MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 183/01/71D

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 **LYNNE JOHN** medical practitioner of Rangiora

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Ms S Cole, Dr R S J Gellatly, Professor W Gillett,

Dr J W Gleisner (Members)

Ms K Davies (Hearing Officer)

Mrs G Rogers (Stenographer)

Hearing held at Christchurch on Wednesday 24 and Thursday 25 October 2001

APPEARANCES: Ms M McDowell and Ms T Baker for the Director of Proceedings

Mr C W James for Dr L John.

The Charge

1. Pursuant to sections 102 and 109 of the Medical Practitioners Act 1995 ("the Act") the Director of Proceedings ("the Director") charges that Dr John is guilty of conduct unbecoming a practitioner and that conduct reflects adversely on the practitioner's fitness to practise medicine.

2. The charge was particularised as follows:

   (a) Between 19 February 1997 and 25 March 1997 Dr John failed to refer her patient, who had been assessed with a fasting blood glucose level of 5.8, for further assessment of gestational diabetes and advice on management.

   (b) On or before 22 May 1997 prior to making her decision to induce her patient Dr John failed to discuss induction of her patient with a specialist obstetrician.

   (c) On 23 May 1997 between 2.00 am and 5.00 am when her patient was not progressing in labour Dr John failed to transfer her patient to Christchurch Women's Hospital.

3. On behalf of Dr John, Mr James advised the Tribunal that Dr John accepted:

   (a) (in relation to Particular 1) that she did not (between 19 February 1997 and 25 March 1997) refer Mrs Dobby for further assessment of gestational diabetes and

advice on management – Mrs Dobby having returned a fasting glucose level of 5.8 on the 19th March 1997;

(b) (in relation to Particular 2) that she did not on or before 22 May 1997 discuss the induction of Mrs Dobby with a specialist obstetrician; and

(c) (in relation to Particular 3) that she failed to transfer Mrs Dobby to Christchurch Women's Hospital when her patient was not progressing in labour.

4. Mr James stated, however, that Dr John contested whether these failures and/or omissions amounted to conduct unbecoming a medical practitioner that reflected adversely on Dr John's fitness to practise medicine.

Factual Background

5. At all relevant times Dr Lynne John was a registered medical practitioner, working as a general practitioner in Rangiora, approximately 45 minutes north of Christchurch.

6. In May of 1997 Mrs Dobby was pregnant with her third child. The estimated delivery date was 11 May 1997. Initially Mrs Dobby received antenatal care from midwife Ms Marja McCarthy but during the pregnancy she nominated Dr John as the lead maternity carer. As such, Dr John had primary responsibility for management of the antenatal care of Mrs Dobby and delivery of the baby. At the time, Dr John had an access agreement with Christchurch Women's Hospital and was therefore able to transfer patients to CWH for care and/or treatment, if necessary.

7. With the delivery of her first child, Mrs Dobby went into spontaneous labour at term plus 10 days after a normal pregnancy. The labour was uneventful and resulted in the normal delivery of a baby weighing 8lb 2oz (3.7kg). No pain relief was required for this labour. The second child was born at term plus two days following a normal pregnancy and the baby was again delivered normally. The second baby weighed 8lb 4oz (3.75kg). No pain relief was required during her labour.

8. For her third pregnancy Mrs Dobby booked for delivery at Rangiora Hospital. Mrs Dobby had a paternal family history of diabetes. This is recorded in Dr John's antenatal notes relating to Mrs Dobby. A glucose challenge test was performed on 19 February 1997, when Mrs Dobby was 28 weeks' pregnant.

9. The test involved giving 50 grams of glucose, with a one-hour blood glucose level being taken subsequently. The test result showed Mrs Dobby's blood glucose to be 8.1 (millimols/litre of serum) which was in excess of the standard allowable level of 7.7. The laboratory report suggested that Mrs Dobby may have gestational diabetes and indicated that a full pregnancy glucose tolerance test was desirable.

10. As a result, Dr John arranged for a full glucose tolerance test to be performed. This was done on 19 March 1997 when Mrs Dobby was 32 weeks' pregnant. This test involves a fasting blood glucose level being done at a laboratory. A 75 gram dose of oral glucose is given and a subsequent blood glucose test is taken after one hour and again after two hours.

11. The laboratory report recorded a fasting blood glucose of 5.8mmol/L. The guidelines under which Medlab in Christchurch was operating provided that a reading of 5.5 or above was diagnostic of gestational diabetes. It also noted that no one-hour blood sample had been received, and that a further test was desirable.

12. Dr John accordingly referred Mrs Dobby for a further fasting glucose test. A fasting blood test taken on 25 March 1997 indicated a glucose level in the normal range at 5.0. Dr John told Mrs Dobby that her test results were satisfactory. Dr John considered that these test results excluded gestational diabetes.

13. One of the risks associated with gestational diabetes is macrosomia (large baby). Both Dr John and the midwife agreed that Mrs Dobby was carrying a large baby. At term Dr John considered the baby to be larger than normal and estimated its weight to be around 4.0 kgs.

14. There are no concerns recorded about the baby's size in the obstetric notes. A gravidogram completed by Dr John shows recorded fundus height above the upper limit of normal.

15. On 22 May 1997, at 40 weeks plus 10 days, Mrs Dobby was induced at Rangiora Hospital.

16. Section 51 (Maternity Notice) of the Health and Disability Services Act 1993 and the Criteria for Referral to Specialist Obstetric and Relation Medical Services apply. Section 51 has been operating since 1993, and a new s.51 Notice was issued in 1996. The relevant s.51 Notice provides, inter alia:

> *"3.1.3.6 Lead maternity carers are expected to exercise wise clinical judgement about the services they themselves provide and in doing so should take into account the limits of their own competency and the joint RHA's published Criteria for Related Specialists Medical Services".*

17. The Criteria for Referral applicable at the time, rated induction of labour at '2'. This rating required the Lead Maternity Carer to recommend to her patient that specialist consultation was warranted. The Criteria provided that:

> *"3.1.2.6 It is expected that the principles of informed consent will be followed with regard to these criteria. If a woman elects not to follow the recommended course of action it is expected that the practitioner would take the usual appropriate actions such as seeking advice, documenting discussions and exercising wise judgement as to provision of care."*

18. Dr John did not consult a specialist about the decision to induce or discuss referral with Mrs Dobby.

19. At 8.00 am on 22 May 1997 Dr John began the induction of Mrs Dobby's labour, using a Prostin pessary. Mrs Dobby spent some of that day at home, being reviewed at the hospital at 1.00 pm and again at 3.00 pm. Contractions commenced between 4.00 and 5.00 pm and she returned to the hospital at around 6.45 pm. Dr John met her at the hospital and examined Mrs Dobby at 7.00 pm.

20. Dr John examined Mrs Dobby, the foetal heart was 132 bpm and she noted that the first stage of labour was progressing normally. Contractions at this time were recorded as 1 every 5 minutes. The foetal head was recorded at station minus 1. This refers to the position of the lowermost portion of the head in relationship to the ischial spines, that defines the approximate midpoint of the birth canal.

21. An artificial rupture of membranes was performed at 8.25 pm and the liquor was clear. At 8.30 pm Dr John noted that the "*…head had descended to station minus 1 cm and was firmly applied to the cervix, which had still not begun to dilate. FH good*". Dr John told Mrs Dobby that she expected her to deliver her baby by midnight.

22. At 9.45 pm Dr John noted that Mrs Dobby's labour seemed to be progressing normally and that the foetal heart rate was excellent. No vaginal examination was performed at this time. At 10.00 pm Mrs Dobby was experiencing contractions at the rate of one every two to three minutes.

23. At 10.30 pm Mrs Dobby's cervix was 5 cm dilated. It is recorded in the clinical notes by the midwife that the head was at station minus 2.

24. At approximately 11.15 pm a vaginal examination revealed the cervix was 7cm dilated and the baby's head still at station minus 2. Mrs Dobby at this stage asked to transfer from Rangiora Hospital to Christchurch Hospital because Mrs Dobby was becoming concerned about her lack of progress and pain. She was also concerned that the labour seemed harder than in her previous pregnancies.

25. Ms McCarthy discussed this request with Dr John by telephone at 11.30pm. Ms McCarthy told Dr John that upon vaginal examination, Mrs Dobby was found to be 5cm dilated at 10.30pm and 7cm at 11.30pm. Dr John instructed Ms McCarthy to offer Pethidine for pain relief and Mrs Dobby agreed, and the pain relief was given at 11.50pm. Mrs Dobby was not transferred to Christchurch Hospital.

26. At 1.20am Ms McCarthy performed a further vaginal examination. She considered that Mrs Dobby was almost fully dilated, with an anterior lip remaining. The station was recorded at minus 2.

27. Dr John, assuming that Mrs Dobby would be about to deliver (on the basis of information provided by the midwife), arrived at Rangiora Hospital at approximately 1.30am on 23 May 1997. She performed a vaginal examination at 2.00am and found the cervix to be less dilated than the midwife had judged. The cervix was assessed at 8 – 9cm dilated. She considered that there was substantially more than the anterior lip remaining. Dr John thought that the earlier examinations performed by the midwife, and which suggested a more rapid progress of labour, may have been inaccurate.

28. Progress of labour continued to be slow. An IV line was inserted and 1 litre of Hartmann's solution was given over the next 30 to 40 minutes. A further litre of Saline followed this over the next 2 hours. These fluids were given because it was thought that maternal dehydration might be affecting the progress of labour.

29. At 3.00am the cervix was 9cm dilated. Mrs Dobby went into the spa until 3.35am. By this stage her contractions had slowed to one every four minutes. At 3.45am the cervix was fully dilated. The foetal heart rate was monitored frequently between and during contractions and was between 120 and 140 bpm. Contractions increased to one every three minutes.

30. Mrs Dobby commenced pushing at 3.45am and was still pushing without much change at 4.35am. Uterine contractions had slowed to one every 5 minutes.

31. Mrs Dobby agreed to continue trying until 5.00am, at which time Dr John decided to attempt delivery using a ventouse. The position of baby's head was recorded as station zero. The ventouse was first applied at 5.10am. Foetal bradycardia was noted at 5.20am when the heart rate was noted at 90 to 110 beats per minute. A final traction was applied at 5.21am and, with good maternal effort, the head descended much more easily to crown.

32. The baby's head was delivered at 5.25am. The baby's shoulders became impacted (shoulder dystocia), Dr John was unable to complete the delivery of the baby and Dr Wanty, a local GP, was called to assist. Dr John also contacted Christchurch Women's Hospital for assistance. Ultimately, some 15-20 minutes later, Dr McNab, a private obstetrician who resided in the Rangiora area was called and Mr and Mrs Dobby's baby, Ethan, was delivered at 5.52am by Dr McNab. On delivery he was floppy, with no discernible heart rate or respiratory effort. He weighed 5.6kgs (12lb 5oz). Resuscitation was commenced immediately and Ethan was transferred to Christchurch Women's Hospital by ambulance with Dr John in attendance, but died that evening.

Evidence for the Director of Proceedings

33. Evidence was given to the Tribunal by Mrs Dobby, the midwife Ms M McCarthy and Dr C Kalderimis, a general practitioner of Wellington.

Evidence for Dr John

34. Evidence for Dr John was given to the Tribunal by Dr John, Professor M W Tilyard of Otago Medical School, and Dr D G Simmers, a general practitioner of Queenstown.

The Law

35. Dr John was charged with conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioner's fitness to practise medicine under section 109(1)(c) of the Act.

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

36. Both counsel referred to Elias J's (as she then was) statement in *B v The Medical Council of New Zealand* (High Court, Auckland Registry, HC 11/96, 8 July 1996) regarding conduct which constitutes *"conduct unbecoming*":

> *"There is little authority on what constitutes "conduct unbecoming". The classification requires assessment of degree. But it needs to be recognised that conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards. That*

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

37. Decisions since that time have established that it is not sufficient to show that a practitioner has been guilty of conduct unbecoming. It must also be proved that the conduct reflects adversely on the practitioner's fitness to practise medicine, in terms of the "rider" added to the charge of "conduct unbecoming" in the 1995 Act; for example, *CAC v Mantell* (District Court, Auckland, NP 4533/98, 7/5/99).

38. In that case the Court (Judge Doogue) concluded that:

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

39. The Court also said in the context of section 109(1)(c) of the Act that:

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

practise medicine. But not every divergence from recognised standards will reflect adversely on a practitioner's fitness to practise. it is a matter of degree."

40. In *Ongley v Medical Council of New Zealand* [1984] 4 NZAR 369, the High Court (Jefferies J) held that:

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

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

42. As has been stated on previous occasions, the relevant principles which can be distilled from these statements (*Ongley*, *B v Medical Council*) are:

(a) A finding of professional misconduct or conduct unbecoming is not required in every case where mistake is made or an error proven.

(b) The question is not whether an error was made, but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations (in all the circumstances of the particular case).

(c) The departure from acceptable standards and/or the failure to fulfil professional obligations must be "*significant enough*" to attract sanction for the purposes of protecting the public.

43. On the basis of both *B* and *Ongley*, both decisions given in the professional disciplinary context and on appeal from specialist tribunals, the question as to whether Dr John's

conduct is conduct which is culpable, ie is conduct warranting an adverse finding, is a question to be determined by this Tribunal. This applies notwithstanding any admissions made in relation to certain or all of the particulars of the Charge, and notwithstanding that any or all of the particulars of a Charge may be proven.

The Standard of Proof

44. The standard of proof in disciplinary proceedings is the civil standard, ie the balance of probabilities. All elements of the Charge must be proved to a standard commiserate with the gravity of the facts to be proved: *Ongley*.

The Burden of Proof

45. The burden of proof is borne by the Director.

The Decision

46. Having carefully considered all of the evidence presented to it. The Tribunal is satisfied that the charge is established and Dr John is guilty of conduct unbecoming and that reflects adversely on her fitness to practice.

Reasons for Decision

47. The Tribunal considered the charge, and the particulars, separately and on a cumulative basis.

Particular 1: Between 19 February 1997 and 25 March 1997 Dr John failed to refer her patient, who had been assessed with a fasting blood glucose level of 5.8, for further assessment of gestational diabetes and advice on management.

48. The Tribunal was satisfied that Particular 1 was not established. There was considerable disagreement as to what constitutes gestational diabetes in the evidence presented to the Tribunal by the expert witnesses. All of the medical practitioner witnesses were credible witnesses, but they had very different views as to what counts as ‘passing’ or ‘failing’ the glucose challenge test, the full glucose tolerance test and the fasting blood glucose test, all of which Dr John arranged to have carried out.

49. Taking into account all of the evidence presented in relation to this issue, the Tribunal considers that:

(a) Dr John did act on the advice she received from the laboratory to have further testing carried out;

(b) that the action she took was appropriate; and

(c) that it was reasonable for her to rely on the results received.

50. The Tribunal also took into account that during Mrs Dobby's pregnancy, Dr John carried out at least 12 urine tests, none of which showed the presence of glucose that might have indicated gestational diabetes.

51. The Tribunal is satisfied that while Dr John may have made some small error of judgement or done something differently, she nevertheless acted reasonably and within appropriate and accepted professional standards. The Tribunal makes this finding on the basis of the information available to Dr John at the time and has come to the view that if it were to find this Particular established, it could only do so with the benefit of hindsight and applying the counsel of perfection.

52. However, the Tribunal is satisfied that Particulars **2** and **3** are established.

Particular 2: On or before 22 May 1997 prior to making her decision to induce her patient Dr John failed to discuss induction of her patient with a specialist obstetrician.

53. The Tribunal considers that good practice required that Dr John either should have referred Mrs Dobby to a specialist for assessment, or at least discussed induction with a specialist prior to inducing labour. At a minimum, Dr John should have discussed induction with Mrs Dobby, in terms of the guidelines, and because of the nature of her professional obligations to Mrs Dobby taking into account all of the clinical facts and circumstances which were known to her by the time of the induction. For example:

(a) By the date of induction Mrs Dobby was 10 days past her delivery date;

(b) Both Dr John and the midwife were aware that Mrs Dobby was carrying a 'big baby' of around 4 kilograms. The Tribunal is of the view that Mrs Dobby's baby was certainly 'big' in that particular (rural) setting;

(c) Mrs Dobby had an 'unfavourable' cervix, i.e. it was 'closed' notwithstanding the size of the baby and its gestational age;

(d) The baby's head remained high. By the date of induction the baby's head had not descended into the birth canal;

(e) A bigger than average baby should have made referral to Christchurch Women's Hospital almost mandatory and any general practitioner practising in a rural setting should or would have considered transferring Mrs Dobby for delivery;

(f) For all practical purposes in the context of this clinical picture, Rangiora Hospital was 'one step up' from a home birth in that it was not equipped to carry out a complicated birth, or an emergency caesarean operation if that became necessary. Nor did it have available any specialist paediatric care.

54. All of these factors were known to Dr John at the date of induction.

55. It was Dr John's evidence that while she had in the past sought specialist advice regarding induction she did not do so for Mrs Dobby because she believed that it would be a 'rubber stamping' exercise.

56. The Tribunal considers that Dr John's failure to consult a specialist was, first, a breach of acceptable standards in so far as these are established by the s.51 Notice and the Criteria for Referral to Specialist Obstetric and Relation Medical Services. The Tribunal accepts the Director's submission that the Guidelines are good evidence as to what were acceptable standards of practice in May 1997.

57. It is also the Tribunal's view that Dr John's assertion that a specialist obstetrician would merely have 'rubber stamped' any decision she made is inadequate, and possibly even disrespectful. It does not adequately take into account the possibility that a specialist

obstetrician would have asked questions or made enquiries that Dr John hadn't thought of or considered. For example, about the size of the baby, the glucose tests, the state of the cervix, the baby's presentation and/or descent.

58. The Tribunal members, are also concerned that Dr John did not appear to discuss with Mrs Dobby what options were available to her, nor did she provide Mrs Dobby with adequate information to enable her to make an informed decision about whether or not delivery ought to be induced, or if it was, whether or not it was appropriate to induce labour at Rangiora given the facilities that were available, and the particular features of her pregnancy/baby.

59. Professor Tilyard in particular expressed the view that most general practitioners would not be aware of the terms of their access agreement, and would not regard the Criteria for Referral as imposing any mandatory requirements regarding referral. The Tribunal accepts Professor Tilyard's evidence that the guidelines …"*were never intended to use to discipline a practitioner, they were intended to improve the safety of obstetric care for both mother and child"*.

60. The Tribunal also accepts that the Criteria for Referral acknowledge that ultimately the practitioner must exercise his or her own clinical judgement. However, the Tribunal is also of the view that the Criteria/guidelines require that if a practitioner is to depart from the Criteria/guidelines then they should at least discuss that with the patient and afford their patient the opportunity to make an informed decision. The information provided to the patient should include an adequate explanation regarding entitlements and/or alternatives.

61. In this regard, Right 6, the Right to make an informed decision, applies and is consistent with the obligations of Lead Maternity Carers set out in paragraphs 3.1.3.6:

"Lead Maternity Carers are expected to exercise wise clinical judgement about the services they themselves provide and in doing so should take into account the limits of their own competency and the joint RHA's published criteria for referral to obstetric and related specialist medical services".

AND

"3.1.2.6 Informed Consent will be the basis of all transactions between the Provider and the woman."

AND

"3.1.2.10 The dignity of all women and families will be respected:

- *The Provider will assess and discuss the needs of women and actively work with them and their families/whanau to meet those needs through the development of the Care Plan in an acceptable manner.*

- *The Provider will create a user friendly environment that is suitable, comfortable and feels safe for the individual woman and her family/whanau."*

62. Taking into account all of these relevant facts and circumstances therefore, the Tribunal is satisfied that Dr John should have discussed Mrs Dobby's induction with a specialist obstetrician prior to inducing her on 22 May 1997, and her failure to do so does not constitute an acceptable discharge of the professional obligations she owed to Mrs Dobby. It also constitutes a failure on Dr John's part to meet acceptable and appropriate professional standards.

63. In making these findings, the Tribunal has taken into account the possibility that a specialist obstetrician would have accepted Dr John's assessment and agreed that the induction should proceed, however the Tribunal accepts the Director of Proceedings' submissions made in this regard. Consultations of the type provided for under the Criteria for Referral do occur on a regular basis in every day medical practice and a telephone consultation may have sufficed in Mrs Dobby's case. However it is equally likely that had all of the relevant facts and Mrs Dobby's clinical presentation been accurately and completely reported, the specialist obstetrician would have either have asked to see Mrs Dobby, or offered information or advice which Dr John did not consider.

64. The clinical picture presented in Mrs Dobby's case may well have alerted a specialist obstetrician to potential issues warranting further inquiry, and that is exactly the purpose underlying the Criteria. Further, the Tribunal does not consider that the Criteria is

particularly onerous, and general practitioners apparently had a significant input into the Criteria when it was drafted. It is also relevant that as a result of this case, the more rigorous requirement that women must be referred to and seen by a specialist obstetrician prior to induction was established very shortly after the events giving rise to this charge.

65. In all the circumstances therefore, the Tribunal is satisfied that Particular 2 is established.

Particular 3: On 23 May 1997 between 2.00 am and 5.00 am when her patient was not progressing in labour Dr John failed to transfer her patient to Christchurch Women's Hospital.

66. In relation to Particular 3, the Tribunal is also satisfied that this Particular is established and that Dr John's failure to transfer Mrs Dobby to Christchurch Women's Hospital for delivery warrants the sanction of an adverse finding.

67. Once again, having carefully considered all of the evidence presented, the Tribunal is satisfied that, by 4.30am at the latest, it had become obvious that labour was obstructed and that Dr John should have realised that meaningful progress had ceased. By that point at the latest Dr John should have made a diagnosis of obstructed labour and to apply the ventouse with the baby's head at station zero, or even at minus-one, was ill-advised.

68. Dr John appears not to have appreciated that labour had slowed down and there was a need for caution or review. The situation was exacerbated by the lack of appropriate facilities at Rangiora and Dr John's failure to discuss the situation and the possibility of transferring Mrs Dobby to Christchurch Women's Hospital for delivery with Mr and/or Mrs Dobby in any meaningful way.

69. It is the Tribunal's view that by the early hours of the morning of 23 May 1997, Dr John should have recognised that things were not progressing as they should.

70. It seems clear from the evidence that Dr John expected Mrs Dobby to deliver her baby by midnight. Dr John gave evidence that she had gone to sleep at home and when she awoke at 1.00am she was surprised that she had not been called to the hospital to delivery Mrs Dobby's baby. She went to the hospital at around 1.30am expecting an imminent delivery.

When she assessed Mrs Dobby at 2.00am she found the cervix not to be as dilated as she had been told by the midwife, but the discrepancy between her findings and those reported by the midwife did not alert her to the possibility that 'something was going on'. It was also Dr John's evidence that, while she had found Ms McCarthy's assessments to be accurate in the past, she did not discuss the difference in their respective findings with her.

71. The Tribunal accepts Dr Kalderimis' evidence that, by 2.00am, Dr John should have been considering the possibility of transfer, or a specialist consultation. The Tribunal is of the view that, by this time, Mrs Dobby had been in active labour for approximately 5 ½hours. She had progressed relatively quickly to 7 cms dilatation, but made no further significant progress. By 2.00 am the cervix was still not fully dilated and the descent of the baby's head was abnormal.

72. The clinical picture got worse from that point on with contractions decreasing in frequency and a lack of progress notwithstanding full dilatation and active pushing. The second stage of labour was significantly abnormal in terms of the average length of second stage for a multiparous woman (0-1 hour) and, after 30 minutes at least of second stage labour, all of the signs of uterine interia or an obstructed labour were present, and ought to have been obvious.

73. Given that Dr John was practising in a 'rural' clinical environment; she was isolated from her nearest base hospital; there were no resuscitation facilities available to her; no CTG monitor; no facilities for an emergency Caesarean; an earlier request for transfer had been made, and Dr John was a relatively experienced practitioner, the decision to attempt an instrumental delivery was a significant error of judgement.

74. The Tribunal also considers it relevant that while Dr John apparently considered that it was Mrs Dobby's preference to be delivered at Rangiora, that an ambulance trip would be painful for her and that there was a risk of delivery in the back of ambulance on the way to Christchurch Women's Hospital, Dr John did not discuss any of the options that were available in the circumstances, the risks and benefits of transfer, or the progress of the labour, or her concerns, or the risks and/or benefits of attempting an instrumental delivery at Rangiora, or any other relevant matters with Mr and Mrs Dobby. As a result, they were

denied the opportunity to give their informed consent to transfer or not and/or instrumental delivery or not.

75. Taking into account all of these factors and the evidence presented to it, the Tribunal is therefore satisfied that Dr John failed to meet acceptable standards of care and that Particular 3 is established. Having determined that Particulars 2 and 3 of the charge are established, the Tribunal also considered the charge on a cumulative basis and determined that it is established and that Dr John's failings constitute conduct unbecoming and that reflects adversely on her fitness to practise medicine.

76. In accordance with its usual practice, the Tribunal orders as follows:

(1) The Director of Proceedings is to file submissions on penalty with the Secretary of the Tribunal and serve a copy on Counsel for Dr John within 14 days of the date of receipt of this decision.

(2) Counsel for Dr John is to file his submissions on penalty with the Secretary of the Tribunal and serve a copy on the Director of Proceedings no later than 14 days after receipt of the Director of Proceeding's submissions.

DATED at Wellington this 10th day of December 2001

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W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal