than 5.00 pm on Friday 25 January 2002.

90. Counsel for Dr H is to file his submissions with the Secretary of the Tribunal and serve a copy on Counsel for the Complaints Assessment Committee no later than 5.00 pm Friday 8 February 2002.

91. The District Court has made interim orders prohibiting publication of the respondent's name. The Tribunal asks that counsel include in their submissions on penalty, submissions as to whether or not permanent name suppression is sought and/or opposed. It will therefore be necessary for Mr Waalkens to advise Ms Davenport whether or not such orders will be sought in advance of the preparation of submissions.

92. Accordingly, Mr Waalkens is requested to advise Ms Davenport by 14 January 2002 if permanent name suppression orders will be sought so that Ms Davenport can include the Complaints Assessment Committee's submissions in this regard in the submissions to be filed on 25 January 2002.

93. Leave is reserved to the Complaints Assessment Committee to file submissions in reply to Dr H's submissions in relation to any application for permanent name suppression. Any such submissions to be filed no later than 15 February 2002.

DATED at Wellington this 14th day of December 2001

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W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal