Medical Practitioners Disciplinary Tribunal

PO Box 5249 Wellington Telephone (04) 499-2044 Facsimile (04) 499-2045
All Correspondence should be addressed to The Secretary

NOTE: NAMES OF RESPONDENT AND COMPLAINANT

<u>NOT FOR PUBLICATION</u>

DECISION NO: 97/99/48D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against **M** medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Dr R S J Gellatly, Dr J M McKenzie, Dr A D Stewart,

Mrs H White (Members)

Ms G J Fraser (Secretary)

Ms L Tipene (Stenographer)

Hearing held at xx on Wednesday 13 October 1999

APPEARANCES: Ms T W Davis the Director of Proceedings and Mr M F McClelland

Ms J Gibson for Dr M.

1. THE CHARGE:

1.1 THE Director of Proceedings designated under Section 15 of the Health & Disability Commissioner Act 1994 has reason to believe that a ground exists entitling the Tribunal to exercise its powers under Section 109 of the Medical Practitioners Act 1995 ("the Act");

The substance of the ground believed to exist, and the particulars of the charge are:

"Take notice that pursuant to sections 102 and 109 of the Medical Practitioners Act 1995, the Director of Proceedings charges that on or about 5 March 1997 whilst treating his patient, Mrs, Dr M being a Registered Medical Practitioner acted in such a way that amounted to Professional Misconduct in that he provided services of an inappropriate professional standard.

In particular he:

1. Failed to appreciate the significance of the symptoms of a 23-week pregnant patient, those being:
   - (a) 11 hours of collicky infra-umbilical pain;
   - (b) Pain that had been increasing in intensity and frequency, with the pain occurring every five minutes;
   - (c) Three loose bowel motions;
   - (d) No nausea or vomiting;

and/or

2. Failed to consider a threatened miscarriage as a differential diagnosis;

or

3. Considered a threatened miscarriage as a differential diagnosis but failed to take appropriate steps to confirm or exclude the differential diagnosis of a threatened miscarriage;

and/or

4. Failed to appreciate the significance of the uterine fundus position;

and/or

5. Failed to undertake or arrange for bi-manual pelvic and/or speculum examination of the cervix;

and/or

6. Failed to arrange transfer of his pregnant patient to a hospital for further assessment."

2. FACTUAL BACKGROUND:

2.1 **THE** charge against Dr M arises out of a consultation he undertook with the complainant patient on 5 March 1997. On that date the complainant attended at the xx Accident and Medical Centre ("the Centre") complaining of stomach pains. The Centre was located just across the road from the complainants' home. She had previously attended the Centre for minor complaints, but had not previously seen Dr M. At the time of the consultation, the complainant was approximately 24 weeks pregnant. It was her first pregnancy.

2.2 **THE** complainant's general practitioner was located near to her place of work, but approximately half an hour by car from her home. In any event, he no longer took on maternity cases and the complainant's lead maternity carer was xx Hospital. A midwife had been allocated to her but, at the relevant date, she was overseas and another xx midwife was to be allocated to take over the complainant's care until her return. In the course of her pregnancy,

the complainant had attended xx for routine checkups and had been seen by her midwife and a doctor on each occasion. She had not experienced any problems with her pregnancy.

2.3 **XX** had given the complainant information about her pregnancy including a booklet about symptoms and what to expect during her pregnancy. xx is located in xx, estimated by the complainant to be about 5 mins by car from her home. At 8.00 am in xx traffic that is probably somewhat optimistic, but in any event, xx is a relatively short distance by car from xx.

2.4 **THE** complainant presented at the Centre with a history of stomach pains commencing at approximately 9.00pm the previous evening. By morning her husband had become sufficiently concerned to urge the complainant to go to the doctor. He thought that she was in labour and arranged to stay at home for the day because he anticipated spending the day at the hospital with his wife. In contrast, the complainant did not think that the pains had anything to do with her pregnancy, but she was concerned to find out if her pregnancy could be affected by whatever was wrong with her.

2.5 **THE** complainant walked to the Centre but by this time was experiencing severe pains which she described as "*deep and hard cramps*". At one point in her journey to the Centre the pains stopped her from walking, she was grunting and she had to hold on to the traffic pole to get through the pain. Her husband followed her to the Centre and waited for her in the Reception area. Her Centre name label records an admission time of 7.52 am.

2.6 **BY** the time she was in the consultation room she was experiencing pains every 5 minutes or so, and had to hold on to a chair grunting with the pain. She recalls Dr M entering the room,

seeing her crunched over the chair, and he asked her if she "had something wrong". She recalls him thinking that she had something wrong with her legs or her feet.

2.7 **DR** M does not recall seeing the complainant experiencing pains at any time during the consultation which lasted about 15 - 30 minutes, although he has recorded in his notes that the complainant "*has bad stomach pains … every 5/60*". The complainant told Dr M that she had stomach pains since the previous evening, increasing in frequency and severity, and that she felt she had to push like she was going to the toilet. Dr M recorded "*Moving bowels relieves the pain for a short time.*"

2.8 **FOLLOWING** his examination of the complainant, Dr M diagnosed gastroenteritis. There was apparently an epidemic of gastroenteritis around at the time, although Dr M conceded that none of the patients he had seen with this illness had also been pregnant.

2.9 **HE** gave the complainant a prescription and told her to drink as much fluid as possible and not to eat. He also said that because she was pregnant she should have a blood and urine test and that if things got worse she was to contact him. At the laboratory which is adjacent to the Centre, the complainant continued to experience strong cramping pains, to the extent that the women staff members present were sufficiently concerned to ask her if she needed any assistance.

2.10 **THE** complainant, with her husband's assistance, returned to her home. She took the medicine prescribed by Dr M and went to rest on her bed. Her pain became worse but she refused any assistance or comfort from her husband, apparently because she was satisfied that she had gone to the doctor and been told that she had gastroenteritis; she had taken the medicine prescribed

and the illness would pass. She continued to feel a strong urge to go to the toilet. While she was on the toilet, her husband and her brother left the house to take the dogs for a walk.

2.11 **THE** complainant was by this stage pushing to relieve her pains, which had intensified and increased in frequency since the time she arrived at the Centre (a little over an hour previously), and while pushing felt something come out between her legs. She put her hands down and felt some legs. Her baby arrived within seconds and was breathing. The complainant gave the baby mouth to mouth resuscitation. The telephone number for the Centre was on a form which she had left nearby on her table so the complainant telephoned the Centre and a doctor and two nurses immediately came over to assist. The time of attendance is recorded in the complainant's patient record as 9.30 am.

2.12 **THE** complainant and her baby were taken to xx by ambulance. The baby died on the way to the hospital. The complainant's husband returned home to find a note telling him what had happened and that his wife was in xx.

3. EVIDENCE FOR THE DIRECTOR OF PROCEEDINGS:

The complainant and her husband

3.1 **BOTH** the complainant and her husband gave evidence. Dr C J P Leathart, a General Practitioner of Christchurch, also gave evidence on behalf of the Director of Proceedings.

3.2 **BOTH** the complainant and her husband described the events of 5 March 1997. The complainant described the pain she had as starting at about 9.00pm on the 4th of March, and feeling like period pains. She was unable to sleep, but was not "*in agony*". The complainant

described herself as "*pretty strong and [I] can tolerate pain. I'd say that I have got a high pain threshold*". Her husband agreed with this assessment. It seems clear from her evidence however, that by the morning of the 5th the complainant was experiencing a high level of intermittent pain, increasing in intensity and frequency. She had no nausea or vomiting.

3.3 **THE** complainant also described a feeling of wanting to push with the pain. She was spending a lot of time on the toilet and "*when the pain came I would push as if I was going to pass a motion and then the pain would seem to go away*." She also described the pain as occurring "*in my lower abdomen below my navel and above my pubic area.*" She said that this is how she described the pain to Dr M. She said that she also told him what had gone on during the night, and that she remembers telling Dr M about having to lean over the bed because of the pain. She also told him about feeling as if she needed to go to toilet, but that "*nothing would come.*"

3.4 **SHE** is sure that she "*did not underplay the pain.*" In significant respects, all of this evidence accords with the consultation notes made by Dr M. The complainant's husband confirmed her evidence to the extent that he had observed her overnight discomfort and pain, and her obviously painful journey across the road to the Centre; to the laboratory for tests, and their return home. Perhaps most significantly since he had no medical background or knowledge whatsoever, he thought that his wife "*might be having contractions or be in labour*".

3.5 **HE** described his wife as "*a very strong and independent woman*". However he had no experience of pregnancy or labour, and was obviously hesitant about interfering in matters about which he had no knowledge. He deferred to his wife's belief that what she was experiencing

had nothing to do with her pregnancy and, having persuaded her to go to the doctor, he was reassured by Dr M's diagnosis of gastroenteritis - "*I was no longer worried because we had the magic potion from the chemist so I knew I [now] just had to help A get home.*" Once home, his wife wanted to be left alone, so he and her brother (who lived with them), left to go for a walk.

Dr Leathart

3.6 **DR LEATHART** is an experienced General Practitioner practising at the Ilam Medical Centre in Christchurch. Between 1985 and 1997 he did some GP obstetrics, and he currently still does shared antenatal care, but that is a very small part of his present practice. Dr Leathart was asked by the Director of Proceedings to review the relevant documentary material, including all of the complainant's medical records relating to the events at issue, provided to him by the Director of Proceedings, and to give his opinion regarding the episode of care which is the subject of the charge.

3.7 **IN** reviewing the notes of the consultation, Dr Leathart gave evidence that the recorded history of a patient who is around 23 weeks pregnant, with an 11 hour history of colicky (periodic) infraumbilical pain; pain occurring every 5 minutes; 3 loose bowel motions; no nausea or vomiting, is a history consistent with labour. It was Dr Leathart's opinion that "*on the basis of that history alone ... a threatened miscarriage should have been considered as a differential diagnosis*". He went on to state, "*I note there is no reference in Dr M's clinical notes to suggest threatened miscarriage as a differential diagnosis. Given the fullness of the notes this is surprising.*"

3.8 **IT** was Dr Leathart's opinion that:

"*Threatened miscarriage should be a differential diagnosis in any woman who is pregnant and has abdominal pain of any sort regardless of the symptoms. A doctor must always have a high level of suspicion of the possibility of something going wrong during the pregnancy. There is a wide variation of "normal" in women's experiences of pregnancy. Late miscarriage can occur with a woman feeling virtually no contractions at all. The crucial point, in my mind, is that a doctor must always have a high level of suspicion of the possibility of complications of pregnancy."*

3.9 **DR** Leathart expressed his firm opinion that late miscarriage should have been a differential diagnosis and should have been ruled out by Dr M. Dr Leathart explained the mechanism of "*differential diagnosis*", which involves the doctor ranking possible diagnoses and then, through a process of elimination carried on in the context of his clinical examination and findings, confirming or excluding each of the possibilities. In answer to a question from the Tribunal, Dr Leathart stated that he would have ranked premature labour as "*No 1*" in terms of a differential diagnosis for the complainant.

3.10 **DR** Leathart stated that, in his opinion, if Dr M did consider the possibility of miscarriage then appropriate steps should have been taken urgently to either confirm or exclude that diagnosis. He did not agree that the complainant's symptoms were such that gastroenteritis was the only possible diagnosis. A vaginal examination was the most important step which should have been taken and if Dr M did not feel comfortable undertaking such an examination, or was uncertain as to the advisability of doing so, then he should have arranged either for a colleague to do so, or arranged for the complainant's transfer to xx as a matter or urgency.

3.11 **IT** was Dr Leathart's opinion that: *"when a pregnant woman is experiencing regular pain as described by [the complainant] it would be important to refer the patient to a woman's hospital to have her assessed. This must be done as a matter of urgency*

because if a woman is in premature labour or threatening a late miscarriage then there is no time to lose."

3.12 **DR** Leathart was also of the opinion that it was unreasonable for Dr M to send the complainant for blood and urine tests and await the results before deciding if further management was warranted. Dr Leathart conceded that even if the correct diagnosis had been made and the complainant transferred to xx immediately, her baby may not have survived. However she would have been spared the distress of having a miscarriage at home alone and without any warning.

Mr B

3.13 **A** statement of evidence by Mr B was submitted by consent. Mr B's evidence was that xx has two assessment units available for pregnant women. Women who are miscarrying their babies are placed in one; the other is for women who are in premature labour. Both units are open during the day, and one is open 24 hours a day. All xx GPs and Midwives should know about the units.

3.14 **XX** will assess any woman, regardless of who refers her. The patient may request a referral herself. In an emergency situation, or if the woman's lead maternity carer is not available, xx will carry out the initial assessment.

4. EVIDENCE FOR THE RESPONDENT:

Dr M

4.1 **DR** M is vocationally registered as a general surgeon, and combines his practice with a general practice. He practices from rooms located at the Centre. He confirmed that the consultation

of 5 March 1997 was the only occasion he had seen and treated the complainant. On that occasion she was a first time or "walk in" patient at the Centre.

4.2 **HE** did not have a patient booked at the time, so he was asked to see the complainant. Dr M gave evidence of his previous experience as superintendent of xx Hospital, a position he held from 1981 to 1991. During that time he was often asked to review patients who were admitted to the surgical ward with a threatened miscarriage.

4.3 **DR** M saw the complainant and reviewed her reported symptoms with her. He has recorded his findings in the notes of the consultation which were produced to the Tribunal. The notes are detailed; Dr Leathart referred to the "*fullness of the notes*", and Dr C, who gave evidence on behalf of Dr M, described them as "*thorough*". Unusually for proceedings such as this, the most significant aspect of the notes is what is <u>not</u> recorded, rather than what is. For example, the notes do not indicate that Dr M considered either premature labour or late miscarriage as a differential diagnosis, nor do they record any findings which would suggest that he did consider these possibilities but discounted them after examining the complainant.

4.4 **IN** addition to the symptoms and history already referred to, the clinical notes record that the complainant's pain was described as colic-like occurring every five minutes or so. She had no urinary symptoms or PV loss. Her blood pressure was 120/80, her pulse regular, and she was not unduly distressed. Her abdomen was soft with mild tenderness in the upper right para-umbilical region. Her bowel sounds were normal. Dr M did not consider a vaginal examination was appropriate because of the site of the pain, the loose motions reported and the lack of any PV loss.

4.5 **AT** the time, there had been a mini epidemic of gastro-enteritis. He made the diagnosis of gastroenteritis and arranged for urgent (i.e. a report would be received by fax later that day) serum electrolytes, full blood screen and midstream urine tests. He prescribed gastrolite to increase hydration; advised her that he would telephone her to advise the results and to check on her; and he would have told her to phone him if she got worse or if she had any concerns.

4.6 **DR** M stated that he did not believe the complainant was in labour because she had no PV loss, bleeding or "*show*". The location of the pain was infraumbilical and mitigated against premature labour. The complainant had had three loose motions over the previous 12 hours but "*no contractions or bearing down*". It was his evidence that the complainant "*at no time during her consultation with me appeared to be in severe pain, nor did she advise me of that*."

Dr C

4.7 **DR** C is a General Practitioner with a wide experience in clinical practice, and as an office holder in several professional organisations including a term as Chairman of the xx Association. He has been honoured for services to medicine in the community. Dr C gave evidence that, in his opinion, while Dr M had clearly made an incorrect diagnosis, he did not consider that his conduct fell below a reasonable standard of practice, for a number of reasons.

4.8 **IN** particular, he stated:

- That he did not know why Dr M did not consider late miscarriage as the most appropriate diagnosis, but that he had seen a number of patients with gastroenteritis in the period of time preceding his consultation with the complainant;

- The complainant's high pain threshold may have misled him; and her stoicism may have caused the complainant to give a misleading picture of the nature of her earlier pains;
- It is not common practice for general practitioners to document a list of differential diagnoses. This is sometimes done, but is not a general rule;
- The usual practice is to formulate in one's mind a range of possibilities and then test examination findings against the possibilities;
- The most appropriate course of action, had Dr M not been convinced the complainant had gastroenteritis, would have been to arrange to transfer her to xx;
- A vaginal examination might have had its own risks, and the preferred course would have been to transfer her to xx;
- Late miscarriage is not a common condition;
- There is a whole spectrum of the level of pain one gets with gastroenteritis from infrequent episodes of pain to constant pain.

4.9 **IN** cross-examination, and in questions from the Tribunal, Dr C also agreed:

- Dr M got it wrong, but he was thorough in getting it wrong;
- A pregnant woman presenting with abdominal pain should be treated with a high degree of suspicion;
- With hindsight, the findings reported by Dr M were consistent with labour;
- The absence of contractions would be an important sign excluding labour as a possibility;
- The fact of an outbreak of a particular illness is a factor doctors take into account in making a diagnosis;
- In the situation where the practice is located close to xx, and there is the prospect of complications arising and of drawing the wrong conclusions from a vaginal examination, the

most appropriate course of action if a premature labour had been suspected would be to refer the patient;

- If he thought the diagnosis was gastroenteritis but the patient was pregnant he would have palpated for contractions, checked on the nature of vaginal discharge and symptoms, and probably sought an ultrasound examination;
- If he had a pregnant patient, with "*a small possibility*" that she was in labour, he would refer her.

Other evidence for the respondent

4.10 **A** statement of evidence by Dr D was submitted by consent, as was a letter from Dr E. Both of these attest to Dr M's professional reputation, and to their opinions of Dr M as a careful and diligent practitioner.

5. SUBMISSIONS:

Submissions for Director of Proceedings:

5.1 **FOR** the Director of Proceedings, Mr McClelland submitted that there was no doubt at all that when the complainant saw Dr M on the morning of 5 March 1997, she was in labour, and that Dr M failed to make the correct diagnosis. These facts are significant, said Mr McClelland, when the Tribunal considers credibility issues and inconsistencies between the evidence of the complainant and her husband, and Dr M. The level of pain that the complainant and her husband described is "*entirely in keeping with a woman in labour whereas Dr M's attempts to downplay that pain is not*."

5.2 **IT** was the thrust of Mr McClelland's submissions that Dr M did not consider the possibility that the complainant was in labour. He made the diagnosis of gastroenteritis early in the consultation, and failed to appreciate the significance of the symptoms recorded by him in his notes.

5.3 Mr McClelland concluded by submitting that Dr M's management of the complainant fell well below the standards to be expected, and, as such, a finding of professional misconduct was warranted. This is not a case of 'there but for the grace of God'. Dr M failed to carry out the basics. He considered this just another case of gastroenteritis and was blinded by that. Dr M made no attempt to exclude any other diagnosis, and that was not a 'mere error' on his part.

Submissions on behalf of the respondent

5.4 **FOR** Dr M, Ms Gibson made submissions that were effectively in two parts: the first part directed first, at the Tribunal's discretionary powers to (a) find a charge proven at a different level to that nominated in the charge, and, (b) to amend a charge as provided in Clause 14 of the Act. The second part of the closing submissions on behalf of the respondent was directed at the matters which Ms Gibson submitted the Tribunal ought to take into account in determining the charge.

5.5 **AS** to the first part, it was Ms Gibson's submission that the Tribunal must find Dr M guilty of the charge at the level of professional misconduct, or not guilty. Ms Gibson submitted that the Tribunal may not simply find the respondent guilty at a lower level of professional misconduct unless it amends the charge in accordance with Clause 14, and that Clause requires that any such amendment be made before closing submissions are heard. Ms Gibson submitted:

"The reason for that is as follows:

Pursuant to the MPA 1968 s.43, there was distinct power for The Tribunal or disciplinary committee as it was then to find one of two charges so where practitioner was charged with professional misconduct it was open to committee to find professional misconduct or conduct unbecoming. That differs from your powers, in section 109 governing your powers, you have the ability to make a finding on any level of charge but that does not assume with respect that a matter can be referred upwards or downwards without notification to the practitioner concerned and I take that inference from Clause l4 of the First Schedule because Clause 14(2) anticipates the Tribunal will notify a practitioner of any change in the charge and give that practitioner the option of making submissions regarding whether or not he or she would be embarrassed in their defence by such a change of charge."

5.6 **THE** submissions in relation to the exercise of the Tribunal's discretionary power to find a respondent guilty of professional misconduct at a level different to the level nominated in the charge will be dealt with later in this Decision.

5.7 **IN** relation to the second aspect of her submissions, Ms Gibson warned of the dangers of considering events with the benefit of hindsight. The Tribunal must be careful not to simply weigh up on the balance of probabilities what it thinks the complainant told Dr M, and what Dr M might have thought in turn. It must take into account the evidence presented to it in relation to each of the Particulars of the charge.

5.8 **IT** was not the case that Dr M had a predetermined view that the complainant was suffering from gastroenteritis, and excluded other possibilities. The complainant's symptoms were conceded by both of the clinicians who gave evidence to be consistent with that illness, and on that basis Dr M asked the right questions and did the right examinations. He did consider the possibility that the complainant was in labour, but excluded it on examination. He got it wrong. As such he is guilty of a mere error, and 'mere error' does not constitute professional misconduct.

6. BURDEN OF PROOF:

THE burden of proof is borne by the Director of Proceedings.

7. STANDARD OF PROOF:

IT is well-established that the standard of proof in disciplinary proceedings is the civil standard, namely, that the Tribunal must be satisfied on the balance of probabilities that the charge against Dr M is proved. It is equally well-established that the standard of proof will vary according to the gravity of the allegations, and the level of the charge. The elements of the charge must be proved to a standard commensurate with the gravity of the facts to be proved: *Ongley v Medical Council of New Zealand* [1984] 4 NZAR 369, 375 - 376.

8. FINDINGS:

Finding No 1

8.1 **IT** was necessary for the Tribunal to consider and to make determinations in relation to all of the submissions made by Ms Gibson because the majority of its Members are satisfied, for the reasons to be given, that the charge against Dr M is proven and that the conduct complained of constitutes conduct unbecoming a medical practitioner and that conduct reflects adversely on Dr M's fitness to practise medicine.

8.2 **AS** stated in paragraph 8.1 above, this Decision is a majority decision by the Tribunal. Also for the reasons to be given, the Chair of the Tribunal is also satisfied that the charge is proven and is in complete agreement with all of the substantive findings made by the majority. However the Chair is satisfied that the conduct complained of constitutes professional misconduct by Dr M and would uphold the charge at that level.

Finding No. 2

8.3 **IN** relation to Ms Gibson's submission made in the first part of her closing submissions, the Tribunal has determined that the well-established approach of the Professional Disciplinary Committee and for the past three years this Tribunal, that having found that a disciplinary offence is proven it is for the Tribunal ultimately to determine the level at which the charge is established, is correct.

8.4 **THAT** approach has continued to be followed by this Tribunal established under the 1995 Act in exactly the same way it was under the previous legislation. That approach is of course also subject to the Tribunal observing the requirements of natural justice, which requirements include taking into account the requirements of Clause 14 of the First Schedule to the Act, and all other relevant statutory provisions.

9. REASONS FOR FINDINGS:

Finding No 1

9.1 **IN** accordance with the decision of the Court of Appeal in *Duncan v MPDC* [1986] 1 NZLR 513, the Tribunal, when presented with a comprehensive charge, considered each of the Particulars supporting the charge separately, and having made findings on each of them, then went on to determine the overall gravity of the misconduct in respect of which it found Dr M guilty.

Particular 1: Dr M failed to appreciate the significance of the symptoms of a 23 week pregnant patient, those being (a) 11 hours of colicky infra-umbilical pain; (b) Pain that had been increasing in intensity and frequency, with the pain occurring every five minutes; (c) Three loose bowel motions; (d) No nausea or vomiting.

9.2 **THE** Tribunal is satisfied that this Particular is proven. The most compelling evidence supporting this finding in the Tribunal's view is the written record of the consultation made by Dr M at the time. Both of the practitioners who gave expert evidence commented on the quality of the consultation note. Dr Leathart referred to it's "*fullness*"; Dr C described the record as "*thorough*". Dr M said that it was his practice to try to make sure that he wrote everything down.

9.3 **DR** M does not recall seeing the complainant leaning on a chair for support during an episode of pain which occurred when she was in the consultation room. But he has recorded the complainant's report of "*bad stomach pains*", their duration, their intermittent nature and that "*xx is looking after pregnancy*."

9.4 **THE** Tribunal finds that had Dr M appreciated the significance of the symptoms reported to him, then he would have recorded that in the notes and taken a different course of action. For example, when asked what he would do with the benefit of hindsight Dr M said that he would contact xx and ask them to assess the complainant immediately.

9.5 **IN** this regard, Dr M gave evidence of his experience as a surgeon and former superintendent of xx Hospital. In that capacity, he was often asked to review patients admitted to the surgical ward with threatened miscarriage. These were usually patients in the first trimester of pregnancy, but also sometimes patients in their second trimester. He is therefore not inexperienced in examining and treating women whose pregnancies are at risk of threatened miscarriage.

9.6 **DR** M also gave evidence that he had carried out numerous vaginal examinations on such patients, as many as one or two a week over a 10 year period. Whether or not such an examination was advisable in the circumstances, Dr M is familiar with the nature of the inquiry and examinations which are necessary when treating patients for a threatened miscarriage.

9.7 **BUT** there is simply no sufficient evidence to indicate that Dr M carried out any inquiry which focussed on the fact that the complainant was pregnant and that was directed at investigating the reported symptoms in that context. All of his examinations and inquiries, reported both in the notes and by the complainant, indicate that Dr M's inquiry was of a more general nature. For example, the further tests he ordered were to ascertain whether or not the complainant had any infection which might put her pregnancy at risk. He also said that he considered and excluded appendicitis and peritonitis as possible diagnoses.

9.8 **DR** M spoke of a seeing 'mini-epidemic' of gastroenteritis among his patients. However, he conceded that none of those patients had been pregnant and it is clear that he failed to attach any significance to that fact , and thus to treat the complainant any differently, or more cautiously, for that reason. Dr Leathart gave evidence that the "*crucial point … is that a doctor must always have a high level of suspicion of the possibility of complications of pregnancy*". This is especially the case given that if complications do develop appropriate action needs to be taken urgently. The level of risk to both mother and baby is extreme.

9.9 **HOWEVER** there is no sense of any such level of concern on the part of Dr M, either in the consultation notes or from the evidence relating to the episode of care in its totality. He sent the complainant to the adjacent laboratory for tests; he prescribed gastrolite, and said he would

contact her later that day. Evidence was also given to the Tribunal attesting to Dr M's reputation as a careful and diligent doctor. The Tribunal is satisfied that there is no basis not to accept that evidence, but acceptance of that evidence is also a reason for inferring that on this occasion Dr M simply failed to understand the significance of his patient's symptoms. Had he done so, the Tribunal has no doubt that he would have immediately arranged for the complainant to receive the appropriate care.

9.10 **ACCORDINGLY**, and for all of these reasons, the Tribunal is satisfied that Particular 1 is proved.

Particular 2: Failed to consider a threatened miscarriage as a differential diagnosis;

or

Particular 3: Considered a threatened miscarriage as a differential diagnosis but failed to take appropriate steps to confirm or exclude the differential diagnosis of a threatened miscarriage.

Particular 2

9.11 **BECAUSE** Particulars 2 and 3 were expressed in the alternative, and because of the way in which the evidence was presented, it was necessary for the Tribunal to consider Particulars 2 and 3 together. Having had the opportunity to observe Dr M giving his evidence, the Tribunal is satisfied that he was a generally credible witness. Also, the complainant was unable to recall every detail of the consultation and of Dr M's examination. This is, in the Tribunal's opinion entirely understandable given the traumatic nature of the events and the passage of time.

9.12 **DR** M gave evidence that "*it crossed his mind*" that the complainant was in labour but he excluded that diagnosis on the basis of his clinical findings, most notably, that her abdomen was soft on palpation; that the location of her pain was a 'mild tenderness in the right para-umbilical

region' and that mitigated against labour; and that "*she had no contractions or bearing down or PV loss*".

9.13 **IN** the absence of any evidence to the contrary, the Tribunal finds that Dr M should be given the benefit of the doubt in relation to Particular 2, and therefore determines that this Particular is not proven.

Particular 3

9.14 **HOWEVER,** there is nothing in the record that indicates that Dr M seriously considered premature labour as a differential diagnosis, or that he examined for and excluded such a diagnosis on the basis of the findings referred to in paragraph 9.12 herein.

9.15 **HAVING** carefully reviewed the evidence given by both Dr M and the complainant, the Tribunal is satisfied that to the extent that Dr M did include premature labour in his differential diagnosis any such consideration was fleeting, and he failed to take appropriate steps to confirm or exclude the differential diagnosis of a threatened miscarriage. To the extent that such a diagnosis did 'cross his mind' he did not accord it a high priority in terms of a differential diagnosis, and he discarded it early in the consultation. The absence of any reference either to premature labour or a threatened miscarriage or to any of the symptoms Dr M said he relied upon in excluding labour as a differential diagnosis in the consultation notes militates against any other explanation.

9.16 **THE** Tribunal accepts the evidence given by Dr C that a doctor may not always record all of the possible differential diagnoses, nor the symptoms proving or excluding any one of them. But in this present case, involving a 23-24 week pregnancy and a report of '*bad stomach pains*'

the possibility that the patient was in labour was an obvious differential diagnosis, such that the Tribunal is satisfied that it is fair to infer that its omission from the consultation record accurately reflects Dr M's state of mind.

9.17 **ACCORDINGLY**, the Tribunal is satisfied that the allegations contained in Particular 3 are proven.

Particular 4 was withdrawn in the course of the hearing.

Particular 5: Failed to undertake or arrange for bi-manual pelvic and/or speculum examination of the cervix.

9.18 **THE** Tribunal finds that this Particular is not established. The onus of proving that such examinations ought to have been carried out, and that the failure to carry out such an examination is conduct which departs from acceptable professional standards, is on the Director of Proceedings.

9.19 **THE** Tribunal is satisfied that Dr M's decision not to carry out such examinations does not constitute an error or any such departure from acceptable professional standards. Taking into account its findings in relation to Particulars 1 and 2, the Tribunal considers that is in unlikely that Dr M turned his mind to deciding whether or not a vaginal examination of the cervix was warranted. The Tribunal has determined that he was satisfied early in the consultation that the complainant was suffering from gastroenteritis. In those circumstance, such examination would not be indicated.

9.20 **ON** the basis of the evidence of Dr M's clinical experience, he was certainly capable of carrying out such an examination if he thought it necessary. There is also good evidence to suggest that

such an examination may have carried its own risks, and should have been carried out if at all in a more controlled environment. Also, an ultrasound or other less invasive investigations might have been preferred.

9.21 **ACCORDINGLY,** it is not safe for the Tribunal to assume that either a bi-pelvic or a speculum examination of the cervix were the proper steps to be taken to exclude premature labour, and thus to determine that the failure to carry out such investigations is culpable and ought to attract the sanction of an unfavourable professional disciplinary finding.

Particular 6: Failed to arrange transfer of [the complainant] to a hospital for further assessment.

9.22 **IN** many respects, the Tribunal finds this to be the most serious failing on the part of Dr M. The simplest and prudent step for him would have been to have arranged for the complainant's immediate transfer, either by ambulance or car, to xx. This is especially so given that he was told by the complainant that xx were managing her maternity care; the hospital was close by, and it had available 24 hr, specialist care.

9.23 **NEITHER** of the Centre or Dr M was equipped to deal with a premature labour, or a significantly pre-term baby. The Tribunal is satisfied that the failure to transfer the complainant, even if only by car with her husband and by way of precaution or to rule out premature labour, constitutes more than 'mere error' on the part of Dr M.

9.24 **IN** Dr Leathart's opinion "*when a pregnant woman is experiencing regular pain as described by [the complainant]it would be important to refer the patient to a woman's*

hospital to have her assessed." He referred to the urgency of doing this, and to consequences of delay.

9.25 **DR** C also, although obviously reluctant to be critical of Dr M, conceded that even if there was only a '*small possibility'* that the patient was in labour or experiencing complications with her pregnancy, he would refer her for specialist care.

9.26 **THESE** findings do not indicate any mere deferral on the Tribunal's part to the opinions of either of the practitioners who gave evidence as to what would be acceptable professional practice or what they might have done in similar circumstances. The finding as to whether or not Dr M met a reasonable standard of care is for the Tribunal.

9.27 **IN** the context of the Tribunal's finding in relation to this Particular, the statement of Gaudron J in *Rogers v Whitaker* [1992] 175 CLR 479, 493, is apposite:

"The matters to which reference has been made indicate that the evidence of medical practitioners is of very considerable significance in cases where negligence is alleged in diagnosis or treatment. However, even in cases of that kind, the nature of particular risks and their forseeability are not matters exclusively within the province of medical knowledge or expertise. Indeed, and notwithstanding that these questions arise in a medical context, ***they are often matters of simple commonsense. And, at least in some situations, questions as to the reasonableness of particular precautionary measures are also matters of commonsense."***

9.28 **THE** Tribunal is satisfied that, even if only as a matter of commonsense, Dr M should have referred the complainant to xx. His failure to do so in the face of the risks to the complainant if she was in premature labour, which risks tragically transpired, constitutes a serious omission by Dr M. Accordingly, the Tribunal is satisfied that Particular 6 is established.

Finding No 2

9.29 **AT** the conclusion of the hearing day on 13 October 1999 the hearing was adjourned to enable the Tribunal to deliberate and reach its decision pursuant to section 109 of the Act. It quickly became apparent that Ms Gibson's submission went to the heart of the Tribunal's deliberations, both by its virtue of the issues it raised, but more relevantly in the circumstances of this case when it became apparent that there was a divergence of views amongst the Tribunal members, with the majority in favour of finding the charge established at a lower level than that nominated in the charge, (professional misconduct (section 109(1) (b)). In her oral submissions Ms Gibson appeared to argue that this was a course which was not available to the Tribunal.

9.30 **ACCORDINGLY**, the Tribunal wrote to both Counsel and sought their written submissions on the point. In Ms Gibson's case, to ensure that what she was asserting was clear to the Tribunal, and, for the Director's part, to afford her the opportunity to respond.

9.31 **IN** brief, Ms Gibson asserts that, by virtue of Clause 14 the Tribunal can only amend a charge during the course of the hearing. If the Tribunal chooses not to exercise that discretion, then the Tribunal must find the charge proved at the level nominated in the charge, or dismiss it, or, amend the charge at any time "up until the issue of its decision" and notify the practitioner concerned of any intended amendment and allow the opportunity of response.

9.32 **THIS** submission is made on the basis that:

(a) Section 43 of the 1968 Act specifically provided that the [Committee] had the option to find the charge made out at a level of professional misconduct or conduct unbecoming;

(b) That Act had no specific power to amend;

(c) Clause 14 only permits the Tribunal to amend a charge during the hearing;

(d) It would be in conflict with the NZ Bill of Rights Act 1990, and issues of natural justice if the practitioner was not advised of any amendment and not given any opportunity of response.

9.33 **IN** reply, the Director's position is that:

(a) She agrees that the practitioner is entitled to be informed of any amendment, and that has been done in this case;

(b) If the practitioner will be embarrassed in his or her defence then he or she should have the opportunity to seek an amendment to prepare any further legal submissions;

(c) There are no grounds to grant such an adjournment in this case because Dr M is not prejudiced by a finding of offending at a lesser level than that nominated by the Director because the nature of the Tribunal's inquiry is essentially the same.

9.34 **IN** anticipation that the point may not be finally determined by this Tribunal, the reasons for its determination are set out at some length. It goes almost without saying that this is an important point with significant implications for the Tribunal. It is necessary to commence by reviewing the nature of the determinations made by the Tribunal, and its purpose and function, both generally and in the context of this particular case.

10. FINDINGS OF THE TRIBUNAL IN TERMS OF CATEGORIES OF OFFENCES:

Professional Misconduct

10.1 **DR** M is charged at the level of professional misconduct. The test for professional misconduct

is well-established. The most often cited formulation being that of Jefferies J in *Ongley v Medical Council of New Zealand* (supra):

"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."

10.2 **IN** *Ongley v Medical Council of New Zealand* (supra), the Court also held that:

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

10.3 **THE** *Ongley* test was formulated in the context of the 1968 Act, and in the context of the common law of its time. In significant respects, the *Ongley* test, with its reference to an objective test, accurately presaged subsequent developments in the law of medical negligence, particularly in Australia and Canada.

10.4 **IN** *B v The Medical Council of New Zealand* (unreported), HC 11/96, 8/7/96, Elias J made it clear that it is now beyond doubt that the question as to whether or not a doctor has been negligent or, in the professional disciplinary context, if he is guilty of professional misconduct, is an objective test and is to be determined by the trial judge or tribunal. In that Decision, Elias J referred to both *Rogers v Whitaker* [1992] CLR 479, and the Canadian case of *Reibl v Hughes* [1980] 2 SCR 880 and confirmed the rejection in New Zealand of the so-called *Bolam* principle (*Bolam v Frien Hospital Management Committee* [1957] 1 WLR 582) that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper

by a responsible body of medical opinion even if other doctors adopt a different approach.

10.5 **ON** the basis of both *Ongley* (supra) and *B* (supra), both decisions given in the context of professional disciplinary proceedings, and both on appeal from specialist tribunals, the question of whether Dr M's conduct is culpable, i.e. it is conduct which warrants a finding of professional misconduct, is a question squarely for determination by this Tribunal. While the evidence as what other doctors would have done, or of acceptable practice generally in the circumstances which presented in this case, is a useful guide, perhaps even the best guide, it is no more than that; such evidence must be weighed against the judgment of the trial judge or tribunal, in this case, a specialist tribunal comprising medical practitioners and lay persons.

10.6 **AS** was said by Gaudron J in *Rogers v Whitaker* (supra):

"The matters to which reference has been made indicate that the evidence of medical practitioners is of very considerable significance in cases where negligence is alleged in diagnosis or treatment. However, even in cases of that kind, the nature of particular risks and their forseeability are not matters exclusively within the province of medical knowledge or expertise. Indeed, and notwithstanding that these questions arise in a medical context, ***they are often matters of simple commonsense. And, at least in some situations, questions as to the reasonableness of particular precautionary measures are also matters of commonsense.*** *Accordingly, even in the area of diagnosis and treatment there is, in my view, no legal basis for limiting liability in terms of the rule known as the "Bolam test" which is to the effect that a doctor is not guilty of negligence if he or she acts in accordance with a practice accepted as proper by a responsible body of doctors skilled in the relevant field of practice. That is not to deny that, having regard to the onus of proof, "the Bolam test" may be a convenient statement of the approach dictated by the state of the evidence in some cases. As such, it may have some utility as a rule-of-thumb in some jury cases, but it can serve no other useful function."*

10.7 **IN** a very recent judgment of the High Court of Australia, *Naxakis v Western General Hospital* (1999) 73 ALJR 782, Gaudron J re-affirmed these comments. In *Naxakis* the appellant (aged 12 years at the time of his accident) was admitted to hospital with a head injury. Following a CT scan, a provisional diagnosis was made of subarachnoid haemorrhage. After

admission the appellant lapsed into unconsciousness for five minutes. He suffered various other symptoms, including muscle spasms. He was treated in hospital for several days. Two days after discharge he suffered a burst aneurysm. The appellant suffered serious and permanent impairment.

10.8 **THE** appellant brought an action in negligence in the Supreme Court against the hospital and the treating neurosurgeon. The Court held that on the available evidence it was open to the jury to infer that the neurosurgeon did not give due consideration to the possibility that an aneurysm was the underlying cause of the appellant's symptoms rather than the minor trauma. If the jury had reached the conclusion that the neurosurgeon did not consider the possibility of the alternate diagnosis of an aneurysm and the need for an angiogram, then the first step in establishing negligence would have been taken.

10.9 **GAUDRON J** stated:

"In accepting the submission that there was no case to go to the jury and directing the jury to find for the defendants, the trial judge referred to the evidence in the case, and noted that "the overwhelming body of evidence pointed to the conclusion that Mr Jensen was not at fault in persisting with his diagnosis of traumatic subarachnoid haemorrhage". Against that evidentiary background, it was significant, in his Honour's view, that "not one medical witness said that ... he ... would have ordered an angiogram [and n]one suggested that the failure to order an angiogram was in any way open to criticism". On that basis, his Honour concluded that "it ...[was] not ... open to the jury to find that Mr Jensen was in breach of his duty to the plaintiff in failing to so order."

10.10 **HER** Honour referred to *Rogers v Whitaker* (supra) and to the fact that she had "*pointed out that, at least in some situations, "questions as to the reasonableness of particular precautionary measures are ... matters of commonsense"*. Her Honour went on to determine that:

"*In this case, the first question to be determined is, in essence, whether it was*

unreasonable for the hospital and Mr Jensen not to have taken the precautionary measure of excluding other causes of the appellant's symptoms. And assuming there was some evidence that there were steps that could have been taken to exclude other causes, it was for the jury to form their own conclusion whether it was reasonable for one or more of the steps to be taken. It was not for the expert witnesses to say whether those steps were or were not reasonable. Much less was it for them to say, as they were frequently asked, whether, in their opinion, the hospital and Mr Jensen were negligent in failing to take them."

10.11 **IN** *Naxakis* there was evidence that ""*all was not well, all was not as it appeared" and that the pattern of bleeding revealed by the CAT scan was such as to "raise the suspicion that there may have been some other cause [of the subarachnoid haemorrhage] … than simply a blow to the head. Critically, there was also evidence that "if one did have a suspicion of another cause, the logical thing would be to do a cerebral angiogram."*

10.12 **ON** the available evidence therefore it was open to the jury to determine that the neurosurgeon did not give due consideration to the possibility of that there was alternate diagnosis, and if the jury did so determine, "*the first step in establishing negligence would have been taken*."

10.13 **THE** nature and purpose of this present Tribunal's inquiry differs from a judge or jury's in only one significant respect; it is a statutory body and as such its functions and powers are prescribed by the Act. It is also a specialist tribunal and, as stated most succinctly in *Ongley,* the Tribunal's "*…focus is on the given conduct … judged by the application to it of reputable, experienced medical minds supported by… layperson[s] at the* [*Tribunal*] *stage*."

10.14 **AS** a specialist, professional disciplinary tribunal its primary responsibility is the protection of the public and the maintenance of professional and ethical standards. In a court setting, having found that the subject acts or omissions are culpable, the judge or jury then goes on to

determine the degree of culpability (and sanction) in terms of the relief sought by the plaintiff, whereas the Tribunal's task is to assess culpability and to make its decision in terms of the penalties provided in section 109 of the Act.

10.15 **THE** classification of the conduct which warrants a professional disciplinary sanction "*requires an assessment of degree*" by the Tribunal. At the 'end of the day' (which in terms of section 109 is "***after*** *conducting a hearing on a charge laid under section 102*") the Tribunal may be satisfied that a charge is established on any of the grounds provided in section 109, and it is open to the Tribunal to find the charge established at a level which is different to that nominated in the charge laid under section 102.

10.16 **THAT** has always been the case: refer *Duncan v Medical Council* (supra); *Ongley v Medical Council* (supra); and *B v The Medical Council of NZ* (supra); et al. In the Tribunal's opinion, the determination the Tribunal is required to make under section 109 is quite distinct from its power to amend a charge at any time "***during*** *the hearing of any charge laid under section 102 of [the] Act*", as provided in Clause 14 of the First Schedule.

10.17 **EQUALLY** of course, the Tribunal may determine that the charge is upheld at a higher level than that nominated in the charge. In which case, quite different considerations would apply. In the unlikely event that the more serious nature of the conduct had not become evident in the course of the hearing thereby requiring the charge to be amended in some way (Clause 14 would apply), the Tribunal would be required to advise the parties that it was satisfied that the charge was established at a higher level and invite the parties to respond by way of submissions, or possibly to resume the hearing to give the respondent doctor an opportunity to defend such a finding.

10.18 **SUCH** course would be required, not by Clause 14, but by Clause 5 of the First Schedule to the Act, and the requirement that the Tribunal "*shall observe the rules of natural justice at each hearing*." It being implicit that the requirement to observe the rules of natural justice subsists throughout the period of the Tribunal's jurisdiction to deal with charges laid under section 102.

11. THE TRIBUNAL'S POWER TO AMEND CHARGES:

11.1 **IT** is the Tribunal's view therefore that Ms Gibson's submissions confuse the Tribunal's right to amend a charge (bearing in mind that the charge comprises allegations, particulars and the nominated level of the professional misconduct complained of), and the Tribunal's power to determine charges pursuant to section 109, and the common law. The ultimate determination as to the level at which the charge is proven is, and always has been, a matter for the professional disciplinary bodies, and their appellate courts.

11.2 **THE** Tribunal does not accept that section 109 of the present Act differs in any substantive way from the provisions of section 43 of the 1968 Act as was submitted by Ms Gibson. Ms Gibson concedes that the Tribunal's predecessor, the Medical Practitioners Disciplinary Committee (the Committee), had the option to find a charge made out at a level of professional misconduct or conduct unbecoming a medical practitioner.

11.3 **UNDER** the 1968 Act, there were three categories of offences for which a doctor could be disciplined (those three categories are essentially the same under the 1995 Act, the only difference being the so-called rider attached to the lowest level of charge, conduct unbecoming). The only significant difference between the present Tribunal and the Committee, is that the

jurisdiction of the Committee included the option referred to in paragraph 11.2 above. Only the Medical Council could find a doctor guilty of the most serious charge, disgraceful conduct in a professional respect. Divisional Disciplinary Committees (DDC) had the least jurisdiction and were confined to determining charges of conduct unbecoming only. The Chairman of the Committee initially determined which body should have jurisdiction over complaints as they were received.

11.4 **UNDER** the 'split' hierarchy of disciplinary bodies provided under the 1968 Act, each of the Medical Council (via the convenor of the Preliminary Proceedings Committee), the Committee and the DDCs could refer charges 'upwards' and 'downwards' at any of several points in the prescribed disciplinary procedures.

11.5 **THEREFORE,** under that regime with its myriad of options there was simply no need to explicitly provide any of the disciplinary bodies with the power to amend charges. In practice, charges could be 'amended' at several points in the disciplinary process. Under the new Act however, the Tribunal deals with all charges, which are brought under section 102 of the Act. Thus, section 109 is drafted in exactly the same terms as section 43 of the 1968 Act, with the only difference being that section 109 takes into account the Tribunal's expanded jurisdiction (i.e. compared to any of the previous disciplinary bodies).

11.6 **THE** issue therefore comes down to considering whether or not Clause 14 has the effect of making the Tribunal's powers in determining charges substantially different from its predecessor disciplinary bodies, specifically from the Committee's? On the face of it, if Ms Gibson's submission is correct, Clause 14 and section 109 appear inconsistent. On the basis of Ms

Gibson's submission, Clause 14 requires the Tribunal to [pre-]determine "*during*" the hearing if a charge is proven (or is likely to be proven) and at what level. If it was satisfied that the charge is proven (or may be proven) at a level different to that nominated in the charge brought to the Tribunal under section 102, it would have to notify the parties and give them the opportunity to respond **before** it has had an opportunity to deliberate, and **before** the hearing is concluded.

11.7 **SECTION** 109 however, requires that the Tribunal only determine which ground (or category) it is satisfied the offence falls within **after** conducting a hearing on a charge laid under section 102. By virtue of section 109, the Tribunal's determination of the category of misconduct that the offence falls into is an integral part of it's jurisdiction, and, the Tribunal suggests, also is intrinsic to its purpose and function.

11.8 **BY** section 5(h) of the Acts Interpretation Act 1924 (now superceded by the Interpretation Act 1999), every schedule or appendix to an Act *"shall be deemed to be part of such Act"*. As such -

"*they must be read together with the rest of the Act. The provisions of the schedule can assist in interpreting the rest of the Act, and vice versa. If there is any inconsistency between the provisions of the schedule and the provisions of the rest of the Act the Court will doubtless reconcile that inconsistency as best it can. However, there is some authority, none of it very recent, that in the event of inconsistency the provisions of the main part of the Act prevail."* Burrows, *Statute Law In New Zealand,* p.204 (1992) citing, *Arnerich v R* [1942] NZLR 380 at 385 per Myers CJ; and *Dominion Council of of Commercial Gardeners Ltd v Registrar of Industrial and Provident Societies* [1951] NZLR 842 at 844 per Hay J.

11.9 **HAVING** carefully considered the submissions by both parties, the Tribunal is satisfied that the apparent inconsistency can be reconciled by carefully reading both the 1968 and 1995 Acts together. By coalescing the previously relatively disjointed disciplinary regime into one

jurisdiction, the legislature removed the means by which charges could be referred upwards and downwards by (and to) the different disciplinary entities. The practical effect of its expanded jurisdiction is that only the Tribunal can "amend' or change charges by adding or deleting allegations or particulars once the charge is brought within its jurisdiction.

11.10 **IT** was therefore necessary to give the Tribunal the power to amend charges, because it is the only body that can do so once a charge is presented, and it may be necessary to do this during a hearing when evidence may emerge requiring such amendment. Previously, " *either before or after a hearing is completed, [the Committee] may form the view that the allegation should more properly be considered as one of "disgraceful conduct in a professional respect". In those circumstances the [Committee] shall cease to inquire or deal with the charge and refer it to the secretary of the [Council] (refer s43(1))*"; Collins, *Medical Law In New Zealand*, (1992), p 225.

11.11 **STANDING** back and looking at the nature of the Tribunal's jurisdiction and the disciplinary regime provided under the Act, the purpose of Clause 14 becomes quite clear. Its placement in the First Schedule, rather than in the main part of the Act, clearly indicates that Clause 14 is intended to inform the operation of main provisions, including section 109, not to dominate or change their function or operation in any substantive way.

11.12 **IT** also important to point out two things:

(a) With the exception of being in jeopardy of being struck off the medical register if found guilty of disgraceful conduct, the penalties a practitioner is exposed to under section 109(1)(a), (b) and (c) **are the same.** Submissions as to penalty are a separate matter

and are sought, received and considered by the Tribunal only after a practitioner is found guilty; and

(b) Clause 14 is an *abbreviated* version of section 43 of the Summary Proceedings Act 1957 (SPA).

11.13 **TWO** consequences flow from these. First, the Tribunal considers that both the fact and nature of the abbreviation are significant; and, secondly, a practitioner is given the opportunity to make submissions to the Tribunal regarding penalty after its interim decision announcing its findings is released and the Tribunal takes these considerations into account before it makes its final decision.

11.14 **IT** is the Tribunal's view that the abbreviated form reflects the following:

- first, the fact that the Tribunal's jurisdiction is a civil jurisdiction, it is not a criminal jurisdiction, and it's specialist, quasi-judicial nature;
- secondly, that notwithstanding that a charge may be amended (except if amended up to disgraceful conduct and such amendment would be caught by Clause 5 (3) and/or Clause 14) a practitioner is liable to the same penalties no matter what grounds the Tribunal is satisfied are relevant; and,
- thirdly, the abbreviated form allows Clause 14 to operate consistently with the Tribunal's power to determine charges provided in section 109 of the Act.

11.15 **THE** Tribunal considers that if the legislature had intended the Tribunal's powers to amend charges to operate and be subject to all of the requirements set out in section 43 of the SPA it could simply have incorporated that section into the Act, either as a principal provision of the Act, or in Clause 14.

11.16 **AS** Ms Gibson has pointed out in her submissions, section 43 SPA includes express safeguards as to the process to be adopted after the amendment of a charge, including the entitlement to re-plead; the entitlement to an adjournment and the entitlement to cross-examine or re-examine witnesses whose evidence has already been given. None of these provisions are included in Clause 14. In contrast, Clause 14 simply provides that, the Tribunal may, in its discretion, if it is of the opinion that the practitioner may be embarrassed in his or her defence by reason of an amendment made during the hearing, adjourn the hearing.

11.17 **FOR** example, if during a hearing, evidence is given of fresh allegations or of possible offending that is not particularised in the charge before it, or becomes apparent that a charge should be amended upwards in terms of its gravity, then it is likely that either the practitioner would seek an adjournment, or the Tribunal itself may adjourn the hearing to give the practitioner a fair and proper opportunity to defend the new allegations or the more serious charge. This would apply especially if a charge was amended upwards to disgraceful conduct with potential for the practitioner's name to be removed from the medical register.

11.18 **THAT** is quite a different situation to the Tribunal's right, under section 109, to determine if a charge is proven, and the level of offending. A practitioner is unlikely to be embarrassed if he or she is found guilty at a lesser level of offending than that at which he or she was charged, and in any event it has always been the case that practitioners, and their counsel, defend charges on the basis that either the practitioner is not guilty of the charge, or if guilty, is guilty of offending at a lower level of the categories of charges; *B v The Medical Council of NZ* (supra), i.e. that 'at the end of the day' the level of offending is a matter of an assessment of degree and is a matter for the Tribunal to decide.

11.19 **THE** Tribunal notes also that under the previous Act, the practice was that charges were laid in the alternative. Thus it was explicit from the outset that a practitioner was exposed to the range of charges available. When the Tribunal was establishing its procedures submissions were made to the Tribunal that this practice was unfair, and that a single category of professional misconduct should be nominated. The Tribunal accepted those submissions and directed that, in future only one category of offence should be nominated. It may be that that decision, made under Clause 5 of the Act, should be revisited to permit charges to be laid in the alternative to more accurately, and fairly, reflect the purpose, intent and operation of the Act.

11.20 **ON** the basis of the foregoing analysis, the Tribunal does not accept Ms Gibson's submission that if it is satisfied **after** conducting the hearing on a charge, that the practitioner is guilty of a professional disciplinary offence in a category lower than that nominated in the charge brought under section 102, it is obliged to notify the practitioner, or any other party, and give them an opportunity to respond.

11.21 **THE** Tribunal is satisfied that the terms of section 109 quite clearly anticipate and provide that, after conducting a hearing and if it is "*satisfied*", it may find that a medical practitioner is guilty of professional misconduct on any of the grounds provided in section 109 (1) (a) (b) or (c), or any of the other grounds which may have given rise to the charge, subject of course to the requirements of natural justice.

11.22 **ANOTHER** factor supporting this analysis is the relationship between sections 103 and 109. Section 103 expressly distinguishes between:

> "*s.103(1)(b) … such particulars as will clearly inform the practitioner of the substance of* ***the ground believed to exist*** [entitling the Tribunal to exercise its

powers under section 109];

and

"*s.13(1)(c) Specifying* ***the particulars*** *of the charge*".

11.23 **THUS**, there are required to be provided in a notice of a charge, <u>both</u> particulars as to "*the ground believed to exist"* (i.e. such existence or otherwise being a matter for the Tribunal to determine "*after hearing*" the charge), and "*the charge*" - Parliament must have intended for there to be a difference for the two, <u>and</u> for "*the ground believed to exist*" to be entirely a matter for the Tribunal in terms of section 109.

11.24 **IF** that is the case, then the operation of Clause 14 is even more clearly confined to amendments which become necessary "*during the hearing*". Sections 103 and 109 are entirely consistent. In section 103, the ground is a discrete issue, its existence or otherwise is unresolved; being a matter for ultimate determination by the Tribunal, by virtue of section 109, "*<u>after</u> conducting a hearing on <u>a charge</u>".*

11.25 **IN** a recent case, *CAC v Chan*, Decision No 94/99/39C it was also submitted that the Tribunal must be satisfied that the charge is proven at the level nominated, or dismiss it. In that case however, the submission was accompanied by Counsel's concession that, as a matter of principle, it was open to the Tribunal to find the charge proven at any level, but the Tribunal should discourage charging at the highest level if that technique was used as a de facto way of laying charges in the alternative.

11.26 **IN** that case, the Tribunal found that the Act required CACs and the Director to "*frame an appropriate charge*" and any such adoption of the practice of charging at the highest level

regardless of whether or not that was appropriate in the circumstances of the alleged offending would amount to a breach of the relevant sections of the Act, and/or otherwise to an abuse of process, and there were remedies available to practitioners both within the Tribunal's jurisdiction and in the courts generally, by way of redress.

12. CONDUCT UNBECOMING THAT REFLECTS ADVERSELY ON A PRACTITIONER'S FITNESS TO PRACTISE MEDICINE:

12.1 THERE are now a number of Decisions defining what constitutes "conduct unbecoming" and, more recently "conduct unbecoming [which] reflects adversely on the practitioner's fitness to practise medicine", the so-called "rider". The most oft-cited formulation under the previous Act is that stated by Elias J in *B v The Medical Council of NZ* (supra), at p.15:

"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. 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 ... 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. .... 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 to what is acceptable professional conduct is the standards applied by competent, ethical, and responsible practitioners. ..."

12.2 FROM this statement three basic and essential principles emerge:

(a) The departure must be significant enough to attract sanction for the purposes of protecting the public.

(b) A finding of conduct unbecoming is not required in every case where error is shown.

(c) The question is not whether error was made, but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations.

12.3 **THE** rider has been the subject of a Decision in the District Court, Doogue DCJ *Complaints Assessment Committee v Colin David Mantell* District Court Auckland NP 4533/98 7 May 1999. At page 16 Judge Doogue stated:

"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 consistent 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 standard will reflect adversely on a practitioner's fitness to practise. It is a matter of degree."

12.4 **IN** this regard, and in relation to Finding No. 2 of this Decision, it is relevant to record the observations made by Smellie J in *Lake v The Medical Council of New Zealand* (HC 123/96 Auckland Registry, 23/1/98:

"A further related issue is whether, if the matter is to be judged upon the basis of what colleagues would have reasonably regarded as "conduct unbecoming", does that relate to the views of the members of the MPDC and the Medical Council - even if, as in this case, they had no or limited obstetrical expertise - or to the general body of the profession or to the views of other specialists in the same area? Gallen J addressed that question in Faris v Medical Practitioners Committee [1993] 1 NZLR 60 as follows:

> *"Mr Gendall raised a subsidiary matter as to whether the fixing of standards by the medical peers of persons subject to charges, refers to the disciplinary committee or to the wider body of practitioners. The answer to that I think is that the disciplinary committee is to be regarded as a representative body. It would be impracticable and undesirable to endeavour to set standards by some kind of referendum.* ***Those standards must be fixed by the members of the committee themselves, but in doing so they must bear in mind that they act in a representative capacity and must endeavour to formulate standards which are themselves seen as representative, rather than an expression of their own personal views.*** *The standards are professional in nature and need to be seen in that light. No doubt there are certain difficulties theoretically in arriving at and*

> *expressing such standards. However, this is the way in which professional bodies have always acted and in practical terms I think there would be little difficulty in determining those standards in an acceptable way. That view is in accordance with the comments in Ongley v Medical Council of New Zealand". (emphasis added).*

In the end it seems to boil down to this: if a practitioner's colleagues consider his/her conduct was reasonable the charge is unlikely to be made out. But the disciplinary tribunals and this Court retain in the public interest the responsibility of setting and maintaining reasonable standards. What is reasonable as Elias J said in B goes beyond usual practice to take into account patient interests and community expectations."

12.5 **THESE** comments, in which his Honour expressly approved Elias J's statement of the position in *B*, together with Judge Doogue's Decision in *Mantell*, define, and refine, the path the Tribunal must follow in when it deliberates, post-hearing, to determine if the practitioner is guilty or not guilty of a professional disciplinary offence and the concomitant level of 'guilt' in terms of the 'trilogy of offences' available to it under section 109 of the Act.

12.6 **THE** nature of the Tribunal's task under the present Act is, for all practical purposes, unchanged to that required under the previous legislation:

> *"The text of the rider ... makes it clear that all that the prosecution need to establish in a charge of conduct unbecoming [with the rider] is that the conduct reflects adversely on the practitioner's fitness to practise medicine. It does not require the prosecution to establish that the practitioner is unfit to practise medicine. ... .Mantell, (supra, p.16/17)*

Judge Doogue confirmed that Elias J's assessment contained in *B* "*remains a useful analysis of what amounts to conduct unbecoming. … It would be most surprising",* he stated, [if the legislature intended to require that the prosecution] "*had a more onerous burden*", [under the present Act], i.e. of proving that the practitioner is unfit to practise, in order to establish an offence at the lowest level of a trilogy of disciplinary offences, ranked in ascending order of gravity and penalty.

12.7 **THE** Tribunal accepts and, in any event, is bound by Judge Doogue's Decision, which was essentially that the 'assessment of degree' is effectively unchanged, both as to its methodology and its substance; it is a matter for the Tribunal. It is equally not a matter that the Tribunal may resile from. In any event, it must be remembered that the Tribunal deliberates on the evidence; it is the evidence which is material to the assessment as to the degree of culpability which is present and thus the level at which the Tribunal is satisfied that the charge is established. The purpose of submissions is to seek to persuade the Tribunal as to the view it should take of the evidence and the weight it should place on particular aspects, facts or circumstances.

12.8 **THE** Tribunal is satisfied that the terms of section 109 are clear. Clause 14 has no application in the context of that deliberation. If Ms Gibson elected to make no submissions as to Dr M's guilt or innocence in context of the possibility that the Tribunal might find him guilty at the lesser level of conduct unbecoming that reflects adversely on his fitness to practise, so be it. Certainly she had the opportunity to make such submissions, and, because the principles and practice in this area are so well-established, such submissions are invariably made.

12.9 **COUNSEL**, in any forum and subject to the rules of court and the interests of their clients, are free to present their case as they see fit. From time to time that will include running a novel argument or fresh interpretation for the court's consideration and deliberation. In such a case they generally adopt the prudent course of running such argument in the alternative, particularly in circumstances where the challenge is directed at statutory provisions which have operated over a long period of time and/or legal principles which have been developed and refined in a substantial body of relevant cases determined at the highest level and in a number of jurisdictions. If Counsel elects to confine their case in any way, or to limit the evidence they

present, so that the case is presented in a way that is most favourable for their client, that is a matter for them and their clients.

12.10 **THIS** Tribunal and its predecessors have <u>always</u> taken the approach that it is a matter for the Tribunal, after hearing all of the evidence, to determine if the practitioner is guilty and, if so, at what level the charge is established and that is well-known to counsel and to practitioners. It has adhered to that approach in this case. Accordingly, the Tribunal does not consider that in finding Dr M guilty of the lesser offence of conduct unbecoming and that reflects adversely on his fitness to practise, it is treating him unfairly, or that it should invite further submissions in that regard because Counsel elected not to make any such submissions at the hearing, for whatever reason.

12.11 **THAT** is especially the case in these proceedings because the Tribunal advised the parties immediately after the hearing that it is satisfied that the charge is upheld but that it had not yet determined the level at which it is established. As detailed earlier in this Decision, because Ms Gibson's submission on the operation and effect of Clause 14 was so novel, and was made orally in her closing submissions only, the Tribunal took the precaution of advising her that, while it was satisfied that the charge was established, it had not determined the level at which it might be satisfied that the charge was proven and, for that reason, wanted to be certain that the members correctly understood the submissions that had been made.

12.12 **NOTWITHSTANDING** that the Tribunal thereby gave her notice that it had determined that the charge was established, but that it had not determined the level at which it was established, i.e. if the charge was proven at a level of professional misconduct (s109(1)(b) or conduct

unbecoming that reflects adversely on Dr M's fitness to practise (s109(1)(c)), Ms Gibson's further submissions were confined to expanding upon her argument as to the operation of Clause 14 and did not address the issue of Dr M's being found guilty of the lesser charge in any substantive way, possibly also because she took the view that the facts of the case are relatively straightforward and uncontentious; it is not disputed that Dr M made an error in his diagnosis and treatment of the complainant. In light of that, and the fact that the Tribunal advised the parties that it was satisfied that the charge was proven, the purpose of any submissions on behalf of Dr M could only have been to seek to persuade the Tribunal that it ought to find him guilty at the lesser of the two levels of offending, in terms of the 'trilogy of offences' provided in section 109.

12.13 **IT** cannot be said therefore that Dr M has suffered any prejudice because the Tribunal has found him guilty at the most favourable level of the options available to it. Any suggestion of prejudice could only be based on a submission that, had the lesser charge been 'on the table' (and the Tribunal says that it was, and is always) then the evidence might have been treated or presented differently. It is hard to see, on the facts of this case, how a submission of that sort (on the part of the respondent) could be substantiated, and even more so, how that could be the case when the outcome for the respondent is more favourable than would have been the case had the Tribunal upheld the prosecution case in all respects.

12.14 **THEREFORE,** the Tribunal does not consider that Dr M has suffered any prejudice, or that it has failed to observe the principles of natural justice in determining the charge in the way that it has, and it does not seek any further submissions from the parties (except of course for submissions as to penalty which, in any case, are dealt with quite separately).

12.15 **THE** majority of the Tribunal members are satisfied, after hearing all of the evidence and submissions, that the charge is established at a level less than professional misconduct, but that the conduct which is the subject of the complaint does warrant the sanction of an adverse finding. In coming to its decision, the Tribunal has also taken into account the fact that Dr M does not normally treat maternity patients, and that his general practice is relatively confined to elderly patients.

12.16 **HOWEVER,** it is not infrequent for it to find a practitioner guilty of conduct unbecoming that reflects adversely on his or her fitness to practise, even in circumstances where the complaint has arisen in a situation that was unusual or novel in terms of the practitioner's overall practice. That reflects the fact that the focus of the Tribunal's inquiry is solely on the subject-matter of the complaint and the evidence presented to it at the hearing. Even the most exemplary of practitioners may falter from time to time; and that is taken into account. Not every error will be culpable. However, the Tribunal is satisfied that, in the circumstances of this complaint, Dr M's error was culpable and that the charge is proven and constitutes conduct unbecoming and that it reflects adversely on his fitness to practise medicine.

13. DETERMINATION

13.1 **THE** submission made by Mr McClelland on behalf of the Director that *"this is not a case of 'there but for the grace of God'"* is accepted without hesitation by the Tribunal. Dr M' diagnosis that the complainant was suffering from gastroenteritis was wrong. He made an error. The Director argues that it was not a 'mere error', but that Dr M failed to carry out 'the basics', and made no attempt to exclude any other diagnosis, including perhaps, the most obvious.

13.2 **FOR** Dr M, Ms Gibson argued strongly that he simply made a mistake, and that his error is not culpable. Ms Gibson also submitted that the Tribunal should treat cautiously criticism of Dr M's conduct made with the benefit of hindsight.

13.3 **HOWEVER**, in cases such as this, inevitably the doctor's conduct must be judged in hindsight. As was commented by Kirby J in *Naxakis* at p 797:

"Although Mr King conceded that his opinion had the advantage of hindsight, this necessarily had to be so. It would be true of any non-treating medical expert qualified to give evidence in such a case. It was open to the jury to disregard such a concession or to treat it as stemming from professional courtesy or collegial sympathy for Mr Jensen."

13.4 **AS** has been said on many occasions, the law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is "*a single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment*": *Sidaway v Governors of Bethlem Royal Hospital* [1985] AC 871, 893 per Lord Diplock. The standard of reasonable care and skill is that required of an ordinary skilled person exercising and professing to have that special skill, in this case, of a general practitioner practising in an accident and medical centre.

13.5 **THE** Tribunal also considers it relevant in the present context that the Centre (and therefore the practitioners working there) held itself out as able to provide emergency (accident) type care to 'walk in' patients, and that it is located in xx with specialist advice and facilities available and accessible. It is relatively easy therefore to refer patients on for more specialised care even if only as a precaution, or to whomever is primarily responsible for the patient, or to obtain advice and assistance by telephone.

13.6 **THAT** Dr M made an error is not disputed. The central issue for this Tribunal is to determine whether or not that error is conduct which departs from acceptable professional standards, and, being satisfied that it does, to determine if the misconduct established constitutes either professional misconduct, or conduct unbecoming that reflects adversely on Dr M's fitness to practise medicine - it is "*a matter of degree*".

13.7 **HAVING** carefully considered all of the evidence, the Tribunal is satisfied that Dr M's conduct on 5 March 1997 did fall below the standard of a reasonable, competent general practitioner.

13.8 **AT** the time the complainant was seen by Dr M she was approximately 24 weeks pregnant. She made that known to him and her appearance and the size of her baby ascertained by Dr M on examination was consistent with that information. She was being cared for in her pregnancy by xx, which was located close by, and which had services and assistance available on a 24 hr basis; simple precautionary measures were available to Dr M, the most obvious would have been to refer her for the appropriate examination and/or tests, or even, at a minimum, to contact xx by telephone for advice.

13.9 **THE** Tribunal also considers that it is relevant that the complainant's evidence was that the reason she went to the Centre was because she was concerned to know if her pains could affect her pregnancy. It is satisfied that had Dr M given her the slightest suggestion that she should contact xx, she would have done so. Dr M effectively denied her that option. He quite simply did not give due consideration to the fact that the complainant was pregnant, and that she could be in labour or about to miscarry her baby.

13.10 **HE** also ignored the level of risk to the complainant, and her baby, if he was mistaken in his diagnosis. In making this finding, the Tribunal accepts that, even if the complainant had been urgently transferred to xx, the outcome for her baby may not have been different. But the outcome for the complainant and her husband would have been very different.

13.11 **AS** stated above, the Tribunal is satisfied that the allegations contained in Particulars 1, 3 and 6 are proven. Particulars 2 and 5 were not proven. It was not necessary for the Tribunal to consider Particular 4. Having considered each of the Particulars alleged, the Tribunal then considered the charge in its totality. As stated above, four of its five members are satisfied that the charge is upheld and constitutes conduct unbecoming that reflects adversely on Dr M's fitness to practise.

Chair's dissent:

13.12 **THE** Chair of the Tribunal concurs with all of the substantive findings of the majority, but considers that Dr M's treatment of the complainant was casual to the point of being recklessly indifferent to the risk to complainant by his not immediately referring her to xx. It is the Chair's view that, on any objective test, Dr M failed to meet the standard of care of an 'ordinary skilled person exercising and professing to have the skills' of an experienced and competent general practitioner.

13.13 **AS** was so succinctly stated by Gaudron J in *Rogers v Whitaker* (supra), '*questions as to the reasonableness of particular precautionary measures are … a matter of commonsense*"; and, as in *Naxakis* (supra), "*In this case, the first question to be determined is, in essence, whether or not it was unreasonable for [Dr M] not to have taken the precautionary*

measure of excluding other causes of the [complainant's] symptoms." The Chair is of the view that, as a matter of commonsense alone, Dr M should have accorded a high priority to the possibility that the complainant was in labour, and that her pregnancy was threatened.

13.14 **THE** so-called "common sense" test of causation was approved by the full Bench of the High Court of Australia in *Chappel v Hart* (1998) 72 ALJR 1344. In that case, all five Judges proceeded on the basis that questions of causation are questions of fact to be answered by applying common sense to the situation, the test recognised as superseding the bare 'but for' test in its decision in *March v I & M H Stramare Pty Ltd* (1991) 171 CLR 506. The Court accepted that the "common sense" test applies in tort as well as in contract, and is to be applied in relation to causation questions in tort, including cases dealing with a doctor's negligent failure to warn (which was the subject of the claim in *Chappel v Hart* (supra)).

13.15 **ON** that basis, the Chair is of the view that it was a significant departure from acceptable professional standards on the part of Dr M not to have taken elementary precautions, which were so readily available to him, to ensure the safety of the complainant's pregnancy and her baby. The consequences of Dr M's failure to take proper care were devastating to the complainant and her husband.

13.16 **AT** a minimum, the risk that the complainant was in labour, and if Dr M was wrong in his diagnosis of gastroenteritis, should have been discussed with the complainant. They were unlikely to be risks that the complainant and her husband would have taken had they been properly informed of their existence. They were not, and thus had no opportunity themselves to take the precaution of contacting xx.

13.17 **IN** this context, and because the Chair is satisfied that there is evidence that the complainant was concerned to ascertain the safety of her pregnancy and she made that known to Dr M, Dr M also had a duty to warn the complainant of the possibility that she might be in premature labour, <u>even if he did not think that she was</u>. The complainant gave evidence that "*Dr M told me he was sure that it had nothing to do with my pregnancy and the baby looked alright*." That evidence was not denied by Dr M, and is consistent with his evidence that "*[he] did not believe at the time that [the complainant] was in premature labour*".

13.18 **THE** risk that her pregnancy (and thus her baby) might be endangered was clearly "*material*" to the complainant, and Dr M was therefore under a duty to warn the complainant of the possible consequences if she was in labour, within the principles of *Rogers v Whitaker* (supra) and *Chappel v Hart* (supra). By not warning the complainant, he denied her the opportunity to seek urgent specialist care.

13.19 **ACCORDINGLY**, the Chair is satisfied that Dr M's conduct constitutes a serious departure from acceptable professional standards such that the charge should be upheld at the level of professional misconduct.

14. PENALTY:

14.1 **THE** charge having been upheld and the Tribunal having found Dr M guilty of conduct unbecoming that reflects adversely on his fitness to practise, the Tribunal invites submissions from Counsel as to penalty. The timetable for making submissions will be as follows:

14.1.1 **THE** Director of Proceedings should file submissions with the Secretary of the Tribunal and serve a copy on Counsel for the respondent not later than 14 working days from the date of receipt of this Decision.

14.1.2 **IN** turn counsel for the respondent should file submissions in reply with the Secretary and serve a copy on the Director of Proceedings not later than 14 working days from receipt of the Director of Proceedings' submissions.

14.2 **THE** Tribunal reminds counsel, and any other person whether a party to this proceeding or not, that the Tribunal has made orders that:

(a) That the names of the complainant patient and her husband are suppressed pending further order of this Tribunal;

(b) That the name of the medical practitioner is suppressed pending further order of this Tribunal;

(c) That there is to be no publication of any details which might lead to the identification of the complainant patient, her husband or the medical practitioner respondent, pending further order of this Tribunal.

14.3 **ACCORDINGLY,** the Tribunal invites counsel to address the issue as to whether or not those orders ought to remain in place, or be discharged in their further submissions.

DATED at Auckland this 26th day of November 1999

....

W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal