MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

PO Box 5249, Wellington • New Zealand
Ground Floor, NZMA Building • 28 The Terrace, Wellington
Telephone (04) 499 2044 • Fax (04) 499 2045
E-mail mpdt@mpdt.org.nz

DECISION NO: 176/01/70D

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 **JEFFREY NORMAN HARRILD** medical practitioner of Masterton

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Ms S Cole, Dr M G Laney, Dr A M C McCoy, Dr B J Trenwith (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Masterton on Wednesday 20 June 2001

APPEARANCES: Ms K McDonald QC and Ms T Baker for the Director of Proceedings

Mr C J Hodson QC and Ms G Phipps for Dr J N Harrild.

Supplementary Decision

1. In decision 163/01/70D dated 4 July 2001, the Tribunal found Dr Harrild guilty of professional misconduct. In keeping with its usual practice, this decision should be read in conjunction with that decision ("the substantive decision").

2. The finding of professional misconduct was made following the Tribunal hearing of a charge laid by the Director of Proceedings. The charge arose in the context of Dr Harrild's specialist care and management of the latter stages of Mrs McLeod's pregnancy, following her presentation at Masterton Hospital with clinical signs indicating foetal compromise.

3. At the hearing of the charge, the Director sought leave to withdraw Particular 1, and leave was granted. Dr Harrild admitted Particulars 2, 3 and 4 and he denied Particulars 5 and 6. Dr Harrild denied that any of the particulars of the charge amounted to professional misconduct and, on his behalf, Mr Hodson conceded that, in the alternative, the Tribunal might find Dr Harrild guilty of conduct unbecoming that reflected adversely on his fitness to practise medicine.

4. In finding Dr Harrild guilty of professional misconduct, the Tribunal determined that Dr Harrild's failure to correctly interpret the presenting clinical signs, to appreciate signs of foetal distress, and to immediately deliver Mrs McLeod's baby by caesarean section, did amount to professional misconduct.

5. In relation to Particular 5(a), the Tribunal was not satisfied that the allegation that Dr Harrild failed to appropriately communicate with Mrs McLeod prior to his attempt to

startle, or stimulate the baby into movement whilst undertaking an ultrasound examination, was established. In relation to Particular 5(b), while the Tribunal was satisfied that the allegation that Dr Harrild failed to communicate with Mr and Mrs McLeod in a sensitive and supportive manner whilst undertaking an ultrasound examination which disclosed that their baby had died in utero was established, it was not satisfied that his failure in this regard amounted to a professional disciplinary offence.

6. In relation to Particular 6 of the charge, that Dr Harrild failed to offer appropriate support and information to Mr and Mrs McLeod when he advised them that their baby was dead, the Tribunal was satisfied that this particular was established, but that the allegations contained therein were not of the same level of seriousness as those contained in Particulars 2 – 4 of the charge. The Tribunal considered that "*at the end of the day, and in the context of the range of penalties available to it pursuant to s.110 of the Act, the Tribunal must make an 'assessment of degree*". On that basis, the Tribunal was satisfied that Particular 6 amounted to the lesser charge of conduct unbecoming that reflects adversely on Dr Harrild's fitness to practise medicine.

7. Having found that Particulars 2 – 4 were established at the level of professional misconduct, and that Particular 6 was also established and that the allegations contained in that particular warranted sanction, but at a lower level of those contained in Particulars 2 – 4, the Tribunal then determined that it was satisfied that Particular 8, in effect, comprised a separate charge and amounted to conduct unbecoming that reflects adversely on Dr Harrild's fitness to practise.

8. In the context of determining culpability, the Tribunal took into account a number of factors which it considered to be relevant considerations both in the context of the Tribunal's determination of Dr Harrild's culpability, and its ultimate determination as to penalty. The Tribunal came to the view that these factors were also relevant to the extent that it considered they might have contributed to Dr Harrild's serious lapse in judgment in this case. It is also appropriate at this penalty stage to take into account that Dr Harrild has been a specialist practitioner for more than 20 years and this is the first time he has been charged with a professional disciplinary offence.

9. The factors which the Tribunal considered (and still considers) relevant are set out at pages 18 – 20 of the substantive decision.

Submissions on penalty

Submissions by the Director of Proceedings

10. On behalf of the Director, Ms McDonald submits that Dr Harrild's failure to correctly interpret the CTG trace is, on any view of the matter a very significant failure. Dr Harrild's failure to take immediate appropriate action and to arrange for delivery of baby McLeod by caesarean section demonstrates a significant lack of clinical ability and poor judgment on his part.

11. Ms McDonald submitted that, because Dr Harrild had failed to function at an appropriate and safe level of practice, there is a public interest in requiring a proper review of Dr Harrild's competence, and that review should be undertaken by the Medical Council.

12. The Director also seeks that conditions be placed on Dr Harrild's practice requiring review/assessment by the Medical Council and limitations on his practice requiring that he practise in a major centre with adequate professional support. The Director has also suggested that a further condition requiring Dr Harrild to engage with a mentor may be appropriate.

13. It was the thrust of the Director's submissions that the Tribunal has no basis upon which to judge Dr Harrild's current level of professional competence in regard to CTG interpretation, or the extent to which attendance at any professional education courses have been, or may be, appropriate to rectify any lack of knowledge on his part demonstrated in this case. The Director referred to an assessment of Dr Harrild's competence carried out as part of a Wairarapa Health initiative. The Director submitted that the Tribunal would be wrong to rely on this assessment as confirmation of Dr Harrild's competence as the full extent of that assessment is not known.

14. It was further submitted that Dr Harrild should not be permitted to continue practising in a provincial area with limited professional support and that conditions should be placed on

his practice requiring him to practise under supervision, or at the very least in a major centre with full professional support for a specified period of time.

15. In relation to the Tribunal's finding of conduct unbecoming that reflects adversely on Dr Harrild's fitness to practise (Particular 6) the Director submits that the appropriate penalty to be imposed is to require Dr Harrild to undertake a professional relationship/communication course as directed by the Medical Council. It may be that Dr Harrild should be required to engage in a relationship with a professional mentor such as through "mentor associate".

16. The Director submits that the fact that Dr Harrild has indicated in evidence that he has attended a communication course is inadequate and the public interest requires assessment of Dr Harrild's relationship/communication skills by an appropriate professional body, i.e. the Medical Council. In summary, the Director submits that Dr Harrild's conduct in failing to correctly interpret a very seriously flat CTG is woefully inadequate and deserving of a penalty that reflects the significance and seriousness of his failure. Likewise, his inability to communicate with the patient at an appropriate level is significant and deserving of sanction.

17. The Director has also submitted a letter from Mr and Mrs McLeod expressing distress at the Tribunal's findings and seeking, at the very least, that Dr Harrild's practice "be monitored".

Submissions for Dr Harrild

18. For Dr Harrild, Mr Hodson submitted that *"much soul searching, self critical personal review and external review (copy enclosed) and comments have been undertaken contemporaneously with the investigation by the Health and Disability Commissioner and the prosecution process. It is therefore entirely appropriate that the competence of the doctor [be] reviewed and the issue of his ability now to practise safety be settled."*

19. Mr Hodson submitted that there can be no good purpose in suspending Dr Harrild from practice; the submissions of the Director in respect of the imposition of conditions do not

take into account the (four years) interval since the events referred to in the charge; it would be appropriate for the Tribunal to send a copy of its order (regarding penalty) made in this case together with its reasons to the Medical Council for consideration under section 60 of the Act. The practice of the Council is to review the competence of all doctors against whom adverse disciplinary findings relating to competence are made. The Council therefore has full powers to institute a competence programme and to place conditions on Dr Harrild's registration or practising certificate such as it deems appropriate, and for such period of time as may be required.

20. As to censure, the imposition of a fine and costs, these are all matters within the discretion of the Tribunal. However, in relation to Dr Harrild's ability to pay a fine, Mr Hodson submitted that Dr Harrild has been employed for several years in the public sector in Masterton Hospital and he has a small private practice. It is not submitted that there is anything in Dr Harrild's financial circumstances which would affect his ability to pay a fine however if the Tribunal is minded to exceed to the Director's submissions and order a fine then it is submitted it must take into account not only the considerable time and consequent loss of income inherent in undergoing a competency review and any competence programme, but also the impact of the order for costs likely to follow.

21. Furthermore, the Director is pursuing proceedings against Dr Harrild before the Complaints Review Tribunal. An obvious injustice may result as the Tribunal cannot at this time give effect to the intention of section 110(4).

22. In relation to costs, Mr Hodson submitted that in fixing the percentage of costs to be awarded against Dr Harrild, the Tribunal is asked to take into account the length of time involved in the Health and Disability Commissioner's investigations, which will inevitably have increased the cost if section 110(1)(f)(i) is to be included, and also the admissions made by Dr Harrild, and the savings in time, ought also to be taken into account.

23. Further, Mr Hodson submitted that the personal views of Mr and Mrs McLeod are acknowledged, however the following factors should be taken into account:

(i) Dr Harrild has consistently and from the earliest opportunity acknowledged his error and expressed remorse;

(ii) Dr Harrild has provided a written letter of apology to Mr and Mrs McLeod as well as his oral apology made at the hearing of the charge;

(iii) Dr Harrild has complied with all of the recommendations of the Health and Disability Commissioner;

(iv) the enormous publicity attendant on the hearing and the spirited and continuing media publicity since has itself been an ordeal of a nature scarcely to be comprehended by anyone who has not been subjected to this degree of publicity in such process; and

(v) given referral back to the Medical Council, the effects of this case will continue indefinitely for Dr Harrild.

Findings

24. The Tribunal has taken all of the submissions made to it into account, together with the correspondence from Mr and Mrs McLeod, and from Wairarapa District Health Board. The latter correspondence was forwarded to the Tribunal in response to the Tribunal's enquiry as to the outcome of the recommendations made by the District Health Board following its review of the events giving rise to the charge.

25. The District Health Board advises that following those events and the District Health Board's review, Dr Harrild made a commitment to update his skills in CTG interpretation and ultrasound scanning techniques and applications. He attended a number of clinics for high risk patients at Wellington Hospital over a period of time in 1998 (the Tribunal records that Dr Harrild's competence in ultrasound scanning techniques and applications was not at issue in this case).

26. Dr Harrild has spent one week at National Women's Hospital in August 1998, a detailed programme being determined with the assistance of Mr Alistair Roberts, Department of

Obstetrics and Gynaecology, and Ms Jenny Westgate, Senior Lecturer in Obstetrics and Gynaecology at Middlemore Hospital.

27. Dr Harrild has participated fully in the improved communication strategies, undertaken by the maternity team at Wairarapa District Health Board, which strategies have been ongoing. Dr Harrild has also met with a psychologist for assistance in the development of his communication skills.

28. A recent patient satisfaction survey undertaken in conjunction with the Medical Council showed a high percentage of positive responses. Perhaps most importantly from the Tribunal's point of view, the recruitment of a third obstetrician and gynaecologist at Masterton Hospital, has also helped in the development of the maternity service and provided more readily available consultative backup and peer review. It is the Board's opinion that Dr Harrild is a "*hard working conscientious clinician who is a valued member of the senior clinical team*".

Decision

29. Having reviewed its substantive decision, and taken into account all of the matters referred to above, the Tribunal has concluded that the following penalty should be imposed:

(i) Dr Harrild is censured;

(ii) Dr Harrild is fined $3,000. Copies of this decision and the Tribunal's substantive decision are to be forwarded to the Medical Council together with a request that the Council consider whether or not a review of Dr Harrild's competence is required, and a competency programme instituted;

(iii) Dr Harrild is required to pay 15% of the costs and expenses of the investigation by the Health and Disability Commissioner and prosecution of the charge by the Director of Proceedings, and the hearing by the Tribunal. The Secretary of the Tribunal will forward a schedule detailing the amount Dr Harrild is required to pay in accordance with this decision. The total amount of costs Dr Harrild is required to pay is $6,531.17.

(iv) The Secretary of the Tribunal shall cause a notice under section 138(2) of the Act to be published in the New Zealand Medical Journal. The Tribunal records that Dr Harrild has not at any time sought name suppression.

Reasons

30. In relation to the submissions made by the Director, the Tribunal considers that there is little point in suspending Dr Harrild from practice given both the length of time it has taken to conclude the investigations into Mr and Mrs McLeod's complaint and the steps that have been taken in the four years since the events giving rise to the charge. In this regard, the Tribunal accepts the submissions made by Mr Hodson. The fact is, Dr Harrild has been practising for approximately four years since the incident that is the subject of the charge without any risk to patient safety being identified to the Tribunal.

31. In relation to the imposition of conditions, the Tribunal also accepts the submissions made by Mr Hodson and, to the extent that conditions might be appropriate, then it seems most practical that any such conditions be addressed to specific defects identified by the Medical Council in the event it determines that it is appropriate to undertake a competency review, and order a competency programme.

32. The Tribunal does not consider that it is necessary or desirable to order conditions requiring Dr Harrild to work under supervision, or in a particular location. However it would be concerned if Dr Harrild (or indeed any specialist practitioner) was to resume practice in isolation, or under circumstances such as existed for many years prior to the events giving rise to this charge.

33. In this regard, the Tribunal refers to the recommendations made by the District Health Board (then CHE) following its review of the events giving rise to this charge, in particular the recommendation that a closer relationship with the Wellington Unit should be encouraged so that specialists based in Masterton (and patients) are able to obtain a second opinion and professional and collegial support.

34. The Tribunal supports the following recommendations made by the external review team:

(i) Mr Harrild should receive professional advice and help in order to significantly rectify his communication deficiencies. This problem should be reviewed regularly and his progress monitored. For example, a Patient Satisfaction Survey, as available from the RNZCOG should be administered every 3 years.

(ii) Mr Harrild must update his CTG interpretation skills. This could be achieved by attending a CTG course and regular visits to the High Risk Clinic in Wellington. Our impression is that the entire unit would benefit from a CTG update programme.

(iii) A closer relationship with the Wellington Unit should be encouraged. This should include early recourse to second opinion in difficult cases, and the faxing of all relevant clinical information, including CTGs, where appropriate.

(iv) Mr Harrild should update his ultrasound scanning techniques and applications This should involve attendance at a formal course designed for this purpose He should also regularly subject his scanning techniques to peer review.

(v) A formal pathway to enable patients and staff to seek a second Obstetric opinion should be developed and put in place.

(vi) The inter-personal problems and lack of trust within the Obstetric Unit need to be addressed. We believe this will need to be an independent review by someone outside the Obstetric Unit. It is vital that working relationships be re-established so the Unit can function safely.

(vii) The on-call structure for the Obstetricians should be changed to a strict 1 in 2 roster with the Obstetrician on call for the day being responsible for all secondary obstetric patients within the Unit.

(viii) The CHE should establish a system of back-up for either of the Obstetricians, for times of significant physical or emotional stress (e.g. a short-term locum via the Wellington Unit). This would allow the Obstetrician concerned to address the health issue, without undue stress being placed on his remaining colleague.

(ix) The CHE should review how it responds to a traumatic obstetric event. Any debriefing meeting should also consider how best to help the family affected. This

will usually involve personal contact from the CHE, an offer to meet with them, and an apology if an error has been made.

35. It is the Tribunal's very firm view that, given its findings in relation to the factors it considers contributed to the events giving rise to this charge, if the District Health Board cannot give effect to the recommendations at all times then it should not offer a specialist obstetric and gynaecology service at Masterton Hospital. The Tribunal is concerned that, if the recommendations cannot be instituted and maintained, (and especially if a third obstetrician cannot be appointed and retained) then patient safety at Masterton Hospital may be compromised.

36. In making these findings and the decision regarding the penalty which ought to be imposed, and in determining that it is appropriate in the circumstances to adopt a 'systems' approach to Dr Harrild's conduct and management of this case, rather than simply focussing solely on Dr Harrild's error the Tribunal does not seek to diminish, in any way, the seriousness of his error of judgment, and the trauma suffered by Mr and Mrs McLeod. Further, there can be no doubt that their suffering has been exacerbated by the length of time it has taken for the charge, and the hearing of the charge, to eventuate.

37. However, the Tribunal is satisfied that both Dr Harrild and the District Health Board have accepted responsibility for the shortcomings disclosed in this case and that appropriate remedial procedures and requirements have been identified. The Tribunal has therefore taken into account all of the efforts that both Dr Harrild and the District Health Board have made to ensure that such a tragedy does not occur again.

38. It is appropriate that Dr Harrild should be censured.

39. As to the pecuniary penalties, the Tribunal has taken into account all of the submissions made to it. In determining the amount of the fine, the Tribunal has also taken into account the fact that Dr Harrild's admissions in relation to Particulars 2, 3, 4 considerably shortened the length of the hearing (from 3 days to 1 day).

40. As to costs, this also is at the lower end of orders made in similar cases. This is because the Tribunal has endeavoured to balance (a) the presence of the other factors which it considers contributed to Dr Harrild's lapse in judgment, and (b) the seriousness of Dr Harrild's error in failing to correctly interpret the CTG recording.

DATED at Wellington this 26th day of October 2001

.....

W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal