Medical Practitioners Disciplinary Tribunal

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NOTE:

NAME OF COMPLAINANTS

AND ANY IDENTIFYING DETAILS

NOT FOR PUBLICATION

DECISION NO: 113/99/53C

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by a Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against **LYNDA MEY BATCHELER** medical practitioner of Auckland

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Mrs J Courtney, Dr R S J Gellatly, Dr J W Gleisner,

Dr A D Stewart (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Auckland on Wednesday 1 and Thursday 2 March 2000 and Thursday 9 March 2000

APPEARANCES: Mr M F McClelland and Ms J Elliot for a Complaints Assessment Committee ("the CAC").

Mr A J Knowsley for Dr L M Batcheler.

1. THE CHARGE:

THE Complaints Assessment Committee pursuant to section 93(1)(b) of the Medical Practitioners Act 1995 ("the Act") charges that Dr Lynda Mey Batcheler, Registered Medical Practitioner of Auckland;

In regard to her management and treatment of A during her pregnancy in the period to 17 April 1996:

1. Failed to maintain records at the standard expected of a specialist obstetrician of her consultations with A during the pregnancy;
2. Failed to take adequate account of Mrs A's expressed concerns about the progression of the pregnancy to the extent that Mrs A did not feel listened to and lost confidence in Dr Batcheler;
3. When told by Mrs A at her appointment on 10 or 12 April 1996 [there being a dispute about the date] that there had been a decrease, change or alteration in the baby's movements, failed to take appropriate clinical action;

4. Failed to adequately inform Mrs A as to the intended role of Midwife Harrison with the result that Mrs A believed that Midwife Harrison had a shared care role in relation to ante-natal care whereas Midwife Harrison understood from Dr Batcheler that her role was in regard to delivery and post-natal care;

5. On 16 April 1996 when advised by Midwife Harrison that Mrs A had telephoned her expressing concerns about the changes in the baby's movements failed to take appropriate clinical action and failed to ensure appropriate systems were in place to manage the concern expressed by Mrs A in her telephone call

being conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioner's fitness to practise medicine.

2. FACTUAL BACKGROUND:

2.1 **THE** charge laid against Dr Batcheler arises out of her care of Mrs A during the period of her pregnancy with her daughter, B. B was stillborn on 18 April 1996. At the time of her delivery she was a full-term baby and no cause for her demise *in utero* has been identified. Dr Batcheler had previously provided ante-natal care to Mrs A during her first pregnancy in 1991 -1992 and had delivered Mr and Mrs A's son, C, in April 1992.

2.2 **FOLLOWING** C's birth, Mrs A suffered a severe case of post-natal depression. Throughout the period 1992 - 1996, Mrs A received treatment for her depression. In the main, this treatment was provided by xx and Dr D, a Consultant Psychiatrist. In the course of her treatment for depression, Mrs A was prescribed anti-depressant medications

including Prothiaden, Lithium, and Prozac. She also received training in relaxation and stress management.

2.3 **A** claim for medical misadventure on the grounds of an alleged late diagnosis of post-natal depression was lodged by Mr and Mrs A in 1994. This claim was declined. At the time of B's conception in 1995 Mrs A was taking Prozac (60mg) and Prothiaden (50mg).

2.4 **IN** both 1992 and 1995, Mrs A suffered miscarriages and for the first 12 weeks of her pregnancy she received ante-natal care at the xx Clinic. The basis for this referral by Dr Batcheler was to enable Mrs A to receive extra support and reassurance in the early stages of her pregnancy, rather than because she was a "high risk" patient, i.e. at risk of losing her baby. The clinical standard of "high risk" for referral to the Clinic was apparently three miscarriages.

2.5 **MRS** A also continued to receive care and treatment at xx for her depression and anxiety in the early stages of her pregnancy. At 13 weeks into her pregnancy the care provided by the xx Clinic came to an end and Dr Batcheler referred Mrs A to the xx Health Service ("xxHS") attached to xx Hospital ("xxH"). Mrs A's care under this service was managed by Dr E, a Liaison Psychiatrist and the leader of the xxHS team.

2.6 **THE** xxHS team were to monitor Mrs A's mental health throughout her pregnancy and arrangements were also to be put in place for Mrs A to receive post-natal care and support from the xxHS, if necessary.

2.7 **THROUGHOUT** the early stages of her pregnancy Mrs A was concerned about her continuing need for medication to manage her depression and anxiety, and she attempted to reduce her medication, and at times, to discontinue taking any medication at all. However, approximately 26 weeks into her pregnancy Mrs A reported a recurrence of her depression and anxiety. This manifested as insomnia, trembling and shakiness. Mrs A contacted Dr E urgently and was advised to recommence her medications, Prothiaden and Prozac.

2.8 **SHE** was unable to tolerate this medication, and instead resumed taking diazepam (Valium), which had been prescribed some time previously, and found that this was the only medication she could cope with. When she returned from holiday she consulted Dr E who expressed concerns about the taking of diazepam in pregnancy. She prescribed Melleril (thioridazine) as an alternative.

2.9 **UNFORTUNATELY,** Mrs A suffered an adverse reaction to this medication. Late in the evening of 22 February 1996 Mr A contacted Dr Batcheler who arranged for Mrs A's emergency admission to xxH. Dr Batcheler attended to Mrs A immediately after being advised of her arrival at xxH. Mrs A was discharged from the hospital within 24 hours and recommenced taking diazepam at night, but intermittently.

2.10 **AROUND** this time, Dr E resigned from her position with the xx Health Team and Mrs A lost her support. She reports being very distressed at having to 'start from scratch' with a new psychiatrist. On 17/1/96, Dr Batcheler recorded in Mrs A's record "*…Anxious re P/N. time (E leaving)*." It is clear that Mrs A felt the loss of Dr E keenly, especially

because she also apparently began to have concerns about the care being provided to her by Dr Batcheler.

2.11 **MRS** A's concerns in this regard centre upon her feeling that her appointments with Dr Batcheler were 'rushed' and that she did not seem to be having the same number of tests and scans that she had received in her first pregnancy.

2.12 **MRS** A asked Dr Batcheler for the name of a midwife to assist her. There is a great deal of conflict in the evidence as to the reason for this request and the nature of the role the midwife was to fulfil. Mrs A is adamant that she wanted the midwife to provide her with a 'second opinion' and additional care and support during the antenatal period because of her concerns about the level of care and attention she was receiving from Dr Batcheler.

2.13 **DR** Batcheler is equally adamant that she believed that the midwife was to be sought because Mrs A wanted to be sure that she would be attended throughout her labour by the same midwife, and the midwife would be available to Mrs A in the post-natal period. Dr Batcheler's understanding of the role of the midwife appears to have been shared by Dr E and the midwife, Mrs Harrison.

2.14 **IN** any event, for a number of reasons, Midwife Harrison met with Mrs A on only one occasion prior to the events of 16 and 17 April 1996.

2.15 **FROM** approximately also 24 - 26 week into her pregnancy Mrs A says she reported to Dr Batcheler that her baby's movements appeared to be much quieter than those she had

felt in her first pregnancy. It is important to record for present purposes that the reports of "weaker" or "quieter" movements related to the *quality* of the movements, rather than to their *frequency*. Throughout her pregnancy Mrs A monitored the quantity, or frequency, of baby's movements each morning. Up to and including the morning of 16 April 1996 Mrs A was able to report feeling at least 10 fetal movements every day.

2.16 **ON** each visit, Dr Batcheler examined Mrs A and recorded standard ante-natal maternal and fetal recordings in Mrs A's medical record. Most relevantly, Dr Batcheler records feeling movements, hearing the fetal heartbeat, and that the baby's size was normal for its gestational dates. She has also recorded that Mrs A's blood pressure and other recordings were 'normal'. In all, Mrs A visited Dr Batcheler on 17 occasions. Mrs A also had telephone consultations with Dr Batcheler on 5 or 6 occasions.

2.17 **ON** one occasion, Mr A visited Dr Batcheler on his own volition and 'on the off chance' that she would see him and she did. Mr and Mrs A also have a general practitioner, Dr F. Mrs A stated that she has been seeing him since 1992, and that she continues to have an excellent relationship with him. However, Dr F does not undertake any obstetric care for his patients.

2.18 **ON** 17 April 1996, Mrs A was visited by Midwife Harrison. Mrs A's account of the events leading up to this visit, and the reason for it, differs from that given by Midwife Harrison and Dr Batcheler. Those differences will be dealt with later in this Decision. In any event, at this visit Midwife Harrison was unable to hear the fetal heartbeat, and she referred Mrs A to xxH for a CTG immediately.

2.19 **THE** CTG failed to register a heartbeat. An ultrasound was then undertaken and it was apparent that baby had died *in utero*. Mrs A was advised of this, and Mr A and Dr Batcheler were immediately summoned. Dr Batcheler confirmed that the baby was dead, and arranged for delivery of her the next day.

2.20 **THE** post-mortem examination failed to reveal a cause of death. Subsequently, the case was reviewed at a xxH perinatal mortality review committee meeting, and the Report, apparently completed after that meeting, records that the death is "*unexplained" … No avoidable factor identified. Patient not conversant with possible significance of reduced fetal mvts.*" Receipt of this report caused Mr and Mrs A a great deal of distress. They believe that the report is incorrect, that they did understand the significance of "reduced" fetal movements, and that they reported same to Dr Batcheler.

2.21 **THE** Report was later amended following discussions between Dr G, a barrister instructed by Mr and Mrs A, and xxH. The Report was amended to read:

"Patient aware of significance of reduced fetal movements and reported decline in the quality (strength and speed) of fetal movements over the week prior to the IUD."

2.22 **FOLLOWING** receipt of this Report, Mr and Mrs A lodged the complaint giving rise to the Charge laid against Dr Batcheler.

3. EVIDENCE FOR THE CAC:

3.1 **THE** complainants, Mr and Mrs A, Dr Jeremy Tuohy and Midwife Harrison gave evidence for the CAC. The factual basis of Mr and Mrs A's evidence is outlined above. Both of them also gave evidence as to the circumstances and contextual matrix surrounding

the subject facts and events, and they both made a number of allegations regarding Dr Batcheler's care of Mrs A.

3.2 **DR** Tuohy, a consultant obstetrician and gynaecologist of Wellington, gave expert evidence in relation to each of the particulars of the charge. Midwife Harrison gave evidence as to what she understood to be the role she was to fulfil in the context of Mrs A's ante-natal and post-natal care and delivery.

Mrs A:

3.3 **MRS** A gave evidence of her early classification as a "high risk" obstetrical patient. The most relevant aspect of her evidence in relation to the Charge as framed relates to the period of her pregnancy post-approximately 26 weeks. For the first trimester of her pregnancy, Dr Batcheler referred Mrs A to the xx Clinic for ante-natal care. The Clinic was solely responsible for her care and Mrs A's first visit to Dr Batcheler was at 13 weeks. The reason for this referral has already been referred to in paragraph 2.9 above.

3.4 **THE** first trimester of her pregnancy appears to have proceeded uneventfully and Mrs A had a network of care in place to provide her with the clinical care, reassurance and support she required. Her early pregnancy blood tests included a test for lupus anticoagulant antibodies which tested low level positive. When repeated the test was negative.

3.5 **SIMILARLY**, there appears to have been nothing remarkable about her pregnancy during the second trimester. She had a scan at 20 weeks which showed her baby to be

developing normally and all of the recordings made and recorded by Dr Batcheler during ante-natal visits disclose nothing untoward.

3.6 **ON** the basis of Mrs A's evidence, matters took a turn for the worse from approximately 26 weeks into her pregnancy. It was at this time that she suffered a recurrence of her depressive/anxiety condition, and had to resume taking medication. She also of course suffered the adverse reaction to Melleril necessitating her emergency admission to hospital, and shortly afterwards lost Dr E when she resigned from the xxH xx Health team.

3.7 **BY** around 28 weeks Mrs A says that she was becoming increasingly concerned about the care she was receiving from Dr Batcheler. She was continuing to take diazepam intermittently, and her evidence was that it was at approximately this time that she was becoming concerned about her health, and the health of her baby:

"I continued to feel that she [Dr Batcheler] was always in a hurry, rushing me through, and not listening to my concerns. I expressed concerns about the baby's movements repeatedly and consistently however as time went by I found it increasingly distressing to try and emphasise my instincts to Dr Batcheler that all was not right. … Further I felt uncomfortable about telling Dr Batcheler how she should be doing her job. While I felt Dr Batcheler was not giving me the appropriate care in all the circumstances I was in such a distressed state that I was floundering as what I could do to resolve the situation."

3.8 **MRS** A's evidence was that she asked for a midwife because she felt she needed a second opinion and to provide additional support because of her perception that she was not receiving a satisfactory level of care from Dr Batcheler. Unfortunately, Midwife Harrison was able to visit her only once, at 30 weeks, and was unable to keep any appointments made after that time. Dr Batcheler told Mrs A that the reason for her feeling that this baby's movements were quieter and slower than she remembered from her first

pregnancy might have been the diazepam. Also, the baby's placenta was anteriorly situated, and this may also have affected her ability to feel movements.

3.9 **DR** Batcheler has recorded feeling fetal movements and hearing the fetal heartbeats on each of Mrs A's ante-natal visits. The baby's growth was consistent and normal for dates. At around 37 weeks Mrs A states that she reiterated her concerns about the baby's movements and had hoped for additional tests to check if all was well. No additional tests were ordered by Dr Batcheler, beyond routine ante-natal checks.

3.10 **MRS** A was also uncomfortable and reported quite regular and strong contractions. Dr Batcheler reassured Mr and Mrs A that these contractions were normal Braxton-Hicks 'practising' contractions, and that all appeared well. There was an issue between the evidence given by Mr and Mrs A and Dr Batcheler as to the date of the last ante-natal visit at approximately 38 ½ weeks. Whether the visit was on the 10th or 12th of April, Mrs A says that she reported hard, regular contractions, and that the baby seemed to be moving very slowly. She stated that on this occasion she referred to the movements as "*flutters*", to alert Dr Batcheler to the fact that all was not well.

3.11 **ON** 16 April 1996, Mrs A was again able to feel and to count approximately 10 fetal movements, as usual. However by later that day, baby had apparently stopped moving. Mrs A thought that she was sleeping. It did not occur to her that her baby could have died.

3.12 **SHE** had been expecting Midwife Harrison to visit her. An appointment had been made for 15 April, but Midwife Harrison had again telephoned to change the appointment to the next day. When she did not arrive to keep the appointment, Mrs A telephoned her. There is also some dispute as to whether she telephoned Midwife Harrison on her mobile or by landline. In light of telephone records produced at the hearing, it is likely it was the latter. In any event, Midwife Harrison was at xxH, apparently attending a delivery with Dr Batcheler. Mrs A says that she told Midwife Harrison that she was not feeling regular movements and that she was told to stay at home and wait, and that either Midwife Harrison or Dr Batcheler would attend to her when they were free.

3.13 **MIDWIFE** Harrison told Mrs A that she would see her the next morning. Neither Dr Batcheler or Midwife Harrison returned her call, and Mrs A went to a friend's house "*to take my mind off my worries. I believed the baby was sleeping.*" Mrs A felt no movements overnight and by the morning of the 17th "*had grave concerns about my baby as there had been no movements at all since the previous afternoon. I always counted ten movements every morning and this was the first morning I could not count them*." Mrs A decided to stay in bed and wait for Midwife Harrison to arrive. Mr A went to work as normal.

3.14 **BY** 10.30 am Midwife Harrison had not arrived and Mrs A telephoned her. Midwife Harrison arranged to visit that afternoon. On her arrival, Mrs A said that she asked her about the diazepam and whether or not, and how, it could affect baby. Midwife Harrison told Mrs A that she had no real concerns as she had had another patient who had taken diazepam throughout her pregnancy with no problems.

3.15 **AFTER** some discussion between them, Mrs A thought that Midwife Harrison was packing to leave. She was upset that Midwife Harrison did not appear to be intending to examine her, and she requested her to do so. Midwife Harrison disputed this evidence and said that it had always been her intention to examine Mrs A, and that she had brought her Sonacaid with her for that purpose. Midwife Harrison examined Mrs A and was unable to hear a heartbeat.

3.16 **MIDWIFE** Harrison initially reassured Mrs A by telling her that the batteries were flat in the Sonacaid, and she arranged for Mrs A to go to xxH for a CTG. The subsequent events have already been referred to.

Mr A:

3.17 **MR** A essentially corroborated the evidence given by his wife. He also gave evidence of his independent visit to Dr Batcheler, and of the concerns he expressed to her. He suggested that he may have 'sugar-coated' his expression of concern, but in any event he left that visit feeling reassured that he had made plain the nature of his and his wife's concerns regarding the standard of care his wife was receiving from Dr Batcheler.

3.18 **HE** also gave evidence of his concerns about his wife in the last week or two of her pregnancy, saying "*And yes, I was doing my utmost to try to keep her as Lynda had told me, to just keep her quiet, keep her resting, the baby was expected early. … In that last week I was bending over backwards to keep her calm, that's why we didn't panic, that's why we didn't start jumping up and down because we were waiting*."

3.19 **HE** also gave evidence of having *"no doubts that nothing would be wrong with the baby"*. On the 17th of April he was *"… quite settled in my mind that the baby was just tired, had very little room, and was probably sleeping*." He was clear that he thought that "*there were some fundamental points that we were trying to express that Lynda missed."*

3.20 **SOME** ten months after the death of their daughter Mr A himself suffered a nervous breakdown and was unable to return to work until December 1997. He was under the care of a psychiatrist for some time.

Dr Tuohy:

3.21 **DR** Tuohy is a Consultant Obstetrician and a Senior Clinician in Maternal and Fetal Medicine and the Senior Lecturer at the Department of Obstetrics and Gynaecology at Wellington Hospital. He is in charge of a Recurrent Miscarriage Clinic and he is responsible for the "high risk" pregnancies at Wellington Hospital. He is also the convenor of the Perinatal Mortality Meeting in Wellington.

3.22 **IN** giving his evidence Dr Tuohy referred to the factual matters already recorded, and commented also regarding two further matters. The first that Mrs A was obviously suffering from significant depression at the time of the pregnancy which depression was primarily manifest as anxiety. He referred to the difficulty of balancing the need to assess the pregnancy and react to any adverse events, and to provide reassurance that everything is progressing well.

3.23 **IN** this regard, he referred to the *"cascade of intervention*" which may be caused if concerns of the mother or baby lead to an intervention which is itself causal of an event causing concern and reaction.

3.24 **SECONDLY**, much of his evidence concerned the importance, or significance, of fetal movements as an indicator of fetal well-being. It was Dr Tuohy's evidence that a decrease in fetal movement is a common complaint prior to fetal demise. A sudden decrease indicates a need to perform tests to ascertain fetal well-being. If fetal welfare cannot be ascertained, serious consideration should be given to delivery of the baby.

3.25 **FOR** this reason, routine assessment of fetal movements (by means of a 'kick chart' maintained by the mother) is suggested by many authors, however there is some dispute in the available literature as to the usefulness of monitoring fetal movements. Relevant in the present context, is that many women experience a big difference in fetal movements from pregnancy to pregnancy according to the position of the baby and the placenta and the activity of the woman. Many women will experience a decrease in fetal movements during a pregnancy. The vast majority of these women will have babies who are completely well.

3.26 **BECAUSE** of this great variation in movements for any particular pregnancy, the keeping of a 'kick chart' recording fetal movements is of limited value in terms of providing a reliable indication of fetal well-being. It was Dr Tuohy's evidence that:

"If a fetus has a slowly progressive hypoxia that will be demonstrated by a lack of growth, a decrease in the amniotic fluid, a decrease in the physical activity over time which can be detected by a fetal movement chart. … in a majority of women there is normal fluid, the fetus is well grown and there is a sudden cessation in fetal movements. And the fetus is moving well up to that time. I am not aware of any good studies which have documented changes in fetal behaviour immediately prior

to … fetal demise by fetal stillbirth. … [in the fetal 'kick chart'] I believe it states that if you do not feel any fetal movements at all for a day. That's one of the reasons perhaps why it is not particularly useful. If you have not felt any movements over the course of the day the fetus is usually dead."

3.27 **AS** a result, there is a very important difference between a relative lack of fetal movements over a pregnancy and a sudden lack of movement. "*The former will usually be interpreted as the level of activity detected during that pregnancy and will not usually be specifically recorded in the patient's notes."* Dr Tuohy went on to comment in detail in relation to each of the particulars of the charge, and this evidence is referred to later in this Decision.

3.28 **DR** Tuohy concluded by stating that he was "*unable to obtain a clear picture that Mrs A complained of a sudden alteration of fetal movements. It is clear that she felt the baby move less frequently from about 26 weeks, but I do not believe that has any relevance to the subsequent fetal demise. … In my opinion it is highly unlikely that any intervention at any stage would have altered the outcome."*

3.29 **IN** relation to the other factors present in Mrs A's pregnancy (her requirement for on-going medication; her referral to the xx Clinic; the low-level positive (subsequently negative) test for lupus anticoagulant; the adverse reaction to Melleril; an episode of bleeding; and a family history of blood clotting including the post-partum death of aunt of a pulmonary embolism), Dr Tuohy expressed his opinion that these revolved around Mrs A's health, "*far more I believe than the fetus' health."*

Midwife Harrison:

3.30 **MIDWIFE** Harrison gave evidence as to her understanding of the role she was to undertake in relation to Mrs A's antenatal, delivery and post-natal care, and the events of the 16th and 17th of April 1996.

3.31 **IT** was Midwife Harrison's evidence that her role was not a shared care role and that it was clear to her that Dr Batcheler was Mrs A's primary caregiver in relation to her pregnancy. Having initially been unable to act as midwife to Mrs A but becoming available due to other commitments resolving themselves, Midwife Harrison was asked by Dr Batcheler to attend Mrs A's labour and to see her a couple of times before the birth.

3.32 **MIDWIFE** Harrison understood that the principal purpose of these visits was to meet Mrs A, and 'introduce herself' to baby, so that Mrs A would have the reassurance of a familiar face when she presented in labour.

3.33 **SHE** also anticipated that she would follow up Mrs A in her post-partum period for as long as required. This understanding on the part of Midwife Harrison is consistent with Dr E's advice to Dr Batcheler in a letter dated 12 January 1996. Dr E advised Dr Batcheler that:

"She [Mrs A] is keen to develop a birth plan which will be done in partnership with xx, the Psychiatric Liaison Midwife. She has expressed a desire to find a midwife who will be able to remain with her throughout her labour, and I have suggested that she discuss that with you, as xx is not able to do this."

3.34 **ON** the basis of this understanding, Midwife Harrison anticipated that she would see Mrs A two or three times before she presented in labour; once to meet Mrs A (a 'social' rather

than 'clinical' meeting), and again at around 30-32 weeks, and finally, after Mrs A telephoned to make another appointment at around 38 weeks, to go over the labour and birth plan. This is her customary pattern of attendance in circumstances where another provider (such as a private specialist) is the primary caregiver.

3.35 **SHE** was aware that she had to cancel a number of appointments; some were not actually made but were tentative times only. She had mentioned this to Dr Batcheler and was assured that this was fine as she (Dr Batcheler) was doing Mrs A's clinical check-ups. Dr Batcheler had also commented to Midwife Harrison from time to time that Mrs A was doing well.

3.36 **IN** relation to the events of 16-17 April 1996, Midwife Harrison's evidence was that she recalls that during the call Mrs A mentioned that her baby's movements seemed slower. She remembers Mrs A telling her that she was taking Valium and she asked her if she had discussed this with Dr Batcheler. She confirmed that she had and Mrs A indicated to Midwife Harrison that Dr Batcheler had said that this might be slowing the baby down. She recalls that she told Mrs A that Dr Batcheler "*was around*" rather than that they were together.

3.37 **MIDWIFE** Harrison does not remember the exact details of the conversation but does recall being satisfied after she questioned Mrs A about the number of movements she had felt that morning. She also told Mrs A that she agreed with Dr Batcheler's advice that the Valium could be slowing the baby down. It was her understanding that Mrs A was telephoning her to make an appointment to go over her labour plan with her.

3.38 **SHE** recalls that the telephone conversation ended with the arrangement for a visit on the 17th made, but no time was specified. Midwife Harrison later told Dr Batcheler that Mrs A had telephoned and relayed details of the conversation to her. Dr Batcheler said that she had not heard from Mrs A, *"but not to worry as A always rang her with any concerns"*.

3.39 **THE** next day she went to visit Mrs A at about 2.00pm. Mrs A had telephoned her in the morning to enquire when she would be coming to visit. It was Midwife Harrison's evidence that she asked if this time would be all right, and was told that it was. Mrs A did not mention anything about the baby's movements in that call.

3.40 **ON** arrival, Midwife Harrison discussed the labour and pain relief choices, and other issues relating to the birth. After approximately 30 minutes of discussion, Midwife Harrison says that she told Mrs A to lie on her couch so that she could listen to the fetal heartbeat and palpate her abdomen. She was unable to detect a fetal heartbeat ("*due to static*") and suggested that Mrs A go to xxH maternal assessment unit for a CTG. Mrs A drove herself and Midwife Harrison followed in her car.

3.41 **MIDWIFE** Harrison carried out the CTG test, which failed to register a heartbeat. She then took Mrs A for an ultrasound scan and no heartbeat was seen. She told Mrs A that her baby was dead, and immediately contacted Dr Batcheler. In discussion after her arrival at the hospital, Dr Batcheler told Midwife Harrison that Mrs A had been concerned about the baby's movements at her last appointment, but that the baby was growing well

clinically, had a good liquor volume and she felt the baby moving well at the time of the visit.

4. EVIDENCE FOR THE RESPONDENT:

4.1 **THE** evidence for the respondent was given by Dr Batcheler; Dr Sylvia Rosevear, a Consultant Obstetrician and Gynaecologist of Auckland; Professor Peter Stone, Professor of Fetal Medicine and Clinical Director Maternal Fetal Medicine Service at National Womens Hospital in the Department of Obstetrics and Gynaecology at the University of Auckland; Ms Frances Geddes, Practice Manager of Auckland; and Dr Marian Carter, also a Consultant Obstetrician and Gynaecologist.

Dr Batcheler:

4.2 **IN** most respects, Dr Batcheler's evidence of the factual background to this complaint confirms that given by Mrs A. There were a number of matters of detail - dates and times for example, where differences arose, and several of these were the subject of a quite extensive examination and cross-examination. However, in the context of the most relevant issues, there was very little divergence.

4.3 **IT** was Dr Batcheler's evidence that, clinically, Mrs A's pregnancy was relatively straightforward. She had seen her several more times than she might see other patients, however she understood Mrs A's need for reassurance and support. She referred her to the xx Clinic and to the xx Health Service to ensure that she received all of the reassurance and support she needed.

4.4 **AT** no time was Dr Batcheler aware that either Mr or Mrs A had any concerns about the standard of care she was providing. She gave Mrs A a card which contained all of her contact details and advice to contact her partner, Dr Carter, if she was not available. She responded to every request made of her by Mrs A and generally considers that she went out of her way for her. Mrs A had 'extra' visits when she *"popped in because she was anxious and … [would say] can you have a listen and I was more than happy to do that*."

4.5 **DR** Batcheler rejected a suggestion made to her that Mrs A was *"a difficult patient"* saying that "*the word difficult is [not] appropriate, she was a patient who needed more time and reassurance than most. I understood and accepted that she needed more tender loving care."*

4.6 **DR** Batcheler also rejected suggestions that any part of Mrs A's record was created at any time other than contemporaneously with a consultation, and that there was anything untoward or sinister about differences between the record she maintained for herself and that given to Mrs A so that she could have a record of her pregnancy to keep. The purposes of the two records were different, and the record given to the patient was not intended to be merely a copy of her own record.

4.7 **DR** Batcheler stated that even with the benefit of hindsight her care of Mrs A was not something she looked back on and thought that there was something she should have done differently. She agreed that when she saw Mrs A on the 17th of April, she acknowledged that she wished she had done something else at the time of the last ante-natal visit, however

she "*didn't have the eyes of hindsight, I had the situation that I was presented with and I saw no reason to do any tests at that stage.*"

4.8 **DR** Batcheler stated that at no time was she made aware of any sudden or dramatic change in the baby's movements - "*this was a baby that was quiet, quiet, quiet.*"

4.9 **SHE** recalled Mrs A expressing concern about the baby's movements becoming slower at the time of her last ante-natal visit, "*but that it was not uncommon for [mothers] to say babies are slower in the last weeks of pregnancy. But if they still move as frequently that's what we go by*" and, on examination, she was satisfied that she felt good movements.

4.10 **FINALLY**, Dr Batcheler gave evidence of the perinatal mortality meeting and explained the educational purpose and function of the meeting. At the meeting at which baby B's death was discussed the focus of the 5 - 10 minute discussion was a discrepancy between very clear ultrasound pictures showing a baby with a large liver and pleural effusions and the post-mortem which failed to show these.

4.11 **THE** final comments contained in the Report would have been added after the meeting, and reflects the thinking of the academic staff who reviewed the case. When questioned on the wording of the conclusions to the Report, Dr Batcheler stated that the findings reflected her thinking to the extent that when there was a marked change in movements on the night of 16 and morning 17 April, she was not contacted.

Dr Rosevear:

4.12 **DR** Rosevear confirmed that according to the clinical criteria Mrs A was not a "high risk" patient, but that extra care had been arranged and given to her so that she could get the extra support she needed. It was Dr Rosevear's opinion that there was nothing disclosed in Dr Batcheler's clinical examinations to indicate that this pregnancy was at risk.

4.13 **DR** Rosevear gave evidence that any obstetrician who gets a report from a patient that "*my baby is not moving*" should organise a CTG and a biophysical profile. It is unusual to receive such a call and it is always an indication to do something about it. She agreed with Dr Tuohy's assessment that one is unable to obtain a clear picture that Mrs A complained of a sudden alteration of fetal movements. In the absence of any such report, there would be no indication to take any action.

Dr Marian Carter:

4.14 **DR** Carter practises in partnership with Dr Batcheler. Both of them refer their patients to the other in the event that either of them is not available. Dr Carter confirmed that had Mrs A been unable to contact Dr Batcheler, she could have contacted her and she would have attended to her. She also gave evidence as to the layout of their practice, and the resources available to them at Rawhiti Hospital.

Professor Stone:

4.15 **PROFESSOR** Stone's evidence was related directly to the particulars of the Charge. As to each of these, his conclusions were as follows:

Particular 1 -

4.15.1 He was not critical of Dr Batcheler's standard of record keeping. In his view, her notes of her care of Mrs A were of a similar quality to her colleagues and recorded fuller details than some doctors working both in private and in the hospital sector.

Particular 2 -

4.15.2 Dr Batcheler's management of Mrs A's pregnancy accords with standard acceptable practice and he could see no clinical failures following from Mrs A's expressed concerns.

Particular 3 -

4.15.3 A decrease, change or alteration in baby's movements is not a diagnosis. It is a symptom. The appropriate clinical response is take a history and to carry out an examination. This is what Dr Batcheler did.

4.15.4 On the basis of his experience working with high risk patients, he did not assess Mrs A in that category and there were no particular reasons for this baby to get into trouble. There were no increased risk factors identified by the history and examination and therefore no requirement to take any action over that appropriate action taken. He was not critical of the management undertaken.

Particular 4 -

4.15.5 Professor Stone was unable to identify any reason why the confusion had arisen over the role of Midwife Harrison. Given that Mrs A had easy access to Dr

Batcheler, including on the occasion requiring her acute admission to hospital, it would have been the expectation of private specialists that the patient would have access to them as they are taking responsibility for the management of the pregnancy, that is, the midwife would not have expected Mrs A to telephone her if there was an emergency or she was concerned about something.

Particular 5 -

4.15.6 On the morning of 16 April, when Mrs A telephoned Midwife Harrison, she had felt ten fetal movements, as usual. Objectively this would suggest no acute change in baby's movements, therefore no immediate action was required.

4.15.7 It appeared that the situation was one of a pregnancy where the mother had perceived few fetal movements but clinical assessments had failed to detect evidence of fetal compromise. Maternal anxiety can have an affect on perception of fetal movements and fetal behaviour. Additionally, the placenta was anteriorly situated and it may be that this in part accounted for the difficulties in feeling or perceiving the fetal movements.

4.15.8 Given the information apparently relayed by the midwife to Dr Batcheler, Professor Stone would not have expected any further clinical action to be taken by any specialist obstetrician in these circumstances. No cause for concern was relayed and no further action was required.

Mrs Geddes:

4.16 **MRS** Geddes' evidence related substantially to Dr Batcheler's reputation and her practice generally. Mrs Geddes was questioned very closely about alleged discrepancies in Dr Batcheler's records of Mrs A's ante-natal visits.

5. THE DECISION:

5.1 **HAVING** carefully considered all of the evidence referred to herein, and submissions made by both counsel, and having had the opportunity to assess the credibility of each of the witnesses, the Tribunal is satisfied that none of the Particulars 1 -5 are established and that Dr Batcheler is accordingly **not guilty** of the Charge of conduct unbecoming in terms of section 109 (1)(c) of the Act.

6. REASONS FOR DECISION:

The Standard of Proof -

6.1 **IT** is well-established that the standard of proof in disciplinary proceedings is the civil standard, the balance of probabilities. It is equally well-established that the standard of proof will vary according to the gravity of the allegations and the level of the charge.

6.2 **THE** standard of proof may vary within a single case, such as this, where an allegation that a doctor might have reconstructed medical records some time after the events at issue occurred are made, fairly requires a more rigorous standard of proof than allegations of 'mere' misconduct or error. 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.

Conduct Unbecoming That Reflects Adversely On A Practitioner's Fitness To Practise Medicine -

6.3 **THE** statement by Elias J (as she then was) in *B v Medical Council* (unreported) HC 11/96, 8/7/96, is by now very familiar. In that statement, Elias J formulated the test of what constitutes "*conduct unbecoming*" as follows:

"There is little authority on what comprises "conduct unbecoming." The classification requires assessment of degree. But it needs to be recognised that conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards. That departure must be significant enough to attract sanction for the purposes of protecting the public. Such protection is the basis upon which registration under the Act, with its privileges, is available. I accept the submission ... that a finding of conduct unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which it is unfair to impose. The question is not whether error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations. The threshold is inevitably one of degree. .... The structure of the disciplinary processes set up by the Act, which rely in large part upon judgment by a practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standards applied by competent, ethical, and responsible practitioners. ..."

6.4 **FROM** this statement three basic and essential principles emerge:

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

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

(c) The question is not whether 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).

6.5 **THE** 'rider' added to the charge of "conduct unbecoming" in the 1995 Act, has now been referred to in a number of decisions. In *CAC v Mantell*, DC Auckland, NP 4533/98, 7/5/99, Judge Doogue concluded that "*the text of the rider … makes it clear that all*

that the prosecution need to establish in a charge of conduct unbecoming [with the rider] is that the conduct reflects adversely on the practitioner's fitness to practise medicine. It does not require the prosecution to establish that the practitioner is unfit to practise medicine."

6.6 **THE** 'assessment of degree' the Tribunal must make is therefore effectively unchanged.

6.7 **IN** *Ongley v Medical Council of New Zealand* (supra), Jefferies J held that:

"The structure of the disciplinary processes set up by the Act which rely in large part upon the judgment 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."

6.8 **THAT** is not to say that the Tribunal unhesitatingly adopts the opinions expressed by those practitioners who give evidence as 'experts'. The test is objective; that is, the conduct under review is measured against the judgment of the practitioner's professional peers of acknowledged good repute and competency, *"bearing in mind the composition of the tribunals which examine the conduct; Ongley v Medical Council (supra).*

6.9 **THUS,** while the evidence of what other doctors would have done, or as to how they assess Dr Batcheler's management and conduct of Mrs A's care, or of acceptable practice generally in the circumstances which presented in this case, is a useful guide, perhaps even the best guide, it is never more than that; all of that evidence is weighed against the judgment of the trial judge, or in this case, a specialist tribunal comprising both medical practitioners and lay members.

6.10 **SIMILARLY**, 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, will not determine whether or not a charge is proven. The central issue for the Tribunal 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 a finding against the practitioner.

6.11 **THEREFORE**, a practitioner may be found guilty of a professional disciplinary charge notwithstanding that any actions, failures or omissions on his or her part did not affect the outcome for the patient.

The Burden of Proof -

6.12 **THE** burden of proof is borne by the CAC.

7. FINDINGS IN RELATION TO PARTICULARS:

Particular 1 - Dr Batcheler failed to maintain records at the standard expected of a specialist obstetrician of her consultations with A during the pregnancy;

7.1 **THE** Tribunal is satisfied that the records maintained by Dr Batcheler comprise a true and correct record of her findings, and that they are sufficient both as an *aide memoire* for Dr Batcheler, and as a means of communication to any other practitioner who might require the information to enable them to provide care to Mrs A.

7.2 **APART** from the matters of detail disputed by Mr and Mrs A, none of the practitioners who gave evidence at the hearing, including Dr Tuohy who gave evidence on behalf of the CAC, found fault with the records maintained by Dr Batcheler, and, in the Tribunal's experience, Dr Batcheler's records are of a higher standard than most of those presented to it.

7.3 **MOST** relevantly, none of the practitioners were critical of Dr Batcheler's not recording the level of activity of the baby, or the quality of her movements. The information required to be recorded on the 'kick charts' specifically designed to provide a record of fetal movements is also relevant. Those charts require a record of the *quantity* of movements only. The relevant recordings therefore relate only to the number of movements per day - not to the subjective maternal perceptions of day to day *qualitative* differences, and the reasons for that were explained to the Tribunal by Dr Tuohy and Professor Stone.

7.4 **DR** Batcheler's recording of the fact that she carried out a proper examination and felt movements is sufficient. As to the issue of whether Mrs A's last antenatal visit occurred on the 10th or the 12th, and the incorrect recording of a date in 1997 instead of 1996, the Tribunal has considered all of those matters in the context of Mr and Mrs A's general complaint that Dr Batcheler was always rushed, and that these errors are indicative of a poor standard of professional care and attention generally.

7.5 **THE** Tribunal is not satisfied that that general complaint is established. Dr Batcheler and Mrs Geddes produced all of the relevant diary notes and computer records. They were able to provide acceptable and understandable explanations for the one or two very minor

inconsistencies identified by Mr and Mrs A, and for the need to rearrange appointments from time to time. The CAC did not establish that the workload taken on by Dr Batcheler is out of the ordinary when compared to other specialist practitioners working in private practice.

7.6 **IN** terms of the credibility of the witnesses in relation to these matters, and generally, the Tribunal is very satisfied that all of the witnesses were truthful witnesses, and any inconsistencies or errors as to matters of detail, the content of discussions, or the sequence of events, are either honest mistakes; or reflect the passage of time since the events occurred, or are a result of the distressing circumstances in which they either occurred or which arose subsequently.

Particular 2 - Dr Batcheler failed to take adequate account of Mrs A's expressed concerns about the progression of the pregnancy to the extent that Mrs A did not feel listened to and lost confidence in Dr Batcheler:

7.7 **THE** Tribunal is in no doubt that both Mr and Mrs A now believe that their concerns expressed about the quiet nature of their baby's movements were not listened to and adequately addressed by Dr Batcheler, and that Mrs A may have lost confidence in her. However, it is equally clear that Dr Batcheler was not aware of any such loss of confidence.

7.8 **MR** and Mrs A both gave evidence of feeling trapped in the relationship with Dr Batcheler. They clearly now feel that they were unable to leave Dr Batcheler and find alternative care. The Tribunal is not satisfied that either Mr or Mrs A did in fact lose confidence to the extent now alleged. The Tribunal considers that the conclusions of the

Perinatal Report caused Mr and Mrs A great distress. To the extent that the Report infers that there was more that they could have done which might have saved their daughter it was unfair and patently incorrect. It is likely that such an inference was unintentional; even so, it was insensitive in the extreme.

7.9 **AS** was stated by both of them, from the time they received this Report they began to question the care given by Dr Batcheler. That Mrs A was an extremely anxious patient is unarguable. But the account of the care given by Dr Batcheler demonstrates to the Tribunal that Dr Batcheler understood Mrs A's needs, and responded appropriately to her.

7.10 **MRS** A clearly felt able to 'drop in' to Dr Batcheler's rooms and to ask her to 'just have a listen' to baby, whenever she felt she needed reassurance. Dr Batcheler had told her that she could see Dr Carter if she was unavailable. Mrs A also had the support of the xx Health Service, and her GP with whom she says she has a long-standing and excellent relationship. She had consulted over 40 times in two years with a psychiatrist, Dr D since the onset of her post-partum depression. She had developed an extensive network of care and support since the onset of her depression, and she obviously has an extremely caring and supportive partner in her husband.

7.11 **CONSIDERED** objectively, it is difficult to conclude that Mrs A felt she was without resources or support if she lost confidence in Dr Batcheler. It also appears to be the case that the focus of everyone's concerns about Mrs A's well-being was on her condition. In clinical terms, her pregnancy was 'normal'. In light of the positive clinical picture of her

baby's well-being, the anxiety she expressed about her baby being 'quieter' than her first child was regarded only as a manifestation of her own depression and anxiety.

7.12 **THE** Tribunal accepts that it can only determine these issues from a position of hindsight. However, against the narrative evidence given now as to what Mrs A was feeling at the time, the Tribunal must consider the factual evidence which can be discerned from the documentary material and the conduct of the parties *at the relevant time.*

7.13 **ON** that basis, the Tribunal is satisfied that, whether as result of the number of people involved in her care, discussions at cross-purposes, misunderstandings, or 'sugar-coating' of expressions of concern, any loss of confidence in Dr Batcheler was not made known to her or any other caregiver, either expressly or by implication.

7.14 **THERE** is no evidence that Dr Batcheler failed to take adequate account of any concerns expressed to her either about the baby, or about the standard of care being given to Mrs A. Dr Batcheler appears to have seen Mrs A every time she was asked to do so, as well as in routine appointments. In addition, Mrs A telephoned her on 5 or 6 occasions, and Dr Batcheler responded immediately when summoned in the middle of the night, when Mrs A suffered the adverse reaction to Melleril.

7.15 **IN** addition to her own care and attention to Mrs A, Dr Batcheler arranged for her to receive additional care from other sources such the xx Centre, the xx Health Service and Midwife Harrison. Putting to one side any subjective assessment that Mrs A might have made that she did not feel listened to and lost confidence in Dr Batcheler, the Tribunal is

satisfied that when viewed objectively, Dr Batcheler appears to have provided a very good standard of care and was appropriately attentive and responsive to Mrs A's clinical and psychological needs.

7.16 **ACCORDINGLY**, the Tribunal considers that there is no sufficient evidence on which it could safely find this Particular to be established.

Particular 3 - When told by Mrs A at her appointment on 10 or 12 April 1996 [there being a dispute about the date] that there had been a decrease, change or alteration in the baby's movements, failed to take appropriate action;

7.17 **THIS** Particular articulates the central issue of the Charge. The Tribunal is satisfied that, in substantive terms, whether the subject appointment took place on the 10th or the 12th is immaterial. The fundamental issues which the Tribunal must determine are what was said, what was Dr Batcheler's response, and was her response appropriate in clinical terms? If it was not, does that constitute conduct unbecoming, and that is conduct which reflects adversely on Dr Batcheler's fitness to practise medicine?

7.18 **THE** Tribunal has considered this issue at length and is satisfied that Dr Batcheler was told that the baby was quieter. It is likely that Mr and Mrs A described the baby's movements as "*flutters*" and that this was the only occasion on which that word was used. It is simply not possible now to determine positively if that is factually correct.

7.19 **MR** and Mrs A both impress as being meticulous in their approach to detail. In both of their statements of evidence, Mr and Mrs A state that Mrs A *"often referred to these [movements] as "flutters"* and that "*A would refer to the weak movements as*

'flutters'. However at the hearing both of them changed their evidence on this point and, in oral evidence, stated that it was only on the occasion of the last ante-natal visit that this word was used.

7.20 **FOR** the purposes of determining this Particular, and in fairness to Mr and Mrs A and Dr Batcheler, the Tribunal accepts the oral evidence given by Mr and Mrs A and it proceeded to consider the Particular on that basis. The word *"flutters"* has no clinical meaning - it is descriptive only. It was used in the context of a history of a 'quieter' or 'slower moving' baby subjectively compared to the patient's first pregnancy.

7.21 **WAS** the use of this word, perhaps for the first time, sufficient to put Dr Batcheler on alert that something had changed about this baby, and that this change required clinical inquiry? It is important, when considering these questions to refer to the evidence given by Dr Tuohy, Dr Rosevear and Professor Stone. The opinions expressed to the Tribunal by Dr Batcheler's professional peers are uniformly positive. However, whether or not a practitioner has been negligent, or in the professional disciplinary context if she is guilty of professional misconduct, is an objective test and is to be determined by the Tribunal.

7.22 **IN** *B v Medical Council* (supra) Elias J referred to both *Rogers v Whitaker* [1992] CLR 479, and the Canadian case of *Reibl v Hughes* [1980] 2 SCR 880 and confirmed the rejection in New Zealand of the so-called *Bolam* principle (*Bolam v Frien Hospital Management Committee* [1957] 1 WLR 582) that a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion even if other doctors adopt a different approach.

7.23 **ON** the basis of both *B* (supra) and *Ongley* (supra), both decisions given in the professional disciplinary context, and both on appeal from specialist tribunals, the question as to whether Dr Batcheler's conduct is conduct which is culpable, i.e. is conduct warranting an adverse finding, is a question squarely for determination by this Tribunal. While the evidence of Dr Tuohy, Dr Rosevear and Professor Stone is, given its uniformity, a useful guide, perhaps even the best guide, it is no more than that, and must be weighed against the judgment of this Tribunal, comprising as it does a mix of lay persons and medical practitioners.

7.24 **THAT** is the process followed by the Tribunal on this occasion. Having done so, it is satisfied on the balance of probabilities that Mr and Mrs A did tell Dr Batcheler that the baby had 'slowed somewhat' and that its movements felt like *"flutters"*.

7.25 **IN** turn, the Tribunal is satisfied that Dr Batcheler did take appropriate clinical action. Dr Batcheler examined Mrs A, and her baby by palpation and by listening to her heartbeat. Her clinical record, albeit brief, indicates that she was satisfied that the baby was moving satisfactorily; that Mrs A's report of baby's movements (10 felt every morning, quiet, slow, flutters) was consistent in terms of previous reports over the term of the pregnancy; baby's heartbeat was heard and appeared normal; baby's size for dates was normal, and there were no clinical signs of anything untoward with either mother or baby.

7.26 **IT** is a part of the allegations supporting this Particular that Dr Batcheler should have ordered other tests or examinations such as a CTG, a biophysical profile or an ultrasound. The Tribunal accepts the evidence given by the medical witnesses that no such additional

tests were indicated, or are likely to have produced any information which would have altered the outcome of this pregnancy. After baby B's death Dr Batcheler apparently told Mr and Mrs A that they should regard her death as being similar to a 'cot death'. Professor Stone, in answer to a question from the Tribunal agreed that was an accurate analogy.

7.27 **SIMILARLY**, the allegation that had baby Alexander been delivered at 36 or 37 weeks she would have been born alive, simply states a tautology. The only reason to have brought the pregnancy to an end, either by inducing labour early or by delivering the baby by elective caesarean section, would have been if such a course was clinically indicated. The Tribunal is satisfied that on the basis of the clinical information available to Dr Batcheler at the time, no such interference was indicated. Tragically, it appears that baby B's death was sudden, inexplicable and unpredictable.

7.28 **FOR** all of these reasons therefore, the Tribunal is satisfied that Dr Batcheler's response to the information given to her by Mr and Mrs A was appropriate, and that her management of Mrs A's pregnancy accorded with acceptable professional standards.

Particular 4 - Failed to adequately inform Mrs A as to the intended role of Midwife Harrison with the result that Mrs A believed that Midwife Harrison had a shared role in relation to ante-natal care whereas Midwife Harrison understood from Dr Batcheler that her role was in regard to delivery and post-natal care;

7.29 **IT** was accepted by all of the medical practitioners who gave evidence to the Tribunal that it is the responsibility of the practitioner to ensure that the patient understands the respective roles of multiple caregivers. This is especially necessary in the current era of

obstetrical care, which provides for arrangements for maternity care to be entered into with an array of "*providers*". Notwithstanding the various studies and surveys which have been carried out reporting a 'high level' of satisfaction with such arrangements; to women entering this system, it is often bewildering and confusing.

7.30 **GIVEN** her history of post-natal depression and her need for on-going care and attention which was reliable and reassuring, Mrs A engaged the services of a private specialist, Dr Batcheler. In such circumstances, it was Dr Batcheler's understanding that she was primarily responsible for Mrs A's ante-natal care, the delivery of her baby, and her post-natal care.

7.31 **IN** light of the Tribunal's findings in relation to Particular 2 that Dr Batcheler was not aware of any loss of confidence in her on the part of Mrs A, then her explanation of her understanding of the role that Midwife Harrison was to fulfil in the context of Mrs A's pregnancy and delivery coupled with the nature of the professional relationships and arrangements which exist, is acceptable and entirely credible.

7.32 **AS** far as Dr Batcheler was aware, the reason for Mrs A wanting to also engage Midwife Harrison was given to her by Dr E in her report to Dr Batcheler by letter dated 12 January 1996; Mrs A wanted to find a midwife who could stay with her throughout her labour. Mrs A explained that she initially was unsuccessful in finding a midwife who could 'take her on'. It was only after Dr Batcheler interceded with Midwife Harrison, and she became available because two of her patients delivered early, that Midwife Harrison entered the picture.

7.33 **IN** the absence of any expressions of concern made to her regarding the standard of the care she was providing, Dr Batcheler was completely unaware of any other reasons why Mrs A would want to engage Midwife Harrison; and reasonably so. If Mrs A was engaging Midwife Harrison for any reasons which she had not discussed with any other person, then some obligation did fall upon her to explain those reasons to Midwife Harrison, or at least to explain the nature of the cares and services she was seeking from her. Some discussion of these issues could have been undertaken in the first meeting with Midwife Harrison when she visited Mrs A at 30 weeks.

7.34 **IN** all the circumstances, the Tribunal considers that, on the balance of probabilities, Mrs A did not indicate to Dr Batcheler in any way that the reason she wanted to obtain the services of a midwife was because she was unhappy with the standard of care and attention she was receiving from her. It was Dr Batcheler's understanding that the reasons for Midwife Harrison's involvement were as explained to her by Dr E. Both Dr Batcheler and Midwife Harrison gave evidence that they did explain the nature of the role the midwife would fulfil, and that Mrs A did not indicate that what was proposed was not what she was seeking.

7.35 **THE** Tribunal finds, as a matter of fact, that if there was a misunderstanding between Dr Batcheler and Mrs A and Midwife Harrison as to what Midwife Harrison's role was, it was inadvertent. Any such misunderstanding did not arise as a result of any omission on the part of Dr Batcheler.

Particular 5 - On 16 April 1996 when advised by Midwife Harrison that Mrs A had telephoned her expressing concerns about the changes in the baby's movements failed to take appropriate clinical action and failed to ensure appropriate systems were in place to manage the concern expressed by Mrs A in her telephone call.

7.36 **IN** order to prove that the allegations contained in Particular 5 are proven, the Tribunal must be satisfied as to two matters;

(a) That Mrs A made a telephone call of 16 April 1996 to Midwife Harrison because she was concerned about her baby's movements; and

(b) That Midwife Harrison did advise Dr Batcheler that such a call had been made and that that information required some action on her part.

7.37 **THE** Tribunal is not satisfied that either of these two matters have been proven to necessary standard. As stated above, the Tribunal is satisfied that all of the witnesses were truthful witnesses. On that basis, while there is no dispute that Mrs A did telephone Midwife Harrison at xxH on 16 April 1999, it is by no means certain that Midwife Harrison understood that the call was urgent, or if the call went through the xxH telephone system the operator told Midwife Harrison that the call was urgent; or that the main reason for the call was to tell Midwife Harrison that Mrs A was concerned about the baby's movements.

7.38 **MIDWIFE** Harrison told the Tribunal that she thought the purpose of the call was to arrange an appointment to see Mrs A. She had made and cancelled a number of appointments, and she did intend, and had promised, to see Mrs A before she went into labour, and time was getting short. Specifically, an appointment made for the 15th had not

been kept. Mrs A was expecting her to call the next day (the 16th) to arrange another appointment, and when she telephoned her, an appointment for the 17th was made.

7.39 **THE** Tribunal accepts that in that call, Mrs A did tell Midwife Harrison either that the baby's movements were quieter, quiet or soft, and that she was worried about this. However, Midwife Harrison recalls that movements were discussed, but that "*I remember feeling OK about the number of movements that she had had that morning*." That evidence is consistent with Mrs A's evidence that she did feel movements on the morning of the 16th and that after the call she went to a friend's place to take her mind of her worries.

7.40 **AS** was submitted by Mr Knowsley in his closing submissions, it is important for the Tribunal to keep in mind that Dr Batcheler must not be judged on the basis of what Mrs A told Midwife Harrison - the Tribunal must try to determine what Midwife Harrison relayed to Dr Batcheler. On that basis, and on an objective assessment of all of the evidence, the Tribunal is satisfied that Midwife Harrison did tell Dr Batcheler that Mrs A had telephoned her, and that she was worried about the baby's movements.

7.41 **HOWEVER**, the Tribunal is equally satisfied that, on the basis of the evidence of her response when summoned on the occasion of the adverse reaction to Melleril; of her referring Mrs A to other services for additional support and reassurance; and of her willingness to see or to speak to Mrs A whenever she was asked, had Dr Batcheler formed the slightest concern that anything was amiss, she would have responded immediately.

7.42 **THE** key to this issue appears to be that the discussion between Midwife Harrison and Mrs A was about *movements,* not about a cessation of movements, or about sudden change to the pattern of movements felt over the last trimester of the pregnancy. It is the Tribunal's view, on the basis of the evidence presented to it, that if either of Mr or Mrs A had any inkling that anything was amiss with baby, they would have taken immediate and appropriate steps to summon help. At a minimum they would have contacted Dr Batcheler immediately.

7.43 **THEIR** evidence is unequivocal that they did not, for a moment, suspect that anything was amiss with their baby. They thought that the baby was sleeping or resting. It never occurred to them that baby B had died, and, on the evidence of Dr Tuohy and Professor Stone, there would appear to be absolutely no reason why they should have considered that possibility.

7.44 **ACCORDINGLY**, the Tribunal has determined that on the 16th of April 1996, Dr Batcheler was not advised of any concerns on the part of Mrs A that required her to take any action. In all the circumstances it was reasonable for her to reassure Midwife Harrison that if Mrs A was seriously worried about anything she would contact her (Dr Batcheler).

7.45 **FURTHER,** the Tribunal is satisfied that if Dr Batcheler had formed the view that some action was required, but that she was too busy to attend to her, she would have made appropriate alternative arrangements. She and Dr Carter clearly have a close professional relationship, and each one of them makes herself available to the other's patients as and when necessary. A request to Dr Carter to contact or see Mrs A was clearly an option

open to Dr Batcheler; as was telephoning Mrs A herself and suggesting that she come in to xxH for her to check her.

7.46 **THUS,** the Tribunal is satisfied that Dr Batcheler did have in place appropriate systems and options to deal with any emergency situation, or expressions of concern.

8. CONCLUSION:

8.1 **IN** conclusion, the Tribunal is not satisfied that any errors of clinical judgment or practice on part of Dr Batcheler have been established and she is not guilty of any conduct unbecoming that reflects adversely on her fitness to practise medicine. The Tribunal came to this conclusion on the basis of all of the evidence presented to it, and after careful consideration of each of the Particulars of the Charge, and the Charge in its totality.

8.2 **THE** Tribunal is satisfied that the death of baby B was sudden and inexplicable. It could not have been predicted on the basis of any of the evidence that was available to Dr Batcheler, and it is more likely than not that any additional tests, investigations or examinations, even if indicated, would not have yielded any information which might have altered the outcome. The Tribunal finds no evidence of any 'cover up' or other deceptive conduct or non-disclosure on the part of any person involved in these very sad events.

8.3 **THE** Tribunal's decision is unanimous.

9. COSTS:

9.1 **AS** a result of the Tribunals' decision there are no issues as to costs.

10. ORDERS:

10.1 **THE** Orders made by the Tribunal at the commencement of the hearing prohibiting the publication of Mr and Mrs A's identity, and any of their identifying details, are made permanent.

DATED at Auckland this 27th day of March 2000

.....

W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal