Medical Practitioners Disciplinary Tribunal

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DECISION NO: 70/98/38C

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 **JACOBUS PETRUS DE LA PORTE** medical practitioner of Hokitika

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Ms S Cole, Dr R S J Gellatly, Dr A F N Sutherland,

Dr B J Trenwith (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Greymouth on Wednesday 24 March 1999

APPEARANCES: Mr C J Lange for Complaints Assessment Committee

Mr C J Hodson QC for Dr J P de la Porte.

1. THE CHARGE:

1.1 **A** Complaints Assessment Committee (the CAC) pursuant to section 93(1)(b) of the Medical Practitioners Act 1995 charges Jacobus Petrus de la Porte, Medical Practitioner of Hokitika at approximately 4.30 am on Saturday 27 March 1993 at Hokitika failed to respond appropriately to a request to assist his patient J Stewart in a medical emergency, that amounting to professional misconduct.

2. BACKGROUND:

2.1 **THE** complainant, Ms Stewart, had attended on Dr de la Porte on a number of occasions prior to 26 March 1993. There is no criticism as regards the medical care given by Dr de la Porte up to 25 March 1993. On 25 March Ms Stewart went to see Dr de la Porte believing that her waters had broken. She was full-term at that time. Dr de la Porte referred and admitted her to Grey Hospital in Greymouth where she could be evaluated by a specialist and possibly undergo a scan. The admission took place on Thursday evening 25 March 1993 and Ms Stewart was apparently sent home the next day Friday 26 March. The events to which the charge relates occurred on 27 March 1993.

2.2 **IN** the early hours of the morning of 27 March 1993 Ms Stewart suffered pain and bleeding. She was home at the time. The situation became so severe that she was in her bedroom bleeding and was unable to move without the assistance of her partner, Mr Maffey.

2.3 **AT** around 4-4.30 am Ms Stewart told Mr Maffey to go and get Dr de la Porte, whose house was just around the corner. Mr Maffey went to the house, and knocked on the door, which was answered either by Dr de la Porte or by his wife, Mrs de la Porte (there is a major area of dispute as to who answered the door and what was said).

2.4 **IT** is the CAC's case that Dr de la Porte answered the door. Mr Maffey explained the developments which had occurred, the condition of his partner, that she was on the floor bleeding. He thought she was having a baby.

2.5 Dr de la Porte's response was that he was not on duty and that Mr Maffey should try and get Ms Stewart to Grey Hospital. Mr Maffey said he asked Dr de la Porte to come to their home, but that the request was refused. When Mr Maffey arrived home he found that the baby had delivered without assistance. He then went to a neighbour's house and asked her to come and comfort his partner. From the neighbour's house he telephoned the duty doctor, Dr Bryant, who came to their house. It is noted that Dr Bryant died some time ago.

3. EVIDENCE FOR THE CAC:

Jillian Lynne Stewart:

3.1 **MS** Stewart was not required by Mr Hodson for cross-examination. Her brief of evidence was taken as read.

Paul Raymond Maffey

3.2 **WHEN** Ms Stewart visited the doctor on 25 March he drove her to the surgery and then to Greymouth Hospital. After her discharge the following day he drove her home.

3.3 **HIS** partner's condition got worse on the evening of the 26 March and morning of 27 March. He was becoming concerned about her condition.

3.4 **BETWEEN** approximately 4 and 4.30 am his partner asked him to go and get the doctor. They did not have a telephone at their home. He went to the doctor's home which was a short distance from their residence. He ran to his house which took less than two minutes.

3.5 **HE** knocked on the door of the doctor's home which was answered by Dr de la Porte. He explained to the doctor the developments and pleaded that he come to their home to attend his partner as she was in trouble. The doctor responded by saying no he was not on call and that he should put his partner in the car and take her to Grey Hospital. He told the doctor that his partner was on the floor, she was bleeding and when he left her she could not move and she was about to have a baby. He also explained to the doctor that she had had severe gallstone attacks and thought she was having the baby. The doctor responded by telling him that he was not on call and to try and get Ms Stewart to Grey Hospital and then closed the door. At no time did he ever speak to the doctor's wife. The first time he saw her was at the Complaints Assessment Committee hearing.

3.6 **NO** offer was made by the doctor to contact another doctor or ambulance for him.

3.7 **HE** then returned home to find his partner had given birth unassisted. She was sitting on the floor, blood was everywhere and she was in distress and very frightened.

3.8 **AFTER** trying to comfort his partner and child he then went to a neighbour's house, Angela Robinson, and explained to her what had occurred, of his asking Dr de la Porte to come to their house, of his refusal, of his returning home and finding his partner had already given birth. He asked Angela Robinson to go to their house while he located a doctor.

3.9 **HE** then found Dr Bryant who came straight away and who also telephoned Bev Olsen a midwife to attend. Dr Bryant cut the umbilical cord and attended to both his partner and their child.

Cross Examination by Mr Hodson:

3.10 **IT** did not occur to him that it might be a good idea to check in with Dr de la Porte after discharge from hospital. The hospital said to go home and that's exactly what they did. His partner was surprised the hospital sent her home.

3.11 **ALL** through the evening he questioned his partner whether she should return to the hospital but she said she had been sent home and there the matter rested.

3.12 **IT** was his clear recollection that it was the doctor himself who came to the door.

3.13 **THAT** his partner was bleeding was definitely mentioned.

4. EVIDENCE FOR THE RESPONDENT:

Jacobus Petrus de la Porte:

4.1 **MS** Stewart first consulted him on 22 February 1993 with further consultations on 24/2/93, 26/2/93, 2/3/93, 10/3/93, and 25/3/93. The consultation on 10/3/93 was for a routine pregnancy examination when *"Everything was obviously going well"*.

4.2 **THE** consultation of 25 March 1993 was followed by admission of Ms Stewart to Grey Hospital for specialist evaluation and a possible ultrasound to establish whether her membranes had indeed ruptured or not. The patient was considered not to be in labour, cystitis possibly being responsible for her problems.

4.3 **HE** was not informed by either Grey Hospital or Ms Stewart about her discharge from hospital on 26 March 1993. If he had been informed by Grey Hospital or the patient, that she was being discharged, he would have alerted his wife to the possibility that the patient may contact, even though he was not on call. He would always, and has always, made himself available to specific patients of his even on the weekends that he was not on call, if he was aware of problems that they may have had. Those names would be given to his wife prior to the weekend commencing, so that if there was any question of them calling, she would know that he would see them. If for one or other reason he would not be in town over an *"off"* weekend these patients would be discussed with the duty doctor in case of a call. If he had been informed by either the patient or Grey Hospital that she had been discharged, in this specific case, as with any pregnant woman, he would have followed one of two protocols as usually performed in his practice namely either:

(a) Recalled the patient for further clinical assessment and then, if necessary, re-referred her back to Grey Hospital or;

(b) Informed her of the lack of facilities for home birth options and emphasised the on-call arrangements and procedures for re-admission to Grey Hospital.

4.4 **ON** the following morning (Saturday 27 March 1993) about 4 to 4.30 am his wife answered a knock on their door. A man (Mr Maffey) informed her that his partner (Ms Stewart) was in labour and requested that he should go to her home to assist. His wife informed the man that he was not on call for the town and requested that he get hold of the duty doctor and ambulance. After some discussion the man left. Dr de la Porte was informed of the incident when his wife returned to their bedroom. He had no contact with the patient or her partner. As he did not have the patient's address he discussed with his wife whether he would go into the surgery, collect the patient's records and address and attend her. He thought however that by the time he did that the duty doctor and ambulance would have been there. In retrospect he wishes he had done this.

4.5 **AT** the final consultation on 31 March 1993 Ms Stewart complained to him about the fact that she was sent back from Grey Hospital and then had to deliver her baby on the floor at home.

4.6 **THE** matter was discussed at length and he tried to explain that having referred her to Grey Hospital was exactly the reason to ensure that she did not have to deliver at home. Unfortunately the situation developed the way it did for which he was and still is very sorry but not, he feels, responsible.

4.7 **IN** his house his wife takes all incoming telephone calls or calls at the door. When he is on call these patients are passed on to him. When he is not on call they are directed to the duty doctor. When he is on call he never has and never will refuse to see any patient at any time of the day or night. If the duty doctor was not available he would of course see the patient.

Examination in Chief:

4.8 **HIS** best recollection of what his wife actually reported to him about the caller when she came back to the bedroom, was that his partner was in labour and that he requested help. He indicated that it was the lady that he sent to Greymouth on Thursday, *"so I knew who it was"*. She told him that she asked the caller to get hold of the duty doctor and the ambulance.

4.9 **HE** was told nothing about bleeding. He could not recall being told anything about the patient being immobile on the floor.

Cross Examination by Mr Lange:

4.10 **AT** the time in question he had only been practising in Hokitika for about eight weeks.

4.11 **WHEN** he admitted Ms Stewart to hospital on the Thursday it was for delivery because he firmly believed she was in labour, adding *"I'm convinced she was discharged from Grey Hospital in labour"*.

4.12 **ALTHOUGH** it was conveyed to him that Ms Stewart was in labour, he could not recall that he knew that she was bleeding.

4.13 **HE** accepts it is his role as the doctor to determine when medical intervention is required, not that of his wife.

Ria Elizabeth de la Porte:

4.14 **SHE** told Mr Maffey to get hold of the duty doctor to attend to his partner and the ambulance for urgent transport to Grey Hospital. This advice was repeated a few times. She told Mr Maffey it would be better for his partner to have the baby in the ambulance on the way to Greymouth than at home.

4.15 **ALTHOUGH** she was told about blood, she got the impression that it was a normal *"show"* as expected in early labour. It was her impression that Ms Stewart was not lying on the floor in a pond of blood, and she didn't think it was a life threatening situation.

Cross Examination by Mr Lange:

4.16 **SHE** has compassion for Ms Stewart's situation, but would not take the blame that she did not seek advice earlier in the evening.

4.17 **THE** conversation definitely took place between herself and Mr Maffey, certainly not her husband. She probably made an error in her evaluation of the whole situation, for which she feels responsibility.

4.18 **SHE** could not recall Mr Maffey mentioning that they did not have a telephone.

4.19 **CONCEDING** that she could have asked Mr Maffey to wait while she spoke to her husband, she added *"I could have asked so many things in retrospect which I regret now I did not do ..."*.

5. DISCUSSION AND FINDING:

5.1 **THE** Tribunal must determine whether the facts alleged in the charge have been proved to the required standard. The burden of proof is on the CAC to establish that Dr de la Porte is guilty of the charge, and to produce the evidence that proves the facts upon which the charge is based. If the facts are established to the required standard then the Tribunal must go on to determine whether the conduct established amounts to professional misconduct.

5.2 **THERE** are two significant conflicts in the evidence which we must try to resolve.

5.3 **MOST** unusually we are faced with a direct conflict of evidence on the important point of who answered the door to Mr Maffey between 4 and 4.30 am on Saturday 27/3/93.

5.4 **MR** Maffey was adamant it was Dr de la Porte. On the other hand both Dr de la Porte and Mrs de la Porte were equally adamant that it was Mrs de la Porte who answered the door.

5.5 **THE** testimony of none of the witnesses on this point was undermined in cross-examination.

5.6 **THE** possibility exists for us to prefer the evidence of Dr and Mrs de la Porte on this point given the combined weight of that evidence. On the other hand, however, we must say we found all three of the principal witnesses to be both credible and truthful in the evidence which they gave before the Tribunal. Obviously the evidence of at least one of the witnesses must be mistaken on the point in question. Unfortunately it has not been possible for us to make a finding in this regard.

5.7 **IN** looking at the facts Mr Lange submitted that perhaps in this case the Tribunal does not need to determine who answered the door. We think this submission has some merit.

5.8 **THERE** is no dispute that Mr Maffey called at the doctor's residence and that he conveyed to whoever opened the door his perception of his partner's predicament with respect to the imminence of their baby's birth. This information was imparted to Dr de la Porte immediately, whether in person or by his wife we are unable to determine. Suffice to say Dr de la Porte accepts the decision not to attend on Ms Stewart was ultimately his responsibility alone, it being encapsulated in the Latin maxim *"delegatus non potest delegare"*.

5.9 **THE** second area of conflict in the evidence arises with respect to the information which was given to Mr Maffey when he called at the doctor's residence.

5.10 **ESSENTIALLY** it was Mr Maffey's evidence that he was told he should put his partner in the car and take her to Grey Hospital. Specifically he said no offer was made to contact another doctor or ambulance for him. And neither was anything said to him about contacting the duty doctor.

5.11 **IN** contrast it was the evidence of Mrs de la Porte that her advice to Mr Maffey, repeated a few times, was to get hold of the duty doctor to attend to his partner and the ambulance for urgent transport to Grey Hospital. Dr de la Porte confirmed this was his understanding of the incident.

5.12 **AGAIN**, in terms of a straight forward issue of credibility, it is not easy for us to make a finding of just precisely what information was given to Mr Maffey on the night in question. However in

terms of probability we consider that the version of what Dr and Mrs de la Porte say Mr Maffey was told to do is more likely to be correct. We say that because quite clearly there was an established duty doctor system in place in Hokitika at the relevant time. This is borne out by the meticulously careful evidence given by Dr de la Porte as to the two protocols one of which he said he would have followed had he earlier been informed of Ms Stewart's discharge from Grey Hospital. This evidence has not been challenged. It has a strong ring of credibility and it is accepted by us.

5.13 **HOWEVER** our preference for the evidence of Dr and Mrs de la Porte on this point should not be taken by Mr Maffey as an adverse reflection on his sincerity of recall. Obviously it was a very stressful occasion. It is quite understandable if Mr Maffey's recollection of this aspect of the incident is mistaken.

5.14 **THE** essence of the charge is that Dr de la Porte failed to respond appropriately to a request to assist his patient in a medical emergency. Having found as a fact that Mr Maffey was told to contact the duty doctor, it becomes necessary for us to establish if that was an appropriate response on the facts of this case. Once again it is necessary to focus on and try to establish just exactly what the situation was on the night in question.

5.15 **IT** seems to us that the terse nature of the message imparted by Mr Maffey was sufficient to indicate that the condition of Ms Stewart, his partner, Dr de la Porte's patient, was a medical emergency. Three reasons are given in support of our conclusion that there was a medical emergency.

5.16 **FIRST** it is common ground that Ms Stewart was a patient of Dr de la Porte. The doctor/patient relationship always gives rise to a duty to take reasonable care.

5.17 **SECONDLY** it is not disputed by Dr de la Porte that Ms Stewart was in labour. Noted is his evidence-in-chief that when Ms Stewart was brought to his surgery on 25/3/93 he considered her not to be in labour and that a possible cystitis might be responsible for her problems. However in cross-examination Dr de la Porte acknowledged to Mr Lange that Ms Stewart was in labour, she having been in labour since midday on 25 March 1993 through until 4.30 in the morning of 27 March 1993. Although both Mr Maffey and Ms Stewart may have believed that gallstones were causing the pain and discomfort, Dr de la Porte was clear in his mind that Ms Stewart was in labour. Irrespective of whether Mr Maffey spoke direct to Dr de la Porte or to his wife, it is an uncontested fact that he managed to convey a sense of urgency or emergency surrounding his partner's condition. He explained that Ms Stewart was on the floor, she was bleeding, she could not move, and that if it was not a gallstone attack, that she was going to have a baby.

5.18 **THIRDLY** Mrs de la Porte acknowledged she was told about blood. However she interpreted the bleeding as a normal *"show"* as expected in early labour. Mrs de la Porte explained she *"got the impression that Ms Stewart was not lying on the floor in a pond of blood"* and *"I didn't think it was a life threatening situation"*. Mrs de la Porte added she did not give her husband the impression there was a life threatening situation and she said *"I can kick myself for that"*.

5.19 **MRS** de la Porte also acknowledged Mr Maffey had said that he was not able to get Ms Stewart into his car.

5.20 **LIKE** her husband Mrs de la Porte, too, genuinely thought that Ms Stewart was in labour, that being the reason she said Ms Stewart needed to get back to Grey Hospital as soon as possible. Mrs de la Porte concluded *"... probably I made an error in my evaluation of him and the whole situation - I feel responsible for that ..."*.

5.21 **IN** summary we make the following findings:

(1) The Tribunal does not need to determine who answered the door and spoke to Mr Maffey;

(2) Mr Maffey was instructed to contact the duty doctor to attend to Ms Stewart and an ambulance for urgent transport to Grey Hospital;

(3) The second finding constitutes a response on the part of Dr de la Porte to assist his patient, Ms Stewart, which was less than ideal but understandable in the circumstances that he thought existed. This led to his failure to assist his patient in a medical emergency.

6. DETERMINATION:

6.1 **HAVING** found that the facts alleged have generally been proved to the required standard, the Tribunal must go on to determine whether the conduct established by the proven facts amounts to professional misconduct.

6.2 **THE** CAC accepts that it is for it to establish that Dr de la Porte is guilty of the charge, and to produce the evidence that proves the facts upon which the charge is based.

6.3 **IT** is well established in professional disciplinary cases that the civil, rather than the criminal, standard of proof is required, namely proof to the satisfaction of the Tribunal, in this case the Medical Practitioners Disciplinary Tribunal on the balance of probabilities. At the same time, however, the cases recognise that the degree of satisfaction which is called for will vary according to the gravity of the allegations.

6.4 **MR** Hodson submitted that even if Dr de la Porte had taken the time to get out of bed, get dressed and go to the house, it is clear the duty doctor did attend promptly and the midwife did all that was necessary to be done. On that basis, and given all the evidence adduced, Mr Hodson argued the Tribunal's only concern should be to consider whether Dr de la Porte should be found guilty of conduct unbecoming, or nothing. Otherwise Mr Hodson submitted there is no case to answer a charge of professional misconduct.

6.5 **IF** Dr de la Porte is to be criticised on this occasion, one which Mr Hodson characterised as a *"one-off"* incident, he submitted that his years of faithful rural practice should outweigh any blot on his otherwise good record.

6.6 **FOR** the CAC Mr Lange acknowledged, if not satisfied a charge of professional misconduct had been established, that it would be open to the Tribunal to consider whether the conduct in question constituted conduct unbecoming which reflects adversely on fitness to practise medicine.

6.7 **IN** the first instance we will consider whether the behaviour of Dr de la Porte, on the facts as found, constitutes professional misconduct as charged.

6.8 **ALTHOUGH** the charge was defended on the basis that the behaviour under scrutiny should not attract any penalties, certain concessions made by Dr de la Porte should be noted.

6.9 **WE** consider, if it was Mrs de la Porte to whom Mr Maffey spoke, that she made a poor decision. It is unfortunate that Dr de la Porte did not review and redress that decision. When questioned by Dr Sutherland, Dr de la Porte conceded "*the real reason is I was just too tired, but yes I was awake, and yes I wanted to go. And yes I wish I did go*".

6.10 **A** second important concession made by Dr de la Porte occurred during cross-examination when he stated he believed Ms Stewart to be in labour.

Mr Lange: "*There can be serious consequences in the child birth process correct.*"

Dr de la Porte: "*In any labour, yes, Sir.*"

Mr Lange: "*This was a situation of a medical emergency wasn't it.*"

Dr de la Porte: "*I will accept that birth is a medical emergency, yes.*"

6.11 **ALTHOUGH** Dr de la Porte sought to draw a distinction between a direct request by Mr Maffey and one relayed by his wife, we consider the distinction is semantic. The strong inference we take from his answers is, having been made fully aware Ms Stewart had been in labour for at least 36 hours, that he should have responded to what was clearly a medical emergency.

6.12 **HELPFUL** comments as to the responsibility of a medical practitioner in an emergency are provided by a decision of the Medical Practitioners Disciplinary Committee on 24 September 1986 which concerned a Dr N. Although the background facts in the two cases are quite

dissimilar, the decision of the MPDC is significant by reference to the following principles which it established:

(a) Although a doctor may refuse to attend and accept a patient, he must satisfy himself that it is not an emergency. He must attend in an emergency whether or not it is a patient of his practice. If he decides not to attend on the basis of what is told to him about the patient's condition and does not call to make his own assessment, he must accept full responsibility in the same way as if he had seen him in person.

(b) A patient's account of his condition, or a description of it by a second or third hand caller must necessarily be incomplete, for it provides no clinical assessment. Having accepted medical care of the patient as he must do in an emergency, a doctor must be sure as to his advice for the patient's management, whether or not he will call.

..."

6.13 IN this case the Committee found that Dr N erred seriously in his refusing to attend the patient and thereby was guilty of professional misconduct.

6.14 THE definition of professional misconduct is well established. In *Ongley v Medical Practitioners Disciplinary Committee* [1984] 4 NZAR 369, at 374-5, Jeffries J stated in the context of the 1968 Act:

"To return then to the words "professional misconduct" in this Act. The charge is meant to relate to improper conduct of the middle category.....
In a practical application of the words it is customary to establish a general test by which to measure the fact pattern under scrutiny rather than to go about attempting to define in a dictionary manner the words themselves. The test the Court suggests on those words in the scheme of this Act in dealing with a medical practitioner could be formulated as a question. Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably 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 judgement 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."

6.15 **THE** *Ongley* test for professional misconduct has been adopted by this Tribunal under the 1995 Act in a number of Decisions.

6.16 **BY** reference to *Ongley* we are required to determine whether Dr de la Porte's failure to respond appropriately to the request to assist his patient in a medical emergency, would be reasonably regarded by his colleagues as constituting professional misconduct.

6.17 **FOR** the following reasons we consider, and so hold, that the CAC has failed to establish to the required standard of proof, that Dr de la Porte is guilty of professional misconduct:

1. Dr de la Porte was in bed at 4.30 am. He was not on call and was not expecting to be called.
2. Dr de la Porte had admitted Ms Stewart to hospital, but had not been engaged to conduct her delivery.
3. Dr de la Porte had no communication back from Grey Hospital after arranging Ms Stewart's admission in what he reasonably believed was labour. Subsequently she was sent home. The hospital staff had written no discharge note, there had been no telephone communication with Dr de la Porte, and no obvious plan of management had been put in place. Effectively Ms Stewart was on *"home leave"* before re-entering the hospital for delivery.
4. Hokitika has a well organised after-hours general practice roster to cover emergencies.
5. Ms Stewart and her partner have to accept some responsibility for the preparation for the delivery of their baby. Despite the imminent birth of their child, neither of them had a clear knowledge of the general practitioner's on-call system at Hokitika, and there was no telephone in the house.

6. In the Dr N case, cited earlier, where the practitioner was found guilty of professional misconduct for failing to attend an emergency, the doctor was the only practitioner within 25 kms and the doctor was called on more than one occasion. These important factors are not present in this case.

6.18 **IT** remains for us to consider the alternative, of whether Dr de la Porte's failure to assist Ms Stewart constitutes conduct unbecoming which reflects adversely on fitness to practise medicine.

6.19 **UNDER** the 1968 Act conduct unbecoming, in the practical reality of the workings of the Medical Practitioners Disciplinary Committee, encompassed all the lesser misdemeanours. In general it included rudeness, failure to do things which the doctor said he/she would do, and failure to treat adequately minor situations.

6.20 **IN** the 1995 Act there is an added requirement. In the case of conduct unbecoming a medical practitioner, the Tribunal is only entitled to make orders as to penalty where that conduct reflects adversely on the practitioner's fitness to practise medicine (Section 109(c)).

6.21 **THIS** qualification should not be construed in such a way as to remove the three tier nature of the offences set out in Section 109. Rather, the words have been added to ensure that the Tribunal does not take steps against a practitioner unless the offending has a bearing on his or her fitness to practice. Subject to that the words are widely drawn. A matter may reflect adversely on a practitioner's fitness to practise without making him or her incompetent to practise, and without elevating "conduct unbecoming" above "professional misconduct".

6.22 **THE** meaning of the rider under Section 109(1)(c) of the Act was considered recently in *A Complaints Assessment Committee v Mantell* (Doogue DCJ, 7 May 1999, District Court Auckland NP 4533/98).

6.23 **THE** Court considered the history of the term *"conduct unbecoming a practitioner"* in the previous Act. At p 12 the Judge held that the expression *"conduct unbecoming"* was inserted in 1979 in order to catch conduct which was part of the personal life of the practitioner and behaviour outside the conduct of the profession which would reflect discreditably on the profession as a whole. There was therefore no need to amend the Act further in 1995, to catch that type of conduct.

6.24 **THE** Court went on to consider the rider in the context of the Act, and in particular in the context of the principal purposes spelt out in Section 3 of the Act. The Court said:

"It will be seen that s 3 explicitly links the objective of the principal purpose of protecting the health and safety of the public by, inter alia, providing for the disciplining of medical practitioners. In my opinion, when the legislature amended what was s 109(1)(c) it did so with the objective in view of strengthening the links between the disciplinary process and the main object of the Act. One result is that disciplinary offences under s 109(1)(c) would only be brought in cases where the conduct unbecoming had implications for the health and safety of members of the public. Conduct may be unbecoming and yet not necessarily have such implications.

..... conduct which is objectionable simply because it disgraces the profession does not necessarily pose a threat to the health and safety to members of the public. At the same time it would be possible to imagine some cases which would still qualify. An example might be that of a practitioner who because of his excessive drinking in his private time so debilitates himself that he is not fit to practise during his working hours.

In summary, it may well be that the interpretation which I adopt represents a contraction of the range of conduct which will henceforth be caught by the term "conduct unbecoming". That factor though is neutral so far as interpretation of the section is concerned. There is no reason, for example, why one should start from the position that in amending the Act, the legislature intended to expand the category of cases caught by the section."

6.25 **IN** the Court's view, the following description of the essential features of conduct unbecoming extracted from *B v Medical Council* (Elias J, 8/7/96, Auckland Registry, HC 11/96) still remains a useful analysis of what amounts to conduct unbecoming (p 15-16):

"There is little authority on what comprises "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. ... 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. ..."

6.26 **AT** p 16 the Court in *Mantell* went on to hold that all the prosecution needs to establish for a charge of conduct unbecoming is that the conduct reflects adversely on the practitioner's fitness to practise medicine. It does not require the prosecution to establish that the conduct establishes that the practitioner is unfit to practise medicine. The Court said:

"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. In order to satisfy the requirements of the rider, it is not necessary that the proven conduct should conclusively demonstrate that the practitioner is unfit to practise. The conduct will need to be of a kind that is inconsistent with what might be expected from a practitioner who acts in compliance with the standards normally observed by those who are fit to practise medicine. But not every divergence from recognised standards will reflect adversely on a practitioner's fitness to practise. It is a matter of degree."

6.27 **AT** p 19 the Court stated:

"I conclude that the prosecution in a charge of conduct unbecoming is not required to establish that the practitioner is actually unfit to practise. Evidence that bears on that issue including such matters as evidence in the form of references showing that the practitioner is of good standing in the eyes of the profession is not relevant to the stage of the proceedings at which the Tribunal is considering whether or not a charge is proved. It may well be relevant, of course, on consideration of penalty."

6.28 **ON** the facts of this case, as found by the Tribunal, we are satisfied to the required standard, the balance of probabilities, that Dr de la Porte's conduct in failing to respond to the request to assist Ms Stewart in the birth of her child, is conduct unbecoming a medical practitioner which reflects adversely on fitness to practise medicine. That is not to say that Dr de la Porte is actually not a fit person to practise medicine. As was clarified by Doogue DCJ in *Mantell* at p 17, Section 109(1)(c) "*requires assessment of standards of conduct using a yardstick of fitness*". His Honour explained "*It [Section 109(1)(c)] does not call for an assessment of an individual practitioner's fitness to practise*".

6.29 **ON** the facts of this case it is the Tribunal's judgement that the failure on the part of Dr de la Porte was relatively serious, and not so trivial or unimportant as not to warrant a finding of conduct unbecoming which reflects adversely on fitness to practise medicine.

6.30 **A** similar approach was taken by the Tribunal in *Complaints Assessment Committee v W* (Decision No. 46/98/23C) which was approved in the appeal by *W v The Complaints Assessment Committee* (Thompson DCJ, 5 May 1999, District Court Wellington, CNA 182/98) p 6 the Court said:

"The circumstances of the offences were set out in .... and the appellant's own evidence at the hearing. From that material the Tribunal was able to form a view of whether those circumstances reflect adversely on the appellant's fitness to practice medicine. <u>That is a matter of judgement</u>, rather than a finding of fact, <u>to which the Tribunal can and should apply its collective wisdom</u>. It is similar to, if not identical with, decisions as to whether a practitioner has been guilty of disgraceful conduct in a professional respect or of professional misconduct: see ***Ongley v Medical Council****. The view that the Tribunal came to seems to me to be one entirely open to it."* (Tribunal's emphasis).

7. RESULT:

7.1 **HAVING** made an adverse finding against Dr de la Porte, the Tribunal determines that he is guilty of conduct unbecoming a medical practitioner which reflects adversely on fitness to practise medicine. Submissions are requested of counsel in respect of penalties. The timetable is for Mr Lange to file his submissions by **Monday 28 June 1999** followed by submissions by Mr Hodson no later than **Monday12 July 1999**.

DATED at Auckland this 10th day of June 1999

.....

P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal