**MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL**

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**DECISION NO:** 215/02/90D

**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 **DEVARAJAN CHURCHILL JOSEPH FERNANDO** medical practitioner of New Plymouth

**BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL**

**TRIBUNAL:** Mrs W N Brandon (Chair)

Mr P Budden, Dr I D S Civil, Dr A M C McCoy, Dr A D Stewart (Members)

Mr B A Corkill (Legal Assessor)

Ms K L Davies (Hearing Officer)

Ms H Gibbons (Stenographer)

Hearing held at New Plymouth on Monday 24 June 2002 and Wednesday 30 October 2002

**APPEARANCES:** Ms T Baker for the Director of Proceedings (24 June 2002) and

Ms M McDowell, the Director of Proceedings (30 October 2002)

Ms J Gibson for Dr D C J Fernando.

**The Charge**

1. Pursuant to sections 102 and 109 of the Medical Practitioners Act 1995 ("the Act"), the Director of Proceedings ("the Director") charged that in the course of undertaking an 18-20 week antenatal scan of the complainant on 13 November 1997, Dr Fernando acted in such a way that amounted to conduct unbecoming a medical practitioner and that conduct reflects adversely on his fitness to practice medicine.

2. The particulars of the charge alleged that Dr Fernando failed to detect or record oligohydramnios and/or that he failed to conduct an adequate examination of the foetus in that he:

   (a) incorrectly measured the size of the foetal head; and/or
   (b) reported the kidneys and bladder as normal, in the absence of recorded images to this effect and when such anatomy likely did not exist; and/or
   (c) failed to conduct an adequate examination of the brain.

3. Dr Fernando admitted the particulars of the charge, and that the conduct alleged therein either separately or cumulatively amounts to conduct unbecoming a medical practitioner.

**The hearing of the charge**

4. Pursuant to s97 of the Act, the functions of the Tribunal are to consider and adjudicate on proceedings brought pursuant to s102, and "*to exercise and perform such other functions, powers and duties as are conferred or imposed on it by or under [the] Act or any other enactment*".

5. Accordingly, the Tribunal must give the practitioner proper notice of the charge (s103) and, prior to exercising its powers to discipline a practitioner, it must be "*satisfied*" that the practitioner is guilty of one of the professional disciplinary offences listed in s109.

6. The hearing of the charge commenced at New Plymouth on 24 June 2002. At the commencement of the hearing, Dr Fernando's plea was confirmed and the hearing proceeded by way of an Agreed Summary of Facts. The course of that hearing is recorded in the Tribunal's Minute dated 4 July 2002.

7. In summary, the Agreed Summary of Facts was presented to the Tribunal, and both counsel made submissions as to matters of fact and law. The Tribunal then adjourned to consider all of that material and concluded that it was not satisfied that the charge was established.

8. The Tribunal determined that, notwithstanding that Dr Fernando had entered a plea of guilty to the charge, it was not satisfied that a professional disciplinary offence was established. On that basis, the Tribunal considered that it was not able to determine the charge on the basis of the material and submissions before it.

9. As is recorded in the Tribunal's Minute, the terms of s109 are very clear and "*to adopt any other procedure, or to circumvent the requirements of s109 or any other relevant statutory provision, would be unlawful*". Counsel and the Tribunal's legal assessor subsequently appointed have indicated that they accept that is a correct statement of the legal position under s109.

10. Accordingly the Tribunal determined that, in the circumstances, the fairest course was to adjourn the hearing to give the parties an opportunity to present or provide further evidence.

11. At the commencement of the reconvened hearing, counsel confirmed the Agreed Summary of Facts submitted at the commencement of the hearing and Dr Fernando maintained his plea of guilty to the charge.

**Factual Background**

12. The factual background to the charge is that in November 1997, Dr Fernando was a registered medical practitioner holding a current practising certificate. He was vocationally registered as a diagnostic radiologist by the New Zealand Medical Council in September 1989. He was accredited by the Royal College of Radiologists in August 1985.

13. Dr Fernando saw Mrs McMillan on only one occasion, at the consultation that is the subject of the charge. Mrs McMillan was referred to Dr Fernando for a routine screening scan at 20 weeks gestation. It was Mrs McMillan's fourth pregnancy and she had not felt any foetal movements during the pregnancy.

14. Dr Fernando's report of the scan stated as follows:

> "*LMP = 26/6/97, EDD = 22/4/98. Maturity by dates = 20 weeks, 0 days. There is a single live foetus. Assessment of foetal morphology was suboptimal partly due to maternal build but intracranial structures, abdomen, abdominal wall, kidneys and bladder are all normal. The cardiothoracic ratio however appears to be increased and I would value further evaluation by Andrea Gibb. The liquor volume is normal. The placental position is anterior and clear of the internal os. Normal foetal movements were observed.*
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> *BPD – 3.98cm (17 weeks, 4 days mean) dolichocephalic)*
> *HC – 16.1 cm (19 weeks, 0 days mean)*
> *FAC – 12.3cm (17 weeks, 5 days mean)*
> *FL 0.287cm (18 weeks, 3 days mean)*
>
> *These measurements are at the lower limit of the normal range of the stated maturity.*"

15. Ms Andrea Gibb, who is referred to in the report, was a qualified and experienced ultra-sonographer employed by Fulford Radiology Limited at the relevant time. Ms Gibbs was not subsequently asked to provide any "*further evaluation*" as per Dr Fernando's report.

16. A further ultrasound scan was conducted by another specialist radiologist, Dr Harding, at 31 weeks and four days gestation. Dr Harding's report concluded that "*overall the size of the foetus was that of a gestational age of 28 weeks six days, plus/minus two weeks. Hence small for dates*". That is, the baby was small for its gestational dates by approximately three weeks. Dr Harding's report did not include any reference to the presence or absence of liquor.

17. Dr Fernando was not involved in Mrs McMillan's care at all beyond undertaking the routine 18-20 weeks screening scan and reporting to Dr Brooks, as described above. He was not aware of the outcome of Mrs McMillan's pregnancy until the Health and Disability Commissioner's office wrote to him on 21 July 1999.

18. Mrs McMillan went on to deliver a baby boy, Jacob William, on 28 March 1998 by elective caesarean section. Prior to the birth, Mrs McMillan had consented to a tubal ligation being undertaken at the same time as the caesarean section delivery and a tubal ligation was duly performed. At birth, her baby was discovered to have multiple abnormalities and lived for only four hours post-delivery. No post-mortem examination was carried out and the abnormalities listed below were unable to be confirmed by that process.

19. At birth it was noted:

    (i) there seemed to be no liquor surrounding the baby (oligohydramnios);

    (ii) the baby had a small chest which caused breathing difficulties and congenital heart disease was suspected. He was thought to also have an absent corpus callosum (broad band of tissue that divides the two sides of the brain) and renal agenesis.

20. In the Agreed Summary of Facts, Dr Fernando accepted that parts of his assessment of Mrs McMillan amounted to conduct unbecoming a medical practitioner in terms of the

particulars contained in the charge and he expressed his sincere regret to her and her family.

21. In particular, it is not contested that:

(i) From the recorded scan images oligohydramnios is evident. The images show a squashed shape of the head, chest and abdomen which is typical of oligohydramnios.

(ii) That there are no recorded images to support his report that "*the intra cranial structures, abdomen, abdominal wall, kidneys and bladder are all normal*".

(iii) That he measured the head incorrectly, but did note that the head was dolichocephalic (meaning squashed or elongated).

22. Dr Fernando no longer undertakes ultrasound scans personally as ultra-sonographers are now available in New Plymouth to carry out all routine scans.

**Evidence for the Director of Proceedings**

23. At the reconvened hearing the Director of Proceeding's evidence in support of the charge was given by Dr Bruce Cashmore Allen, a specialist radiologist practising as a consultant in Auckland. Dr Allen is also a lecturer at the Auckland Medical School and his relevant professional interests are in medical ultrasound, in particular in obstetric and interventional ultrasound. He currently performs around 400 obstetric scans a month.

24. Dr Allen gave evidence of the relevant standards for the 17-20 week routine foetal ultrasound scan contained in the Australasian Society for Ultrasound and Medicine (ASUM) Guidelines dated June 1991, which were the guidelines applicable in 1997 and 1998. Mrs McMillan's ultrasound examination was requested by her obstetrician, Dr Brooks. The request form asks for a check on "*foetal morphology*".

25. A routine 17-20 week scan has the following objectives, which have been extensively researched and widely published for many years and, it was Dr Allen's evidence, that these objectives constitute the standard of care that Dr Fernando ought to have met:

"*(a)* *To assess foetal number (i.e. how many babies are present?).*

*(b)* *To assess the gestational age by measurements of the foetal head, abdomen and femur (or thigh bone). (Due to the normal vairations in the size of babies at 20 weeks, the assessment of foetal age by measurement at 20 weeks is only accurate to within ten days).*

*(c)* *To assess amniotic fluid volume.*

*(d)* *To assess foetal anatomy.*

*(e)* *Specific features of the following structures should be examined and standard images should be recorded:*

- *face, including eyes and lips;*
- *spine;*
- *heart;*
- *diaphragm;*
- *stomach;*
- *kidneys and bladder;*
- *cord insertion on the foetal abdomen;*
- *limbs;*
- *hands and feet;*
- *cord;*
- *placenta.*

*This usually requires about 20 images.*

*(f)* *To assess placental position.*"

26. It was also Dr Allen's evidence that the standard of care described above is the appropriate standard to apply irrespective of, and independently from, the ASUM Guidelines. Dr Allen gave evidence of undertaking a review of the 11 images, plus one further image recording foetal dimensions, that Dr Fernando had retained from Mrs McMillan's examination.

27. It was Dr Allen's evidence that none of the images showed any amniotic fluid and at 20 weeks he would normally expect amniotic fluid to be visible on many of the images of foetal anatomy. Traditionally, the squashed deformed shape of the head, chest and abdomen are typical of severe oligohydramnios. It was Dr Allen's evidence that where oligohydramnios is diagnosed at a 17-20 week scan, the next step is to determine its cause. If foetal abnormality is suspected the severity of the abnormality is ascertained to enable appropriate management to be decided, including the option of termination of the pregnancy and/or appropriate counselling. This management would normally be provided by an obstetrician.

28. Dr Allen gave evidence that the head measurements undertaken by Dr Fernando were not measured from the correct site being approximately 2cm above the correct measurement site and it was Dr Allen's view that this raises doubts about Dr Fernando's competence.

29. Similarly an error was made in relation to the abdominal circumference measurement, but an adequate image of the baby's femur was measured appropriately. In terms of the expected 20 or so standard images demonstrating normal structures, only five were present and the other images provided are not standard views and provide no useful record of foetal anatomy. Nor did it attest to a systematic survey of foetal anatomy having been performed, which is an expected standard of care for radiologists.

30. Dr Allen accepted that when oligohydramnios is present it can be difficult or impossible to obtain the standard views of foetal anatomy, but Dr Fernando does not appear to have appreciated that he was unable to obtain the prescribed images of foetal anatomy. It was his evidence that Dr Fernando's reporting of his assessment of foetal morphology was sub-optimal. It was Dr Allen's opinion that Dr Fernando should have detected and reported that there was little or no amniotic fluid present at the time of the scan.

31. Dr Allen stated his opinion in the following terms:

> *"It is also of significant concern that Dr Fernando has recorded the liquor volume as normal when it was not... having failed to detect the oligohydramnios, Dr Fernando should have recognised that he was not able to record the standard images to either measure the baby, or to document the*

> *normal foetal anatomy. He has alluded to this difficulty in the report, ascribing it to the mothers build... However I believe he has mis-read the situation because of his failure to appreciate the oligohydramnios."*

32. Dr Allen also noted that Dr Fernando did not record any images to support his report that the foetal "*intracranial structures, abdomen, abdominal wall, kidneys and bladder are all normal*".

33. Dr Allen noted Dr Fernando's reported concern about the heart size and that he "*would value further evaluation by Andrea Gibb*". Dr Allen's view was that "*this is possibly an appropriate response, as an enlarged heart is often a clue to a serious abnormality, but I would have preferred to see a stronger recommendation for a further assessment. It is unfortunate that his suggestion was not followed.*"

34. The fact that a subsequent scan was conducted at approximately 31 weeks did not alter Dr Allen's opinion regarding Dr Fernando's standard of care and his conclusion was that:

> *"Dr Fernando's examination of the pregnancy failed to provide an appropriate standard of care and that his failure to detect oligohydramnios combined with the technical errors made in relation to three of the four measurements reported, were of a fundamental nature."*

35. Dr Allen described the deficiencies in Dr Fernando's examination as "*fundamental failings*" in terms of the relevant standards reasonably to be expected of him at the time of the screening.

**Evidence for Dr Fernando**

36. In light of Dr Fernando's admissions and guilty plea, the only statement submitted on his behalf was that of Dr Jeremy Hudson Smith, a specialist obstetrician and gynaecologist practising in New Plymouth. Dr Smith commenced practice in New Plymouth in September 1991 and he gave evidence that for the first two or three years of his practice the obstetricians practising in New Plymouth used to do their own antenatal scans. These were mainly used to establish the number of foetuses and to obtain dates as a full service based on their owns skills could not be provided.

37. From approximately September 1994 there were intermittent gaps and difficulties recruiting ultra-sonographers to work in New Plymouth. Andrea Gibb arrived in 1996 and worked at Taranaki Hospital and Fulford Radiology (with Dr Fernando).

38. Dr Smith told the Tribunal that:

> *"It is important to realise that in [New Plymouth], people were not recruited into a system, but rather a system built up around various people's skills and speciality. When we had someone in the ultrasound department who was keen and had sufficient skills, the service gradually built up around that person. This happened with Andrea Gibb, both in her role at Taranaki Hospital and at Fulford Radiology.*
>
> *The difficulties in recruiting ultra-sonographers in New Plymouth, meant that at times, radiologists performed and read ultrasound scans. If they had not done so, then essentially ultra-sonography would have been limited to that performed previously by the obstetricians and gynaecologists."*

39. Dr Smith recollection was that:

> *"During the 90's, meetings between the obstetricians and gynaecologists and Fulford Radiology regarding the service available. These meetings assured that there was discussion and agreement about cases that were referred and the services offered."*

40. Dr Smith confirmed the Minute of a meeting between radiologists and O&G specialists at New Plymouth on 28 July 1997 that was submitted in evidence. That Minute records that the future management of abnormal foetuses was discussed and Dr Smith told the Tribunal that –

> *"It was thought that it would be best to have a further scan for those foetuses with identified abnormalities by Andrea Gibb with Dr Geoff Aitken's involvement (Dr Aitken is a neonatal paediatrician who works with the ultra-sonographers in his specialist role)."*

41. The Minute records that Drs Brooks, Dempsey, John, Smith, and Aitken all were in attendance at the meeting, as was Andrea Gibb, and others. The relevant entry in the Minute records:

> *"Current Business*
>
> *1. Discussion regarding future management of abnormal foetuses. Plan was to have Dr Aitken's input, and inform patient that a further scan will need to be carried out. Andrea to be involved."*

42. Dr Smith stated:

> *"From this time, my understanding was that whenever something was seen that was difficult to see or thought to be abnormal, this was flagged on the ultrasound report, and a further evaluation was undertaken by Andrea Gibb. Essentially I understood this flagging to mean that there was some doubt about what was going on, remembering that some ultrasounds are extremely subtle and what looks like abnormal can be normal and vice versa. If a radiologist from Fulford Radiology had requested a further evaluation by Andrea Gibb, I would have understood that to mean that some further interpretation skill was required by Ms Gibbs. That would have been my own personal view."*

43. Dr Smith also told the Tribunal that during the years that Dr Fernando provided ultrasound reports, he was not afraid to indicate to the obstetricians and gynaecologists when he was not sure of what was going on and extra help was required. Prior to an ultra-sonographer becoming available, this meant that sometimes patients were referred to Auckland for expert antenatal screening, which of course is a speciality in its own right.

**Submissions on behalf of Director of Proceedings**

44. The Director relied on Dr Allen's evidence that Dr Fernando's failings as they relate to the particulars outlined in the charge constitute fundamental departures from the standard of care reasonably to be expected from a specialist radiologist undertaking a routine 17-20 week scan. In that respect, the Director submitted that Dr Fernando's failings are significant enough to warrant disciplinary sanction in the interests of protecting the public. Ms McDowell referred to s3 of the Act which describes the principal purpose of the Act being "*to protect the health and safety of the public by prescribing or providing some*

*mechanism to ensure that medical practitioners are competent to practice medicine.*"

45. The Director referred to Dr Allen's opinion that Dr Fernando should have detected and reported the absence of amniotic fluid on the images and that vital clues to diagnosing oligohydramnios were missed. Dr Fernando should have assessed the volume of amniotic fluid that was present as one of the criteria for a routine 17-20 obstetric scan. Dr Fernando's failure to detect or report oligohydramnios was a fundamental error which must be considered in the context of his reporting that the liquor volume was normal when clearly it was not.

46. The Director submitted that this failing by itself met the threshold test for conduct unbecoming, as described in *B v The Medical Council* (HC, Auckland; HC 11/96, per Alias J):

> *"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 of [counsel for the Appellant] 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 or conduct unbecoming: Doughty v General Dental Council [1988] 1 AC 164; Pillai v Messiter (No.2) (1989) 16 NSWLR 197; Ongley v Medical Council of New Zealand (1984) 4 NZAR 369. 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. 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.*"

47. The Director accepted that, pursuant to s109(1)(c) of the Act, it is not sufficient to show merely that a practitioner has been guilty of conduct unbecoming, it must also be established that the conduct, reflects adversely on the practitioner's fitness to practice medicine. In this regard, the Director referred to *CAC v Mantell* (District Court, Auckland, NP 4533/98, 7/5/99) in which the Court held (at p17):

> "*The section requires assessment of standards of conduct using a yard stick of fitness. It does not call for an assessment of the individual practitioner's fitness to practice.*"

48. The Director also referred to that decision (at p16):

> "*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. It does not require the prosecution to establish that the conduct establishes that the practitioner is unfit 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.*"

49. The Director referred to each of the particulars in turn and to the Agreed Summary of Facts and Dr Fernando's admissions in relation thereto.

50. The Director also referred to Dr Allen's evidence that whatever system existed for a second opinion or referral, such options were irrelevant to the standard of care and conduct undertaken by Dr Fernando at the time of the scan. The Director submitted that:

> "*As a matter of common sense, fundamental failings in the reading of the scan (in the context of certain anatomical structures and liquor volume being reported as normal by the radiologist concerned), cannot be alleviated by a recommendation for a second opinion. In this respect it is to be noted that the referral for a second*

*opinion related to the cardiothoracic ratio and not those aspects of the report which Dr Fernando has been charged with (head, kidneys, bladder, and brain).*"

51. The Director went on to submit that:

> "*23. If, however, the Tribunal determines that the existence of the specialist clinic is relevant beyond mitigation purposes it is submitted that it is not clear that this specialist clinic was in existence and used by relevant specialists at the time. Minutes for one meeting have been provided to the Tribunal. Moreover, it is submitted that such record is sparse and lacking in detail as to the exact nature and implementation of the clinic. Indeed the letter of Dr Aitken implies ongoing meetings from the time of that meeting. This would suggest a developing process of referral.*
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> *24. For any such clinic to be established it would clearly need "buy in" from the relevant specialists…*"

52. The Director also referred to questions from the Tribunal regarding the second ultrasound scan undertaken at 31 weeks, and the reported findings from that examination, and the absence of any further evaluation being undertaken, as was indicated by Dr Fernando in his report.

53. In essence, the Director submitted that other practitioners' conduct with regard to this patient is irrelevant to the Tribunal's consideration of Dr Fernando's conduct at the time of undertaking, and reporting, this particular scan. The Director emphasised that Dr Fernando's report was not silent on the aspects of relevant parts of the foetal anatomy. Dr Fernando reported the normalcy of particular structures, despite the fact that he was having difficulty obtaining optimal images and the Director referred to Dr Allen's description of Dr Fernando's failings as being of "*a fundamental nature*".

54. The charge is laid as a cumulative charge and the Director submitted that in the event that the Tribunal is not satisfied that individual particulars amount to conduct unbecoming a medical practitioner, cumulatively the particulars show fundamental departures from a standard of care which give rise to public protection issues, both in terms of s3 of the Act and the requirement for a significant departure from accepted standards for the purposes of protecting the public, as is referred to in ***B's*** case. The Director also referred to the

unusual developments in this case given that Dr Fernando entered a guilty plea which was not withdrawn, but the Tribunal sought further evidence. As a result, Dr Smith's evidence should not be characterised as evidence in defence of the charge, but rather is best regarded as being relevant to mitigation.

55. In that context, the Director disputed that the existence and/or availability of a second opinion was relevant to the standard of care and conduct reasonably to be expected of Dr Fernando and his failings cannot be alleviated by his recommendation for a second opinion.

56. Finally, the Director suggested that the Tribunal should take into account Dr Smith's concession in cross-examination that the "*specialist clinic*" was a developing process and there was no formal process in place for referrals to Ms Gibbs.

**Submissions on behalf of Dr Fernando**

57. Ms Gibson referred to submissions made at the commencement of the hearing and to the difficult position she was in given that a guilty plea was entered by Dr Fernando and that the factual basis of the charge was not contested. For that reason her submissions should be considered in the context of mitigation, rather than defence but it is important to put the reading of the scan in proper context.

58. In particular, Ms Gibson referred to the Director's discounting of the Minute on the basis of its brevity and that it did not adequately portray what was to become or develop into a formal process or clinic. Nevertheless, Ms Gibson submitted, when Dr Fernando reported Mrs McMillan's scan he had it clearly in his mind at least that Ms Gibbs was available to undertake further evaluation.

59. Dr Fernando also identified, although perhaps not in the explicit detail that Dr Allen would prefer to see, sufficient concern in his report to mean that "*something else*" should have been done with this mother and this foetus. Dr Fernando diagnosed the foetal head as being squashed, regardless of the intricacies of the measurements and he had diagnosed the caridothoracic ratio as being increased and asked for further evaluation.

60. In New Plymouth at the relevant time, the ultra-sonographer, Ms Gibbs, had a more specialised practice than the radiologist in terms of her concentration in ultrasound. Ms Gibson did not understand that to be disputed despite some suggestion to Dr Smith in cross-examination that it was not appropriate for Dr Fernando to refer Mrs McMillan to an ultra-sonographer. Certainly, for those who were practising in New Plymouth at that time, that was an appropriate thing to do.

61. While Dr Fernando accepted that he did not diagnose the oligohydramnios and that he reported the kidneys and bladder as normal when there were not images to support that, he also produced a report that was not a standard normal report and in his mind at that time he understood that there would be a process followed as a result of his report, which subsequently was not.

62. It was Dr Smith's clear evidence that he would have expected a re-evaluation to have taken place within the next week or two. Ms Gibson also referred to Dr Allen being an extremely well-qualified sub-specialist and as having been required to undertake the difficult task of taking himself back five years and giving evidence as to what practice would have been like for general radiologist at that time. Ms Gibson asked the Tribunal to bear in mind the importance of Dr Allen's evidence that oligohydramnios and the combination of abnormalities present in Baby McMillan were rare, something a general radiologist was likely to see approximately once in four or five years.

63. Dr Fernando accepted that he had made an error and Ms Gibson also submitted that it is not appropriate to make assessment of Dr Fernando's fitness to practice in terms of Dr Allen's evidence.

64. In mitigation, Ms Gibson submitted that Dr Fernando should be given credit for entering a plea of guilty to the charge as soon as it was reasonably practicable. This is acknowledged by the Director of Proceedings. Further, Dr Fernando did not seek name suppression and he has been open about the error he made and his acceptance of it.

65. Turning to the single consultation that is the subject matter of the charge, Ms Gibson submitted that it is important to note the following facts:

(i) Dr Fernando saw Mrs McMillan once, for her 20 week routine screening scan. It was not a diagnostic scan, but a screening scan.

(ii) The Tribunal has before it the letter from Dr Aitken, Paediatrician, and the attached minute. It also heard from Dr Smith. It was clear that obstetricians and radiologists had an agreement that abnormal foetuses would be referred for scanning to Andrea Gibb, (ultra sonographer) in conjunction with Dr Aitken. This was the understanding between the obstetricians and radiologists in New Plymouth and was Dr Fernando's understanding when he made this referral. Mrs McMillan's obstetrician was at that meeting.

(iii) With that background, it was reasonable for Dr Fernando to make the referral in the way that he did, when he suggested that a further evaluation be obtained from the ultrasonographer.

(iv) As can be seen from the report, Dr Fernando diagnosed the following:

(a) That assessment of foetal morphology was suboptimal partly due to maternal build.

(b) That the cardiothoracic ratio appeared increased.

(c) That the measurements were at the lower limit of normal range for the state of maturity.

(d) That the baby's head was dolichocephalic.

(v) There is a clear request for an assessment by the ultra sonographer. Unfortunately this was never undertaken.

66. Ms Gibson submitted a number of references from Dr Fernando's colleagues, all of whom attest to his being an honest and reliable practitioner whose reporting is of a high standard. Fulford Radiology, where Dr Fernando practises, has accreditation for both radiology and ultrasound and that requires internationally recognised standards in the delivering of imaging services. Regular reviews are performed by IANZ staff and as of the last review, Fulford Radiology was in complete compliance with all of the requirements for accreditation. Dr

Fernando has not been involved in any other disciplinary proceedings and has not appeared before any other disciplinary body in the course of his professional career.

**Legal Assessor's Directions**

67. Mr Corkill gave the Tribunal a standard direction as to how to approach its task. First, he said, the Tribunal must determine the facts of the case, and in this case much of the factual material placed before the Tribunal is not the subject of dispute. Secondly, the Tribunal must apply the established facts to the charge. Thirdly, the Tribunal must decide if the threshold for discipline has been made out.

68. Mr Corkill referred to two relevant District Court cases; in addition to *B*, (cited above):

(a) *CAC v Mantell* (Auckland District Court, NP 4533/98, 7/5/99, Doogue DCJ) in which the Court stated:

"*In my opinion, when the legislature amended what was s109(1)(c) it did so with the objective in view of strengthening the links between the disciplinary process and the main object of the Act [s.3]...*

*The amendment to s109(1)(c) requires that in order to qualify as a disciplinary offence, the conduct must not only be conduct unbecoming, but it must be such as to put in issue the practitioners fitness to practise medicine. The words used by the legislature plainly to add an element that was not there previously. The charge will not be made out without proof that the conduct adversely reflects on the practitioners fitness to practise medicine...*

*It does not require the prosecution to establish that the conduct establishes that the practitioner is unfit to practise medicine. The focus of the inquiry 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...*

*I conclude that the prosecution in a charge of conduct unbecoming is not required to establish that the practitioner is actually unfit to practise."*

(b) *W v CAC* (Wellington District Court, CMA 182/98, 5/5/99, Thompson DCJ). In that case the Court said:

*"It is to be borne in mind that what the Tribunal is to assess is whether the circumstances of the offence "reflect adversely" on fitness to practise. That is a phrase permitting of a scale of seriousness. At one end the reflection may be*

> *so adverse as to lead to a view that the practitioner should not practise at all. At the other end a relatively minor indiscretion may call of no more than an expression of disapproval by censure or by an order for costs.*"

69. The next topic addressed by Mr Corkill was the standard to be applied and his advice was that the standard against which Dr Fernando is to be judged is that of a registered medical practitioner holding a current practising certificate and vocationally registered in radiology.

70. Mr Corkill also emphasised the point emerging from ***B's*** case about hindsight. As was made clear in that case, the Tribunal must bear in mind that it is required to exercise its judgment in respect of events that occurred in November 1997. As was made clear in ***B*** - "*to require the wisdom available with hindsight would impose a standard which it is unfair to impose"*. "*So in this case"*, said Mr Corkill "*for example, you can't judge the conduct having regard to the tragic outcome. Outcome is not an aspect of the charge. [The Tribunal has] to assess Dr Fernando's actions in light of the information and context in which he was operating as at 13 November 1997. The assessment is on the basis of the system and context then in place, and the reasonable expectations that Dr Fernando could have had as to how his report would be received given his place in the system. Of course, the assessment is on the basis of the 1997 standards.*"

71. Mr Corkill also discussed the role of the expert witness and made the point that while an expert witness may express a view as to the "*ultimate issue*" to be determined by the Tribunal, the expert is not permitted to usurp the Tribunal's decision-making function. Equally, the Tribunal may not substitute its own views, however expert those views might be, for the views of any expert called in the case; *Lake v The Medical Council* (unreported, Auckland HC 123/96, 23/1/98, per Smellie J).

72. However, if the Tribunal accepts the evidence given by Dr Allen, but reaches the conclusion that the level of care indicated by such evidence falls below what the protection of the public and the maintenance of standards within the profession require, then the Tribunal would be permitted to reach that conclusion as a legitimate aspect of its statutory duty.

73. Mr Corkill referred to an English case involving medical negligence; *Loveday v Renton* [1990] (1 Med LR 117, at 125, per Stewart-Smith LJ), as providing a useful template for the Tribunal to have in mind when evaluating expert opinions given to it. In that case the Court held:

> "*The mere expression of opinion or belief by a witness, however eminent, that the vaccine can or cannot cause brain damage does not suffice. The Court has to evaluate the witness and the soundness of his opinions. Most importantly this involves an examination of the reasons given for his opinions and the extent to which they are supported by the evidence. The Judge also has to decide what weight to attach to a witness's opinion by examining the internal consistency and logic of his evidence; the care with which he has considered the subject and presented his evidence; his precision and accuracy of thought as demonstrated by his answer; how he responds to searching and informed cross examination, and in particular the extent to which a witness faces up to and accepts the logic of a proposition put in cross-examination or is prepared to concede points that are seen to be correct; the extent to which a witness has conceived an opinion and is reluctant to re-examine it in the light of later evidence, or demonstrates a flexibility of mind which may involve changing or modifying opinions previously held; whether or not a witness is biased or lacks independence.*"

74. Finally, Mr Corkill referred to the Tribunal's Minute dated 4 July 2002 in which the Tribunal stated:

> "*… The Tribunal confirms that following the presentation of the agreed summary of facts and counsels' submissions, it was not satisfied that the charge was established. The Tribunal came to the view that the terms of s109 are very clear; notwithstanding that a practitioner may plead guilty to the charge, and any agreement between counsel, the Tribunal must be satisfied that the practitioner is guilty of one of the professional disciplinary offences listed therein. To adopt any other procedure, or to circumvent the requirements of s109 or any other relevant statutory provision, would be unlawful.*"

75. It was Mr Corkill's advice that Dr Fernando's plea of guilty must be considered in light of the Tribunal's statement of the legal position under s109. Dr Fernando's concession does not relieve the Tribunal of its responsibility to evaluate all the evidence, written and viva voce, and to determine for itself whether the elements of the charge are made out.

**The standard of proof**

76. The standard of proof is the civil standard, the balance of probabilities. The standard of proof will vary according to the gravity of the allegations founding the charge, and the standard of proof may vary within a single case. All 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.

**The burden of proof**

77. The burden of proof is borne by the Director of Proceedings.

**The decision**

78. The Tribunal has carefully considered all of the relevant legal and factual issues that have been placed before it, counsels' submissions and Mr Corkill's Direction and all of the evidence presented to it. It has also taken into account Dr Fernando's plea of guilty to the charge, and the matters submitted in mitigation. Having carefully considered, and indeed reconsidered, all of these matters the Tribunal is satisfied that, while the factual basis of the charge (as particularised) is established, the Tribunal is not satisfied that (separately or cumulatively) Dr Fernando is guilty of conduct unbecoming and that reflects adversely on his fitness to practise medicine.

**Reasons for decision**

79. The Tribunal acknowledges that its decision is extremely unusual in the circumstances. However it is well-established that it is the Tribunal's responsibility to determine both that the factual basis of the charge is established **and** that the facts established constitute a professional disciplinary offence. In this case, the Tribunal is satisfied that they do not.

80. The Tribunal is satisfied that in carrying out Mrs McMillan's ultrasound examination and reporting to Dr Brooks, Dr Fernando did make errors, and that his conduct in providing a report to Dr Brooks that was deficient was conduct which departs from acceptable professional standards. However, it is equally the case that any such departure must be "*significant enough*" to attract sanction for the purposes of protecting the public. A

finding of conduct unbecoming is not required in every case where error is shown. As was so succinctly stated by the Court in ***B***, "*the threshold is inevitably one of degree*".

81. The Tribunal is also satisfied that Dr Fernando's report was not a "*normal*" report. That was accepted by the Director and, most significantly, by both Dr Allen, who was in effect the only expert witness, and also by Dr Smith, who gave evidence in support of Dr Fernando. It was suggested to both Dr Allen and Dr Smith that Dr Fernando's report could be described as "*guarded*", and both witnesses agreed with that description.

82. The Tribunal is satisfied that the report was sufficient to have put Mrs McMillan's obstetrician on notice that further evaluation was required and that further evaluation should have been undertaken by Ms Gibbs in accordance with the arrangement recorded in the Minute referred to at paragraphs 39-41 above. The Tribunal is satisfied that:

(a) The arrangement for the referral to Ms Gibb whenever something was seen that was difficult to see or thought to be abnormal was 'flagged' on an ultrasound report was sufficiently certain that it was reasonable for Dr Fernando to have acted in reliance on it; and

(b) Ms Gibb was the appropriate person (at that time) to have carried out the 'further evaluation'.

83. Dr Fernando's report recorded that the assessment of foetal morphology was suboptimal; the cardiothoracic ratio appeared to be increased and he "*would value further evaluation by Andrea Gibb*"; the foetal head was dolichocephalic; and the foetal measurements were at the lower limit of the normal range of the stated maturity. The Tribunal is satisfied that all of these features of Dr Fernando's report were sufficient to have alerted Mrs McMillan's obstetrician to the need for a second ultrasound examination. Further, in the context of the arrangements that were discussed at the meeting between O&G specialists (recorded in the Minute) and in the context of the system and arrangements in place in New Plymouth at that time, it was reasonable for Dr Fernando to assume that a further scan would be undertaken by Andrea Gibb within the next week or two.

84. Notwithstanding that Dr Fernando incorrectly reported that the intracranial structures, abdomen, abdominal wall, kidneys and bladder were all normal, and, more significantly, that the liquor volume was normal, any further evaluation undertaken by Ms Gibbs would not have been limited only to those features of the foetal morphology that Dr Fernando raised concerns about. Dr Allen confirmed that had Ms Gibbs undertaken a second scan she would have redone the entire scan. He told the Tribunal "*that would have been the normal approach for her to have taken*".

85. Dr Allen also accepted that the methods of reporting between doctors may be formal or informal and the way in which reports are made between small communities of practitioners may well differ to the way in which reports are made in a larger community. Dr Allen accepted "*that does happen, whether its good or bad its not my place to say*".

86. Taking into account all of this evidence, the Tribunal was satisfied that although Dr Fernando's 'referral' (i.e. that he would value further evaluation by Ms Gibbs) was for assessment of the cardiothoracic ratio specifically and not in relation to the volume of liquor or other aspects of foetal anatomy, had that further evaluation been carried out it would not have been limited only to those aspects of Dr Fernando's report that he highlighted and given the "*guarded*" nature of his report, it was reasonable for Dr Fernando to have assumed that had any further evaluation been carried out it would have involved the entire routine 17-20 week scan being repeated and the baby re-measured and re-assessed.

87. The Tribunal gains support for this determination from Dr Smith's evidence also. In response to a question from Dr Stewart as to what he would have done had Dr Fernando's report come before him in 1997, he responded that he "*would have done as requested in the report and sent [Mrs McMillan] off to Andrea Gibb*".

88. Dr Stewart also asked Dr Smith, "*and you wouldn't have just sat on that report and done nothing?*" Dr Smith responded, "*no, definitely not*". While evidence as to what another practitioner might have done (with the benefit of hindsight) is not determinative, it is evidence that goes to the degree to which the report fell short of acceptable standards in terms of the information provided and what action it may (or should) have initiated on the

part of the recipient. On that point, there was no disagreement between either of the witnesses, both of them agreed that the report was sufficiently abnormal to have warranted 'further evaluation', and they also agreed what that would have entailed.

89. The Tribunal also accepts the Director's submissions that the conduct of any other practitioner involved in Mrs McMillan's care is irrelevant for present purposes. The Tribunal must focus solely on Dr Fernando's conduct. However, it is also relevant that the Tribunal must determine not only if Dr Fernando's conduct amounts to conduct unbecoming a medical practitioner, it also must be satisfied that his conduct 'raises issues' about his fitness to practise medicine.

90. The Tribunal's task is to determine not merely if an error was made, or if Dr Fernando's conduct departed from acceptable professional standards (both of which it is satisfied are established), it must determine if that departure is "*significant enough*" to attract sanction for the purposes of protecting the public. In making that latter assessment, the Tribunal must consider Dr Fernando's conduct in its totality, that is, in the context of the system and professional context in which he was operating, any particular features, arrangements, expectations or practices that were relevant to him and to his practice, and to his role in Mrs McMillan's care and the system for ensuring that she received antenatal appropriate care and treatment.

91. Taking all of these matters into account, the Tribunal does not accept that the fact that Dr Fernando raised concerns about the 'suboptimal' nature of the scanned images but was unable to correctly identify a cause, or that he indicated that the cardiothoracic ratio was low and he would value further evaluation by Ms Gibb but incorrectly reported the normalcy of other foetal morphology, and that his referral for further evaluation might have been more explicit, undermines the overall, and possibly more significant, "*abnormal*" or "*guarded*" nature of his report.

92. The Tribunal does not accept the Director's submission that Dr Fernando's "*failings cannot be alleviated by his recommendation for a second opinion.*" It is the Tribunal's view that the report must be considered in its entirety and the recommendation for 'further

evaluation' is as salient as any other part of it; the report should not be dealt with in any selective fashion, with an emphasis on some aspects and a discounting of others.

93. The Tribunal is satisfied, on the basis of the evidence given by Dr Allen and Smith, that had Mrs McMillan been sent to Ms Gibb for further evaluation as Dr Fernando requested in terms of the arrangements that were in place in New Plymouth at the time, Ms Gibb would have redone the entire scan. While this does not absolve Dr Fernando in terms of his conduct, it is a factor that is relevant to the Tribunal's consideration of the degree to which Dr Fernando's conduct departed from acceptable professional standards. As a matter of fact, the Tribunal is satisfied that Dr Fernando's report was sufficient to indicate the need for further evaluation, and that finding is consistent with evidence given by Drs Allen and Smith.

94. For the reasons set out above, the Tribunal is not satisfied that Dr Fernando's departure from acceptable professional standards warrants the sanction of an adverse finding, and therefore the threshold for conduct unbecoming is not met.

95. Although not part of the charge, it should also be recorded that there was evidence given by Dr Smith that Dr Fernando could not personally have sent Mrs McMillan to Ms Gibb for another scan. Funding arrangements precluded such action on Dr Fernando's part. It is also relevant that, in terms of his role in Mrs McMillan's care, and his place in the system generally, there is no suggestion or allegation that Dr Fernando should have checked to see if the 'further evaluation' was done.

96. For the sake of completeness, the Tribunal records that in terms of the so-called 'rider' to the charge of conduct unbecoming, it is satisfied that, even if it had determined that the threshold for conduct unbecoming was met, it does not consider that Dr Fernando's conduct reflects adversely on his fitness to practise medicine. This finding is made for the reasons already canvassed and, in relation to the 'rider', the Tribunal has also taken into account the following:

- the apparently isolated nature of Dr Fernando's error,

- the several references provided to the Tribunal that attest to the generally reliable nature of his reporting and the high regard in which he is held by other practitioners who have worked closely with him for many years,

- the fact that the error giving rise to the charge occurred five years ago and that he no longer undertakes antenatal ultrasound scans.

97. Taking all of these factors into account, the Tribunal is satisfied that Dr Fernando's conduct does not put in issue his fitness to practise (either currently or in 1997) or disclose any risk to the health and safety of members of the public. In relation to his fitness to practise generally, the Tribunal has also taken into account his willingness to admit to error and to accept responsibility for his conduct.

98. The Tribunal is therefore not satisfied either that the threshold for conduct unbecoming, or the so called "*rider*" to the charge, is established.

99. The Tribunal's decision is unanimous in all respects.

100. In light of the Tribunal's finding, there are no issues as to costs or penalty.

**DATED** at Wellington this 19th day of November 2002

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W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal