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: 218/01/86D

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 **BODIABADUGE CAMILLUS LEONARD ANNESLEY PERERA** medical practitioner formerly of Whangarei but now of Melbourne Australia

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Miss S M Moran (Chair)

Mr P Budden, Dr L Ding, Dr F McGrath, Dr L F Wilson (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Whangarei on Tuesday 4, Wednesday 5 and Thursday 6 June 2002

APPEARANCES: Ms M A McDowell the Director of Proceedings

Mr A H Waalkens for Dr B C L A Perera.

Supplementary Decision on Penalty

1. In Decision No. 208/01/86D dated 12 August 2002 ("the substantive decision"), the Tribunal found Dr Perera guilty of professional misconduct in four respects. In accordance with normal practice, this decision should be read in conjunction with the substantive decision.

2. The finding of professional misconduct was made following the hearing by the Tribunal of a charge laid by the Director of Proceedings. The charge arose in the context of Dr Perera's management of Paree Jan Nicholas ("Paree") during the course of her admission to Northland Health (Whangarei Hospital) during the early hours of 17 July 1999 by which time Paree was deeply unconscious and where she died later that morning of meningitis.

3. At the hearing, Dr Perera defended the charge in all its particulars and denied that he had been guilty of professional misconduct.

Particular 1

4. With regard to Particular 1, the Tribunal found that Dr Perera failed to investigate, or adequately investigate, causes of Paree's clinical presentation at any time following the computerised topography (CT) scan of her head.

5. There were several aspects of Dr Perera's evidence in relation to this particular which the Tribunal did not consider credible and which it did not accept.

6. The Tribunal found that Dr Perera failed to appreciate the significance of the results of the CT scan and the need to investigate urgently his alternative diagnosis of meningitis. It found that he failed to do any other investigation which might have elucidated the cause of Paree's deep unconsciousness and that he failed to follow up the results of an investigation which had already been carried out (blood tests) and which would have assisted in deciding an appropriate management plan.

7. The Tribunal concluded that Dr Perera failed to do several things which he should have done including ordering and viewing a chest x-ray, inserting an arterial line, checking the laboratory data or ordering more tests, and recording the results of examinations. It also found that the charting of medication was minimal and did not involve a management plan of any underlying process.

Particular 2

8. With regard to Particular 2 the Tribunal found that Dr Perera failed to act upon suspected meningococcal disease and/or meningitis by commencing treatment with the administration of antibiotics.

9. Dr Perera conceded he was mindful of the possible diagnosis of meningitis at the material times, that he was aware that meningitis was reaching epidemic proportions in Northland where he practised, that it was his second diagnosis and that it was potentially both a fatal and a treatable illness, and that he had a duty to try and exclude it as a diagnosis and that the way to have done that would have been to have done a lumbar puncture.

10. Dr Perera was unable to advance any reasonable explanation why he failed to commence treatment with antibiotics in view of his own admissions that meningitis was his second differential diagnosis and that he had failed to exclude it.

Particular 3

11. With regard to Particular 3 the Tribunal found -

11.1 That between 4am and 6am on 17 July 1999 Dr Perera failed to consult with, and/or transfer care of Paree to an appropriately qualified specialist in a timely manner.

11.2 Dr Perera was the senior medical officer primarily responsible for Paree's care while she remained in the Intensive Care Unit unless and until he transferred her care to another specialist.

11.3 At the time Dr Perera left the Intensive Care Unit where Paree was, he did not transfer her care to any other specialist nor did he ensure that anyone else did so. Until a paediatrician arrived at a subsequent time, no other specialist was aware of Paree's admission or responsible for her care.

12. The Tribunal found certain aspects of Dr Perera's evidence regarding this particular not credible.

Particular 4

13. With regard to Particular 4, the Tribunal found –

13.1 That prior to leaving the hospital between 5am and 6am on 17 July 1999 Dr Perera failed to adequately communicate his diagnosis and management plan to family and staff.

13.2 Dr Perera had a responsibility to communicate with the family his understanding of the seriousness of Paree's illness, the difficulty with the diagnosis, and his planned approach. His assumption that, by reason of the involvement of Paree's mother, Ms Korach, she was adequately informed, did not meet the standard of a reasonable communication in the given circumstances nor did it discharge Dr Perera's responsibility to communicate those matters to her.

13.3 With regard to communication with staff the Tribunal found the staff were given a partial management plan only, that is, of extubating Paree and waking and weaning her in the morning.

14. In relation to this particular, again there were aspects of Dr Perera's evidence which the Tribunal did not find credible and preferred the evidence of certain nurses who gave evidence and were working in the Intensive Care Unit at the material time.

Submissions on Penalty

Submission by the Director of Proceedings

15. On behalf of the Director, Ms McDowell submitted that both the nature and seriousness of Dr Perera's errors in this matter were aggravating features in the context in which they arose.

16. In relation to Paree's presentation, she stated that Dr Perera was an experienced anaesthetist, well familiar with the hospital's systems and his obligations as consultant to the Intensive Care Unit, and the epidemic proportions which meningitis had reached in Northland; that he failed to undertake fundamental investigations; that he failed to investigate, and to administer antibiotics and/or refer to an appropriately qualified specialist in the context of him suspecting meningitis, that even if his first differential diagnosis was correct he failed to apply standard therapy for that diagnosis; and that nursing staff were gravely concerned at Paree's presentation, and when they attempted to draw that to Dr Perera's attention, he chose not to respond to their queries.

Submissions by Counsel for Dr Perera

17. On behalf of Dr Perera, Mr Waalkens criticised the submissions on behalf of the Director as being one-sided and selective, and paying no or no adequate regard to the time, place and circumstance where the events in question occurred.

18. With regard to time, Mr Waalkens submitted that Dr Perera had worked a full and busy day on the preceding day, Friday 16 July; that his sleep was broken throughout Friday evening when he received five or six calls from staff about patients including Paree prior to his arrival at the hospital just before 4am; and that the focus on Dr Perera was during a "*narrow portion of the evening's events*" which Mr Waalkens submitted was in essence some time between 4.30am and 5.15am.

19. With regard to circumstance, he submitted that while Dr Perera did not consider meningitis likely, but only possible, he believed it was something which could await further investigation until the morning, a decision he very much regrets and one which he will always regret and never forget; that there was an absence of classic meningitis signs throughout Paree's deterioration at the hospital including the petechial rash which was not noted until after Dr Perera had left; that Paree's deterioration from the moment she arrived at the hospital through to 4am/4.30am was rapid as was her deterioration thereafter; that the weight of evidence supports the likelihood that Paree's deterioration had even by 4am (when Dr Perera arrived at the hospital), and certainly by 4.30am (when the CT scan procedure was completed and Paree was being taken to ICU) the prospects of her surviving were extremely remote and that this was another case of many of its type where a doctor had been criticised for his management and efforts with a patient acutely unwell from meningitis (even although Dr Perera had not been charged with a failure to diagnose), and that these were all matters to be taken into account.

20. With regard to place, Mr Waalkens submitted that the fact that this incident arose at Northland Hospital required consideration. He submitted there was much evidence about systems failures and failures by other people. He referred to a character reference of a senior surgeon at Northland Hospital who had indicated gross understaffing issues and the extent to which consultant staff were overworked and the pressures put on Dr Perera.

21. Mr Waalkens submitted that at no time had Dr Perera blamed Northland Hospital for what had occurred. He said the fact remained that Paree's care was not up to standard from the moment she arrived at the hospital at 1.40am and for the next two hours before Dr Perera was even telephoned. He said the records showed her condition markedly deteriorated and yet no other medical (consultant) intervention was requested, recommended or obtained. Mr Waalkens also referred to the other systemic issues which were identified at the hearing which included the inadequate number of staff on call and on duty at the hospital including the absence of a permanent ICU medical officer.

22. Mr Waalkens submitted that while none of those factors, of themselves, were found by the Tribunal to warrant the dismissal of the charge against Dr Perera, they are plainly relevant to penalty.

23. Mr Waalkens submitted that Dr Perera is a competent, well respected anaesthetist and that the references submitted to the Tribunal describe him as a competent general anaesthetist who devoted long hours and much attention to the needs of patients throughout his long period of service (14 years) to Northland Hospital.

24. Mr Waalkens stated that Dr Perera left Northland Hospital "*directly as a consequence of this tragic incident concerning Paree*".

25. With regard to conditions on practice, Mr Waalkens stated that Dr Perera has no intention of returning to New Zealand. He considered he had been inadequately supported and had been left as the "*fall guy*" by Northland Health and that it would be inappropriate to impose conditions on him should he intend to return. He considered the conditions proposed by the Director as unreasonable and that if any conditions are to be imposed (with which he does not agree) it should only be that the Medical Council consider whether Dr Perera is required to undertake a competence review at the time he returns to New Zealand to recommence practice, if he should do so.

26. With regard to publication, he stated that Dr Perera had been the subject of extensive publicity which had caused him significant penalty and hurt.

27. With regard to censure, he recognised that it is likely the Tribunal would censure Dr Perera and that this would add to the penalty he will suffer.

28. With regard to fine, he submitted there should be no fine taking into account the matters already submitted and the suffering Dr Perera has already been through. He stated that Dr Perera's financial position was not strong and gave an indication of Dr Perera's net worth and current income.

29. With regard to costs, given Dr Perera's financial position and other factors, Mr Waalkens submitted that a contribution to costs of no more than 30% would be appropriate.

Decision

30. Having carefully reviewed its substantive decision and taken into account all of the matters submitted on behalf of both the Director and Dr Perera (not all of which have been set out in detail above), the Tribunal has concluded that the following penalty should be imposed:

30.1 Dr Perera is censured.

30.2 Dr Perera is fined $12,000.

30.3 If Dr Perera should return to New Zealand and apply for a Practising Certificate in New Zealand then the following conditions are imposed:

30.3.1 The Tribunal recommends that the Medical Council of New Zealand undertake a competence review of Dr Perera including specific emphasis on intensive care medicine and acute anaesthesia practice.

30.3.2 On resumption of practice as an anaesthetist in New Zealand, Dr Perera is required to work under close supervision until the Medical Council has undertaken its competence review and issued an annual practising certificate.

30.3.3 That on resumption of employment as a consultant anaesthetist within New Zealand Dr Perera be required to advise his employer and senior staff at his place of employment of the conditions that are attached to his practice.

30.4 Dr Perera is required to pay 25% of the costs and expenses of the investigation by the Health and Disability Commissioner and prosecution of the charge by the Director of Proceedings (which amounted to $35,750.74), and of the hearing of the Tribunal (which amounted to $40,739.00). The Secretary of the Tribunal will

forward a schedule to Dr Perera setting out how these amounts have been calculated and the amount he is required to pay in accordance with this decision. The total amount of costs Dr Perera is required to pay is therefore $19,122.44

30.5 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 Perera sought name suppression on two earlier occasions but both applications were declined and reasons given.

30.6 The Tribunal requests that the Medical Council notify the content of this decision to the Registration Board where Dr Perera is currently employed.

Reasons

31. With regard to mitigating factors, the Tribunal referred in its substantive decision to *Tiredness*, and to *Overall Circumstances* (paras. 220 to 229).

32. With regard to tiredness and the time of day, while the Tribunal accepts that this might interfere with interpersonal relationships and the social niceties it should not affect a patient's entitlement or access to acute care as required.

33. With regard to the "*narrow portion of the evening's events*" referred to by Mr Waalkens, the Tribunal accepts that the timeframe was narrow but that it is not determinative by itself.

34. With regard to Mr Waalkens' submission regarding the system at Whangarei Hospital, the Tribunal accepts that this case highlighted systemic inadequacies and resource issues at the hospital. The Tribunal also considered the apparent failure of staff training to ensure that the senior house officer in the emergency department was conversant with the protocols for involving a consultant in the diagnosis and management of a seriously ill patient. While they do not affect Dr Perera's culpability they are mitigating factors. The Tribunal has taken those matters into consideration when considering penalty.

35. The Tribunal has stated in its substantive decision and repeats here that this was not a case about the misdiagnosis of, or failure to diagnose, meningitis or meningococcal disease. It was, rather, about the failure to undertake basic, fundamental investigations as to the cause of Paree's clinical presentation. It was also about the failure to act on suspected meningitis, the failure to refer appropriately and in a timely manner, and the failure to adequately communicate with other healthcare providers and Paree's family.

36. The Tribunal considers that these failures were basic and fundamental failures of the duty of care. They were of considerable concern to the Tribunal.

37. The Tribunal also found that aspects of Dr Perera's evidence were not credible.

38. The Tribunal is of the view that Dr Perera's failures concerning this matter are at the more serious end of the scale. While the systemic issues at Northland Hospital may have affected how Dr Perera handled this matter, they do not excuse his basic failures of duty of care but they have been taken into account by the Tribunal when addressing penalty.

39. The Tribunal is mindful of the principal purpose of the Medical Practitioners Act which is *to protect the health and safety of members of the public by prescribing or providing for mechanisms to ensure that medical practitioners are competent to practise medicine.*

40. To that end, the Tribunal is of the firm view that the conditions which it has imposed on Dr Perera, should he return to New Zealand and apply for a practising certificate, are appropriate and in the public interest.

41. With regard to the issue of costs, any award must be a reasonable one in all the circumstances.

42. The Director, in her submissions, submitted that while Dr Perera was entitled to put the prosecution to proof, his "*not guilty*" plea needed to be assessed in the context of his concessions in cross examination regarding the appropriate standard of care and in the context of the Tribunal's findings particularly as to credibility.

43. Mr Waalkens took issue with this submission, submitting it was unreasonable. He stated there were many factors at play in this case and that it was appropriate that the case be investigated by the Tribunal in the manner in which it has been. He submitted that Northland Health and others would have learned from the investigation and in that regard the purpose of disciplinary hearings which analyse and determine standards was being advanced by the process. He stated that to criticise or penalise Dr Perera for having his say before the Tribunal would be wrong and that members of the profession should not be discouraged from doing so in the manner in which Dr Perera did. He further submitted that Dr Perera did not take any unreasonable points of evidence or of law and was co-operative throughout with the Health and Disability Commissioner's investigation, and the Director of Proceedings and the Tribunal enquiry.

44. The Tribunal accepts Mr Waalkens' submissions. In this particular case, there can be no criticism of Dr Perera in entering a plea of "not guilty" or of the way in which he and his counsel conducted his defence.

45. As to costs, the Tribunal considers that a contribution of 25% is appropriate. In making the award, the Tribunal sought to balance the seriousness of Dr Perera's basic failures regarding his duty of care with the level of the fine and the other factors submitted on his behalf.

46. Almost immediately prior to issuing this decision, the Tribunal received further submissions from Mr Waalkens and the Director of Proceedings.

47. Mr Waalkens referred to a letter dated 7 November 2002 which Dr Perera had received from the Director purporting to give him the opportunity to be heard as to whether proceedings should be issued before the Human Rights Review Tribunal.

48. Mr Waalkens submitted that Dr Perera was shocked at the development and has protested on a number of grounds, outlined in Mr Waalkens' submissions.

49. Mr Waalkens submitted that it was appropriate for the Tribunal to assess its penalty (or reassess it) in the knowledge that this matter may well have not ended for Dr Perera and that, whatever the position, plainly he would suffer further stress and upset as a consequence.

50. The Director filed submissions in opposition refuting the various grounds relied upon by Mr Waalkens and concluding that pursuant to section 54(5) of the Health and Disability Commissioner Act 1995 the Human Rights Review Tribunal must, where the action has been the subject of disciplinary proceedings, have regard to the findings of the disciplinary body and to any penalty imposed on the particular registered health professional; and that therefore any penalty that this Tribunal hands down will be taken into account in proceedings (if any) filed before the Human Rights Review Tribunal.

51. The Tribunal reconvened to consider the further submissions. However, it remains of the view that the orders made are appropriate and reasonable in all the circumstances.

52. It is not persuaded that because proceedings might be issued in another jurisdiction before another Tribunal that it should alter the penalty decision which it has made.

53. The Tribunal is aware that in an appropriate case the Director may pursue proceedings before the Human Rights Review Tribunal as well as before this Tribunal. However, as proceedings have been issued before this Tribunal and are nigh on completion, then the Human Rights Review Tribunal, if proceedings are brought before it, is obliged to have regard to any penalty imposed on Dr Perera by this or any other Tribunal.

DATED at Hamilton this 21st day of November 2002

.....

S M Moran

Deputy Chair

Medical Practitioners Disciplinary Tribunal