Medical Practitioners Disciplinary Tribunal

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DECISION NO: 47/98/25C

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 **COLIN DAVID MANTELL** medical practitioner of Auckland

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Dr R S J Gellatly, Dr A D Stewart, Dr L F Wilson,

Mr P Budden (Members)

Ms G J Fraser (Secretary)

Mrs E McNeile (Stenographer)

Hearing held at Auckland on Thursday 13 and Friday 14 August 1998

APPEARANCES: Ms A Fisher with Ms Watterson for the Complaints Assessment Committee ("the CAC").

Mr H Waalkens with Ms Tupou for Professor C D Mantell.

1. THE CHARGE:

1.1 **A** Complaints Assessment Committee pursuant to Section 93(1)(b) of the Medical Practitioners Act 1995, charges Professor Mantell, medical practitioner of Auckland, with conduct unbecoming a medical practitioner arising out of his management of Mrs A on 7 June 1996, such conduct reflecting adversely on Professor Mantell's fitness to practise medicine.

1.2 **THE** particulars of the charge are that Professor Mantell:

(a) **FAILED** to adequately record in the clinical notes the seriousness of the condition of B & C A's unborn baby on admission to xx Hospital on 7 June 1996.

(b) **FAILED** to inform or adequately inform B & C A on the evening of admission of the seriousness of the placenta abruption and the consequences of this for the unborn baby.

(c) **FAILED** to consult with a paediatrician concerning the unborn baby's condition within a reasonable time.

(d) **FAILED** to transfer Mrs A to xx Hospital within a reasonable time.

1.3 **THE** complainants in this case are B and C A. In June 1996 Mrs A was 26 weeks pregnant. She referred herself to xx Hospital on 7 June 1996 because of vaginal bleeding. She came under

the care of Professor Mantell, the consultant on call at xx Hospital. It is the circumstances surrounding Professor Mantell's management and care of Mrs A, which give rise to the complaint.

2. DOCUMENTARY EVIDENCE

2.1 **TO** assist in its consideration of the charge against Professor Mantell counsel have provided the Tribunal with an agreed bundle of documents. The bundle comprises copies of Mrs A's claim statement to ACC, exchange of correspondence between Professor Mantell and ACC, copies of Mrs A' medical records including the clinical notes from xx Hospital and xx Hospital and the Notes for baby *D*, xx Hospital Protocol, Tables of International Neonatal Outcomes and letter from Dr E to ACC dated 1 April 1997.

3. BACKGROUND SUMMARY OF EVENTS

3.1 **MRS A** was at 26 weeks of gestation when she was admitted to xx Hospital in xx on 7 June 1996. No details are given which would allow the Tribunal to confirm gestational age, but the initial entry in the clinical records by a midwife at 2220 states her gestation as 26 weeks, 3 days. At that time she was noted to be hypertensive and with some vaginal bleeding and lower back pain. Professor Mantell saw her at 2245 and noted that she was equivalent to 26 weeks and 3 days gestation by an earlier ultrasound scan, although that was not available at the time. She was contracting every four minutes. These were quite strong and a fetal tachycardia was noted. Professor Mantell initiated management consisting of intravenous Salbutamol and steroids (Dexamethasone 4mg).

3.2 **SOME** comments were also made about the possibility of fetal infection with Listeria and the need for antibiotics if her temperature increased. However, there is no documentation about the prognosis at that time.

3.3 **THE** next entry in the record is by the Senior House Officer, F, who notes that Mrs A had previously had a caesarean section for a footling breech. Dr F performed a speculum inspection which showed the cervix to be long and closed, and noted that there was blood at the external os.

3.4 **AT** 2345 that evening another entry by Dr G (Registrar) notes that on ultrasound examination the placenta was fundal and there was a single fetus present. It is also noted that there had been no fetal movements felt since that morning. Review of the cardiotocograph (CTG) demonstrates a baseline of 160 bpm with reduced variability. The clinical impression at that time was thought to be of placental abruption.

3.5 **A** note was made in the clinical records that the case was discussed with Professor Mantell who advised to review in 2-3 hours. The Salbutamol infusion continued overnight and there was minimal vaginal blood loss. The CTG remained abnormal and a number of entries in the medical records described the CTG as showing poor variability and shallow decelerations.

3.6 **AT** 0030 Professor Mantell was again informed of the CTG and clinical findings. By 0430 the following morning it is noted that the contractions had stopped but that the CTG remained with poor variability and no fetal movements had been felt since admission.

3.7 **THE** management plan outlined was that the Salbutamol was to be reduced. An ultrasound scan showed no movements or breathing.

3.8 **AT** 0545 there was again discussion with Professor Mantell about the CTG which showed a baseline of 150 bpm and a poor variability.

3.9 **AT** 0745 Professor Mantell made another entry into the records, having seen the patient, and noted that the bleeding had stopped and that there were occasional contractions only. His interpretation of the CTG was that there was a marked reduction in variability and decelerations with contractions and the biophysical showed a score of 4/8. The plan at that stage was for a conference with the paediatrician, an ultrasound to estimate the fetal weight and delivery either at xx Hospital or xx Hospital. Professor Mantell also stated that he would meet Mr A to discuss further management at 0830.

3.10 **THE** next recorded entry for xx Hospital shows that Mrs A was transferred to xx Hospital. The ambulance arrived for her at 09.25. Just prior to discharge the fetal heart rate was noted to be 130 bpm and that she was not contracting. After arrival, she was admitted to xx Hospital at 10.00 am, delivery suite at 10.15 am. The initial assessment made at 11.15 am was a non-reactive CTG with decelerations. An ultrasound was performed which showed a biophysical score of 2 out of 10 and the suggestion of a retroplacental clot behind the fundal placenta. The fetal measurements were consistent with 26 to 27 weeks gestation. The decision then by Dr H at 11.15 am was to deliver immediately by caesarean section due to a significant placental abruption. This was performed via a Pfannenstiel incision. There was a manual delivery of a

male infant at 11.57 am with poor tone and confirmed placental abruption with a clot of 200-300 mls.

3.11 **BABY** *D* weighed 980 grams and was in poor condition as demonstrated by the Apgar of three at 1 minute and two at 5 minutes. The baby required massive efforts at resuscitation and remained hypertensive despite full cardio respiratory support. Even after 2 hours of age the baby was severely acidotic. Later that afternoon a cranial ultrasound revealed bilateral intraventricular haemorrhages.

3.12 **FOLLOWING** a case conference with the parents and other relatives it was decided to withdraw intensive care support and the baby died. The conclusions of Dr E are that the baby died of hyaline membrane disease, bilateral severe intraventricular haemorrhages and perinatal asphyxia secondary to maternal placental abruption. Mrs A had a relatively uneventful post natal course and was discharged home on 10 June 1996.

3.13 **THE** Tribunal will consider each particular of the charge separately.

4. FAILURE to adequately record in the clinical notes the seriousness of the condition of the unborn baby on admission to xx Hospital on 7 June 1996.

4.1 **AS** to this criticism Professor Mantell in his evidence identified 23 separate entries made in the notes, eight written by medical practitioners, most indicating the concern all those involved had for the baby during the 10 hours Mrs A was in the delivery ward at xx Hospital.

4.2 **AS** far as entries made by Professor Mantell personally are concerned, his note at 2245 hours was soon after the admission of Mrs A and test results were required to confirm the diagnosis. His entry at 0745 summarised adequately the critically serious set of clinical findings and outlines a further plan.

4.3 **PROFESSOR** Mantell had spoken to Dr G on the telephone from his home at about 2 or 2.30 am on 8 June 1996. The Tribunal accepts as reasonable Professor Mantell's explanation that his absence prevented him from including the telephone conversation in the hospital notes.

4.4 **THE** Tribunal agrees with Mr Waalkens that Professor I put the point beyond doubt when at page 33 line 15 of the transcript he is recorded as having said "*...there is very clear documentation about the clinical presentation and condition of both mother and fetus*".

4.5 **THE** Tribunal is satisfied to an even higher standard than is actually required, the balance of probabilities, that Particular A of the charge has not been established.

5. FAILURE to consult with a paediatrician concerning the unborn baby's condition within a reasonable time.

5.1 **MS** Fisher submitted the easiest way for the Tribunal to approach this aspect of the matter is to look at what the xx Hospital Protocol for pre-term labour management guidelines states - a Protocol which Ms Fisher reminded the Tribunal Professor Mantell himself has admitted he helped to draw up. Had the Protocol guidelines been followed and a paediatrician called in to talk to the family, in Ms Fisher's view communication would have been clarified and cleared up.

In his evidence Professor Mantell suggested that it was only appropriate to call the paediatrician in when a decision had been made to deliver. But with respect, Ms Fisher argued that is not what the Protocol says. She explained the Protocol states, (in Note 2 on page 31 of the bundle), that: "*Paediatric colleagues should be involved as early as possible at early gestations to assist with management plans and to counsel the family...*".

5.2 **IN** his evidence Professor Mantell described the relationships with the neonatal staff during Mrs A's time at xx Hospital. He explained the obstetric and neonatal staff at xx worked very closely together. He said that he would expect that the Paediatric Registrar would have been in the labour ward at some time during the late afternoon shift, and certainly soon after "hand over" which occurs at 2200 hours. In Professor Mantell's view the Paediatric Registrar would know (even if not contacted directly), the details of patients in labour.

5.3 **IT** was Professor Mantell's further evidence that consultation with a paediatrician would not have changed the management plan at all. He has always been well aware of the survival rates at various gestations and, 10-15 years ago he included in the Department of Obstetrics and Gynaecology's teaching to undergraduates and postgraduate diplomates, a discussion on the responsibilities of all caregivers to patients at 28 weeks gestation. Such discussion was to ensure that all practitioners were made aware that survival for 28 week fetuses could be as high as 85% - quite different from that perceived by many practitioners at the time. Similarly in 1996, Professor Mantell explained he was totally conversant with the outcome results from xx Hospital and elsewhere for babies at 26 weeks which indicated that, provided babies had received the benefits of steroids, and provided there was no concurrent infection or hypoxic damage, 50 percent of these infants would survive. He said he was aware, for example, that by what he

believed was a statistical "trick" the survival rates for 26 week fetuses was higher than that for 27 weeks.

5.4 **RE-EXAMINATION** by Ms Fisher of Professor I elicited helpful comment from him by reference to the Protocol discussed earlier. By reference to the guideline statement that Paediatric colleagues should be involved as early as possible at early gestation to assist with management plans and counsel the family, Professor I began with some general remarks as to when he would expect a paediatrician to be involved in a case such as that of Mrs A. Professor I explained there are two situations in which he would normally involve a paediatrician and would do so quite early on. One would be if a decision had been made to deliver a pre-term infant, or indeed any infant who was going to require admission to the nursery. Professor I explained his belief that the paediatrician should be involved in discussion with the patient prior to making plans for delivery. He went on to explain the second instance would be if a clear decision had been made not to intervene, and to allow a baby to die in utero. If the patient required further information about prognosis, more information than the obstetrician was able to give, then Professor I would involve paediatricians to assist the communication processes. Had Professor Mantell been unaware of the likely prognosis for *D* at first presentation, then certainly Professor I may have expected him to seek advice. However, Professor I said that he did not believe that Professor Mantell needed to seek that advice in this case.

5.5 **AFTER** reviewing Mrs A again about 0700 Professor Mantell chose to share his concerns with Dr J, the Neonatal Consultant on call on the Saturday morning. He went to the Neonatal Unit and rang from there. Professor Mantell discussed the case with Dr J, outlining the relevant

details. Together they determined that although the outcome was not likely to be changed, if baby was to be delivered, it should not be at xx Hospital.

5.6 **THE** Tribunal is satisfied to the appropriate standard, the balance of probabilities, that Professor Mantell did not fail to consult with a paediatrician concerning the unborn baby's condition within a reasonable time. However, earlier consultation with a paediatrician may have assisted the communication process about to be discussed under Particular B of the charge. We will endeavour to explain.

5.7 **THERE** was a real conflict between the evidence of Professor I and Professor Mantell on the subject of the difficult decision whether to intervene in the case of extreme prematurity.

5.8 **PROFESSOR** I explained the normal practice in 1996, given the circumstances of Mrs A of 26 weeks gestation, presence of placental abruption and the evidence of intrauterine hypoxia and acidosis on the CTG tracing would be active intervention by caesarian section to achieve delivery before the fetus could be further compromised. However under cross-examination Professor I conceded that he would have acted as Professor Mantell in a more conservative approach.

5.9 **ON** the other hand it was the evidence of Professor Mantell, after considering all the information relating to the case, he had no doubt it was appropriate not to move to a caesarian section.

5.10 **THIS** aspect of the management and care of Mrs A was not part of the charge faced by Professor Mantell. Consequently it is not necessary for the Tribunal to make any finding in this regard. However the Tribunal notes with approval the evidence of Professor I, that the decision

not to intervene could only be justified if it was the strongly expressed opinion of the mother after she had been accurately and fully informed of the consequences of the action and of intervention. Had there been earlier consultation with a paediatrician, we consider the degree of consultation between Professor Mantell and Mr and Mrs A would probably have been enhanced. Ultimately it would have been a decision made by Mr and Mrs A as to whether to choose active intervention or not. It was the evidence of Professor I, that in his experience most parents do choose active intervention.

6. FAILURE to transfer Mrs A to xx Hospital within a reasonable time.

6.1 IT is common ground between counsel, and accepted by the Tribunal, that this particular of the charge cannot be sustained on the evidence.

7. FAILURE to inform or adequately inform B and C A on the evening of the seriousness of the placenta abruption and the consequences of this for the unborn baby.

7.1 IN her evidence Mrs A explained Professor Mantell did not give her the impression there was anything seriously wrong, although she acknowledged he said there is always a certain amount of risk with babies born at 26 weeks gestation. Professor Mantell told her he would give her drugs to stop the labour and steroids to improve *D*'s lungs in case he was born prematurely. If things were not improved by 2 am, Mrs A said Professor Mantell would transfer her to xx Hospital where her baby would be delivered.

7.2 **DURING** the night, doctors regularly checked on her. Although scanning was undertaken on two occasions, the doctors spoke amongst themselves and did not say much to her.

7.3 **ON** transfer to xx Hospital the next morning, Mrs A explained three young doctors were waiting outside for her. They quickly took her to an examining room just off reception. There was no small talk. The doctors examined her and did a scan. She saw her baby on the screen looking like a lump at the bottom of her stomach. He was not moving at all. The doctors looked alarmed. At that point she knew something was very wrong.

7.4 **WHEN** the doctors looked at the record of the trace from xx, they seemed to panic and swore. They said she would need an emergency caesarean immediately. Everything was action stations as the staff (both doctors and nurses) got her ready for theatre. As they were preparing her they said that her son would be a very sick little boy when he was born and would probably need to be in hospital for at least three months. They talked about premature babies generally.

7.5 **MRS** A explained *"Although I was worried, as I was being prepared for theatre I felt excited about being a mum again. I knew D would be unwell but at that stage I was just happy that he was going to be born."*

7.6 **ABOUT** six weeks after *D*'s death Mrs A and her husband returned to xx for a meeting with Dr E. Professor Mantell also invited them to meet with him to discuss what had happened. They met at Professor Mantell's clinic. He went through his notes and explained a few more things about what had happened to *D*. Before Mr and Mrs A got up to leave she explained that

Professor Mantell said *"If anyone is to blame for your baby dying it's probably me because I may have made the wrong decision"*.

7.7 **MRS** A said Professor Mantell's letters to the CAC were very upsetting to both her husband and herself. His claim he had a number of discussions with them about the seriousness of *D*'s condition, simply did not take place. As far as Mrs A was concerned, Professor Mantell did not involve her or her husband in any of the decision making process, except in relation to the steroids. She said he did not tell them *D* was likely to die. She said they were not told by Professor Mantell how serious the problem was. Mrs A complained *"He did not prepare us at all for what happened."* In contrast Mrs A said Dr E gave them the bad news in a direct and forthright manner, and they accepted it. They would have accepted bad news from Professor Mantell had he done the same.

7.8 **MRS** A concluded the formal statement of her evidence with the comment: *"I believe D was not given the chance that he deserved. Professor Mantell took away that chance. What gives him the right to play God. He took away any chance my baby may have had."*

7.9 **SIMILAR** evidence was given by Mr A. Having read Professor Mantell's letters to the CAC with what he described as "*disbelief*", Mr A went on: *"I had no idea he expected D to die during the night until reading it in one of his letters to the ACC. He did not have "lengthy discussions" with us about D as he claims. I have a reasonably clear memory of these events. There was no discussion about D not surviving or being born severely brain damaged. At no time did Professor Mantell explain we had a choice about intervention, nor did he warn us D might actually die. C and I both feel that if Professor Mantell had*

explained the situation to us properly and included us in the decision making we would have been able to cope much better with our baby's death."

7.10 **A** friend of Mr and Mrs A, K, gave evidence that she came to xx Hospital at 10.30pm to stay with Mrs A as a support person during the night she spent at xx Hospital.

7.11 **MRS** K confirmed Professor Mantell had explained during her presence that there is a risk with premature babies and that 26 weeks is a difficult time for a baby to be born.

7.12 **MRS** K said she had stayed with Mrs A throughout the evening and Professor Mantell did not give any indication he thought that D would not survive. Her impression was that Mrs A had no choice about what sort of treatment she should be given. She explained *"Very little information was given to her."*

7.13 **A** midwife present throughout the night did not, apart from the odd general comment, give Mrs A any information. Mrs K explained that staff who came and went during the night checked on Mrs A and they would then go to the other side of the room and talk quietly. Neither Mrs K nor Mrs A could hear what they were saying and *"They did not seem particularly concerned"*.

7.14 **AS** indicated earlier, evidence for the CAC was given by Professor I, Professor of Obstetrics and Gynaecology at the xx Clinical School which is part of the University of xx. Currently Professor I is Clinical Director of xx. The evidence of Professor I as an expert witness is acknowledged and accepted by the Tribunal.

7.15 **IT** was the evidence of Professor I, from the comments made by Mrs A, and the entries into the clinical records from xx Hospital, that the poor prognosis for this baby was not adequately conveyed to the parents at the time of initial presentation. Professor I noted Professor Mantell had opted for conservative, rather than active management, and his justification for this was the poor prognosis. While acknowledging this may have been an appropriate course of action given the poor prognosis, Professor I noted Professor Mantell's comments that he thought the baby would die in utero. From the clinical record Professor I explained there is no indication that this management plan was discussed with the parents.

7.16 **PROFESSOR** Mantell gave evidence on his own behalf.

7.17 **FROM** the outset Professor Mantell explained he was deeply concerned for baby D's prognosis. He said *"It looked to be very poor indeed"*. Professor Mantell further explained it appeared to him there were two options available - let nature take it's course, so to speak, or intervene and move to a caesarean section delivery. In his assessment the baby's very poor prognosis favoured the first option rather than intervention by caesarean delivery.

7.18 **ALTHOUGH** not now being able to remember all the details of his visits with Mrs A during her brief confinement, and what was said in their discussions, Professor Mantell maintained his standard practice simply precluded him from spending any time with a patient with Mrs A' presentation and not discussing the issue of the seriousness of baby D's condition.

7.19 **PROFESSOR** Mantell went on to explain:

"*On the night of admission I spent nearly two hours in the delivery ward - much of it with Mrs A and on more than one occasion. It is not conceivable that I would fail to discuss what, at the time, were the most pressing likely events. I was aware that the decision to be made was a difficult one and I was providing my opinion on the choice between two disastrous options, namely allowing baby to die in utero or choosing a caesarean delivery with what I judged to be the likely outcome of either a baby who died or one who survived with gross neurological, mental and physical defects. I am concerned that myself and my team were seemingly so unsuccessful in communicating this to the patient."*

7.20 PROFESSOR Mantell concluded his evidence on this note:

"One particular part of the case which I remain very sorry about is that obviously my efforts to communicate with the family have failed. As I have outlined in this my statement of evidence, I am mystified about this but very sorry that for whatever reason, my message has not filtered through. In that regard, I only wish I could turn back the clock although I am as confident as I could be that the outcome for baby D would have been no different."

7.21 LASTLY evidence was given for Professor Mantell by L, a registered nurse and a registered midwife since 1964.

7.22 MRS L was on duty the evening Mrs A was admitted to xx Hospital. Generally it was her evidence that she remembers the case of Mrs A well. It was apparent to her at the time (and certainly is clearly so from her review of the hospital records now), that Mrs A' case was fairly serious and one which created much concern for the medical staff at xx Hospital at the time.

7.23 **MRS** L explained she cannot herself recall exactly what she said to Mrs A throughout the time she remained with her on the night in question. However Mrs L said, if Mrs A had asked any questions of her, she certainly would have clarified them in terms that re-inforced the deep concern that the medical staff and her team had for the outcome of her baby.

7.24 **MRS** L expressed complete surprise to read Mrs A' statement at paragraph 14 *"The midwife who looked after me did not seem concerned and I assumed everything was fine"*. She said this was not the case at all, she having had grave concern about the outcome.

7.25 **AGAIN**, although not being able to remember what she said to Mrs A, Mrs L said it would be most unusual for her not to indicate her concern to Mrs A in her discussions with her throughout the course of the evening.

7.26 **ALSO** Mrs L said, in her experience of xx Hospital practice, it would be very unusual for the medical staff not to indicate their concern to Mrs A because *"We were all very concerned about her baby"*.

7.27 **FINALLY** Mrs L conveyed to us the very high opinion she has of Professor Mantell's professionalism in his work with patients. Mrs L concluded *"He is very kind, sympathetic and quite precise in his explanation to patients with problems or potential problems which he anticipates may happen during their management or treatment at hospital"*.

8. FINDING

8.1 **AT** the outset it is acknowledged there are quite obvious conflicts in the evidence of the various witnesses. Cross examination gave members of the Tribunal valuable opportunity to assess the credibility of the witnesses. It is to the credit of counsel that they did not seek to impugn the credibility of opposing witnesses. The Tribunal has been left with a clear impression of the veracity of all the witnesses who were called to give evidence. That said, nevertheless it has been possible for the Tribunal to gain a reasonably clear appreciation of the situation which developed between the time of admission of Mrs A to hospital, and the birth of baby D some 12 hours later. It would seem that apparently serious communication difficulties occurred which have resulted in misunderstandings, or lack of proper understanding, on the part of both parties to this most unhappy and distressing event.

8.2 **BOTH** Mr and Mrs A impressed as credible witnesses.

8.3 **THE** Tribunal accepts as valid the impression gained by Mrs A, that the team of doctors and nurses attending her in the delivery suite seemed to be more concerned about her condition, than the condition of her baby. The reality is that the medical team was very concerned about the condition of the baby. Unfortunately, however, for reasons which are not entirely clear, the medical team attending on Mrs A, under the leadership of Professor Mantell, failed to convey to her an understanding of the serious implications of the clinical condition at the time of presentation which suggested placental abruption. As was so aptly described by Professor I, the subsequent neo-natal course demonstrated a severely compromised fetus which was hypotensive and aciditoc. Other clinical observations and post natal events combined as retrospective evidence of the very poor condition of the fetus at presentation and poor prognosis.

8.4 **THAT** Mrs A can be perceived by the Tribunal as an intelligent and observant woman, is born out by one aspect of cross examination. Mr Waalkens had suggested to her that the first scan was performed at a quarter to midnight, more than an hour and a half after she had been admitted. Mrs A disagreed, pointing out that the first scan was performed earlier, about half an hour following admission. Mr Waalkens was able to confirm this by reference to the hospital notes.

8.5 **THE** Tribunal accepts Mrs A's version of her viewing of the first scan. Mr Waalkens invited Mrs A to confirm she could see the baby moving around a lot. Mrs A replied *"Not particularly moving around. I mean it was kicking and very much alive."* Consequently it was with much surprise Mrs A acknowledged to Mr Waalkens, that the hospital note made at 4.30am recorded *"No fetal movement since admission."*

8.6 **FROM** some of the cross examination the Tribunal gained an impression that Mrs A could have been expected to have asked more questions of the medical team, and thereby become better informed about baby's condition. We consider an appropriate response to this suggestion was conveyed when Mrs A answered in re examination: *"Even if he [Professor Mantell] had told me I had a placenta abruption I probably wouldn't have known what I had, I would have needed it explained, so no, I feel I didn't have the right to ask him. He knew what he was doing."*

8.7 **THE** Tribunal should correct any misapprehension, that it is not the responsibility of the patient to ask questions to elicit information necessary to make an informed choice as to treatment options. At all times it is the responsibility of the medical profession to share with patients the

information which affects them. This is implicit within the doctor's duty of care, and enables patients to maintain their autonomy while allowing a realistic attitude towards their surgical or medical management.

8.8 **A** brief exchange between Dr Gellatly and Mrs A was enlightening. Because her first born was delivered by caesarean section without any labour, Mrs A explained she would have been more knowledgeable if someone had, for example, used the words *"grave concern."*

8.9 **AN** equally impressive witness was Mr A. He was happy to acknowledge in cross examination by Mr Waalkens, the numerous observations in notes during the xx Hospital stage, that something was amiss. Mr A put it succinctly when he said *".... there was no doubt there was something wrong. It is the seriousness about what was wrong is what this is all about".*

8.10 **WE** think Mr A summed up his understanding when he said in cross examination: *"I don't believe it is up to us to read people's body language. I would prefer to be told directly what the situation was. Not pussy foot around. We handled D's death in what we thought was an admirable way [but] ... there was no direct statement that lead us to believe we were in grave danger of losing D."*

8.11 **MRS** K confirmed the expectations of the parents, that there had been deterioration such that an emergency caesarean would be necessary, but not that a poor outcome was likely.

8.12 **IN** his closing submissions Mr Waalkens quite understandably sought to place Professor Mantell's conduct in the matter in the most favourable light. Although he acknowledged Professor

Mantell could not recall what was specifically said, he referred to his statement that it was *"inconceivable"* that *"I would fail to discuss what, at the time, were the most pressing likely events"*.

8.13 **THE** Tribunal considers some clue to why communication difficulties so obviously occurred, can be gained from certain concessions which were made by Professor Mantell. At page 52 line 10 Professor Mantell is recorded as having said *"Looking back, I realise that I needed to be more direct and perhaps more brutal about the choices, and the options, and why these choices were made"*.

And:

"With the benefit of hindsight it is clear that I need to do two things - one is to be more definite and unequivocal about outcome. And (b) use some techniques to check that the messages have been received."

8.14 **HOWEVER** we agree with Ms Fisher that no practitioner would suggest that an obstetrician should be "brutal" in the way they deliver messages to patients. That is not what Professor I was talking about when he explained the four techniques that may help an Obstetrician when communicating with a patient.

8.15 **BY** specific reference to Particular (B) of the charge, helpful evidence was given by Professor I. In cross examination Professor I had been explaining to Mr Waalkens, in terms of communication, that how effectively a clinician delivers information often depends on how

receptive the patient is. Sometimes Professor I said it is surprising to discover, at a later date, how little people have retained of what they have been told.

8.16 **IN** re examination Professor I elaborated for Ms Fisher on the communication techniques he had earlier been endeavouring to explain to Mr Waalkens. He said:

"..... There are a number of things ..... The first is to try to deliver a rapport with the patient to the point that you are exchanging information in languages that you both understand, by that I mean avoiding the use of medical terminology that the patient or the couple don't understand. The technique of giving the information and then asking the question based on that information to ensure that they have understood the information is very useful and it is also useful to have someone present with you when you are giving that information and the midwife can be very important because as invariably happens in these situations the doctor is present for a short space of time and then moves on to other areas of responsibility and the midwife remains with the woman and if she's been there during the consultation she is in a good position to reinforce what has been said and to answer questions later on."

8.17 **THE** Tribunal commends to Professor Mantell the techniques employed and recommended by Professor I in his evidence before this Tribunal.

8.18 **THE** Tribunal also commends to Professor Mantell the advice of Professor I, that it is also very important to document what the patient is being told. The Tribunal agrees with Professor I it is unfortunate there is no documentation about the information that was being exchanged between Professor Mantell and Mr and Mrs A. Admittedly failure to document such information is not

part of the charge. Nonetheless the Tribunal considers that the obligation to adequately inform a patient, encompasses an obligation to document the nature of the information given to the patient. If this practice is observed, the Tribunal considers that the obligation to adequately inform will be taken just that bit more seriously. The Tribunal endorses Professor I's recommendation that it is a good discipline to write down the nature of the information imparted to a patient. Consequences of not reporting relevant information can affect later management.

8.19 **THE** Tribunal is satisfied, to the required standard, and so finds, that Professor Mantell did fail to inform or adequately inform Mr and Mrs A on the evening of admission of the seriousness of the placenta abruption and the consequences of this for the unborn baby. As was submitted by Ms Fisher, the evidence seems overwhelmingly clear that Mrs A did not make the decision about what was happening in this case. Had she and her husband been involved in the decision-making process, there hopefully would have been no misunderstanding, either as to treatment or to prognosis.

8.20 **AS** was indicated at the completion of the hearing, the Tribunal is not satisfied that the failure which has been identified on the part of Professor Mantell, although constituting unbecoming conduct, reflects adversely on his fitness to practise medicine.

8.21 **MS** Fisher had submitted that the ability to communicate with patients is one of the corner stones of medical practice, and that it is crucial to those practising medicine that they manage to understand the matter.

8.22 **MS** Fisher argued Mr Waalkens was confusing the issue of penalty when he submitted the Tribunal needs to take into account Professor Mantell's mana, and the fact that he has never previously been involved in proceedings before a disciplinary tribunal.

8.23 **THE** Tribunal tends to agree with Mr Waalkens, if an inability to communicate is such a problem for Professor Mantell, one would expect there to have been more complaints of this nature brought against him. In this apparently isolated incident, certain shortcomings or omissions in his conduct and management on the night in question have been identified, such that warrant a finding of "conduct unbecoming", but plainly, in our view, they do not impact on his fitness to practise medicine.

8.24 **THE** onus of proving the charge is on the CAC. That standard is a civil standard but on a sliding scale depending upon the seriousness of the alleged offending.

8.25 **IN** *Cullen v The Medical Council of New Zealand* HC 68/95 Blanchard J 20/3/96 (Unreported) at p3, the Court referred to the burden of proof in this way.

"*The MPDC's legal assessor, Mr Gendall correctly described it in the directions which he gave to the Committee:*

"[The] standard of proof is the balance of probabilities. As I have told you on many occasions, ... where there is a serious charge of professional misconduct, you have got to be sure. The degree of certainty or sureness in your mind is higher according to the seriousness of the charge, and I would venture to suggest it is not simply a case of finding

a fact to be more probable than not, you have got to be sure in your own mind, satisfied that the evidence establishes the facts."

8.26 IN noting there is little authority on what comprises "conduct unbecoming" in *B v The Medical Council* HC 11/96, High Court, Auckland, Elias J, 8/7/96, the Court went onto say:

"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. ....."

8.27 UNDER the 1968 Act Parliament had clearly required that the conduct be "conduct unbecoming a medical practitioner".

8.28 PARLIAMENT clearly intended in the 1995 legislation to raise the threshold of offending/error in respect of "conduct unbecoming" by requiring that the conduct in question "reflect adversely on the practitioner's fitness to practise medicine".

8.29 **THE** Tribunal agrees with Mr Waalkens, in any event, the very caveat signalled by the High Court in *B v The Medical Council* of showing wisdom available with the benefit of hindsight, is applicable in this case. Professor Mantell has exceptional references. This is the first complaint of its kind and certainly the first disciplinary charge which he has ever faced. Balancing all the issues and in particular, the public interest, an adverse finding in terms of the charge faced by Professor Mantell, is not required in this case. The departure in this case is not so significant that it ought to attract sanction for the purposes of protecting the public.

8.30 **IT** would also be unnecessary. Apart from learning from this entire experience, Professor Mantell does not, by dismissal of the charge, seek condemnation or approval by the Tribunal, of his own conduct. To the contrary he has acknowledged that somehow his communication efforts, and those of the members of his team on the occasion in question, obviously did not filter through.

8.31 **THIS** has been a very important case. Although the charge has not been made out to the letter of the law, the Tribunal considers there should be some dissemination of the background facts, and the findings made by the Tribunal, in the interests of members of the profession. We say this because informed choice and informed consent are now keystone concepts when considering the rights of patients. They were discussed by Elias J in *B v The Medical Council* (supra) who adopted the reasoning of the Australian High Court in *Rogers v Whittaker* 1992 175CLR which contains the following comment of particular relevance in this case:

"..... The skill is in communicating the relevant information to the patient in terms which are reasonably adequate for that purpose, having regards to the patient's apprehended capacity to understand that information."

8.32 THE common law dictates concerning informed choice and informed consent are now reinforced by Right 6 and Right 7 of the Health and Disability Commissioner (Code of Health and Disability Services Consumers' Rights) Regulations 1996.

8.33 HOWEVER in the context of these proceedings, Right 5 should never be overlooked. It provides:

Right to Effective Communication

(1) Every consumer has the right to effective communication in a form, language, and manner that enables the consumer to understand the information provided. Where necessary and reasonably practicable, this includes the right to a competent interpreter.

(2) Every consumer has the right to an environment that enables both consumer and provider to communicate openly, honestly and effectively.

8.34 BY consent the suppression orders made in Decision Number 44/98/25C are now vacated.

DATED at Auckland this 23rd day of September 1998.

.....

P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal