

DCC072 RWK-G

MEDICAL TRIBUNAL OF NEW SOUTH WALES

CHAIRPERSON: BLANCH J CJDC

MEMBERS: EMERITUS PROFESSOR W GLOVER AO
DR M CARLTON
ASSOCIATE PROFESSOR B BENNETT

WEDNESDAY 22 MARCH 2006

IN RE DR B AND THE MEDICAL PRACTICE ACT**ORDERS OF THE TRIBUNAL**

1. A suppression order is made of the doctor's name or any material identifying him during the hearing and on a final basis.
2. The complaints are dismissed.
3. The Healthcare Complaints Commission should pay the doctor's costs.
4. The documents in envelope 7 and the original medical records of the Coroner are released and may be returned.
5. The exhibits may be returned after 28 days.

JUDGMENT

CHAIRPERSON: The Health Care Complaints Commission brings these complaints pursuant to s 51(1) of the **Medical Practice Act** 1992 as amended by the **Health Care Complaints Act** 1993. The complaint is that the doctor has been guilty of unsatisfactory professional conduct and/or professional misconduct within the meaning of ss 36 and 37 of the Act in that the practitioner has demonstrated a lack of adequate knowledge, skill, judgment, or care, in the practice of medicine.

The particulars are that on 25 March 2003 the practitioner was an obstetrician on call to A Hospital and had been called in to assist with the delivery of the third child of Mrs A. The practitioner arrived at about

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6.00am and delivered the baby vaginally at about 6.51am. The baby had consistent APGAR scores of zero at one minute, five minutes and ten minutes post delivery. The baby was subsequently resuscitated but died five days later.

It is alleged:

1. The practitioner failed to cause preparations for a caesarean section to be initiated following his assessment of the mother at around 6.00am on 25 March 2003 despite evidence of foetal distress.
2. The practitioner failed to request that a paediatrician be in attendance for the delivery despite evidence of foetal distress and in contravention of hospital guidelines.

The relevant chronology of events is that the mother attended at A hospital at somewhere between 3.15 and 3.30am on 25 March 2003 and it appears at that stage she was three centimetres dilated. The nursing staff at the hospital then proceeded to monitor her in the next hours of the morning and they did that by way of a cardiotocography, referred to as a CTG trace or scan. These CTGs were done on a regular basis until at 5.45am. The nursing staff determined that the doctor should be called.

The doctor was on call as the obstetrician and he was for that purpose staying in a motel room nearby. He was summoned to the hospital and he arrived there within a very short space of time, somewhere between five to ten minutes. He examined the patient at 6 o'clock when he

arrived at the hospital. He noted the patient was seven centimetres dilated at that stage. He noted there was some meconium and he saw the results of the CTG scans. I should explain that meconium is the result of a foetus evacuating its bowels and the evidence about that is that if the meconium is light it does not demonstrate any particular problem but the heavier the meconium is the more likely there is to be a problem firstly because the meconium demonstrates that it was evacuated from the foetus because of some stress and secondly because the meconium can be taken into the lungs of the foetus and therefore cause a problem after birth. The meconium noted by the doctor at 6 o'clock as I have said, was light and he noted the CTG results. He assessed the situation as one where it was necessary for the baby to be born as soon as possible and a watch was kept on the patient between 6.00 and 6.30. At 6.30am or some time not too long thereafter one of the midwives noted that there was pea soup meconium and that is a phrase that is used apparently to indicate that the meconium had become thicker. At some stage about then the doctor also became aware of the thicker meconium and that led to a much more urgent approach to the delivery of the baby. It is unclear precisely when the doctor became aware of the thicker meconium. It may have been shortly after 6.30 or, it was certainly some time up to and before 6.40 because at 6.40 one of the midwives asked the doctor did he want a paediatrician called. The doctor at that stage said no. The baby was born at 6.51, so within eleven minutes or so

of that conversation. Obviously these times are to some extent estimates. There were times noted in the hospital notes, some made at the time, others made thereafter but it is obvious that there is room for error in looking at the times and that has to be borne mind.

One reason that that is relevant is that the doctor did ask the nursing staff to call in a paediatrician when the baby was born. There were two reasons for doing that, one of them the Doctor says is because the staff were free to do that at that point when the baby was being born, and the second reason was that when the baby was born the umbilical cord was wrapped tightly three or four times around the neck of the baby. I should pause to say that there is no suggestion that anyone would have been able, or could have diagnosed the umbilical cord as being around the neck of the baby before the baby was born. It was a most unfortunate circumstance in the birth of this baby that the umbilical cord was in such a position and wrapped around the neck tightly so many times.

The paediatrician was called and the paediatrician attended at the hospital arriving shortly after 7.00. In the meantime a very experienced midwife had attempted the resuscitation of the baby and that was then taken over by the paediatrician. The baby did breathe and lived for a number of days, unfortunately the efforts made were not sufficient to save it and it died some days later.

Arising out of that sequence of events there are two complaints which are made by the Health Care Complaints Commission. The first of them is that the doctor should

have made arrangements for a caesarean birth when he saw the patient at 6.00am. It is common ground that if he had done that it would not have made any difference because it could not have been organised before the baby was actually born. The complaint rather is that the doctor should have adverted to the possibility that his judgment might have been wrong and should have made arrangements for a caesarean birth just in case.

The evidence about that is firstly from Dr Peat who provided a report dated 10 September 2004. Dr Peat is the Director of Obstetrics at the University of South Australia, where he is an associate professor in the Division of Health Sciences. He says in that report:

"An appropriate response to the CTG would have been to initiate the steps required to perform a caesarean section. I accept Dr B's judgment was that vaginal delivery would occur as soon by the vaginal route as it would by caesarean section. However I am of the opinion that a wiser course of action would have been to cover the possibility that delivery was delayed and that caesarean section might prove faster than waiting for her to reach full dilation. I accept that he appreciated that the CTG and the meconium was serious and therefore he remained in the labour ward to be able to effect delivery as soon as possible. However I am not certain that he appreciated that the baby was in danger of dying from hypoxia. His failure to initiate the process of caesarean section would invite my severe disapproval and I believe it would invite the disapproval of the general body of my colleagues. Imagine if he had been called at 4.15am, would it still have been appropriate to await vaginal birth in the event the baby was born at 6.51am and it is indeed questionable whether it could have been born any sooner at this hospital."

The other evidence relied upon about this comes to a very slight extent from Dr Hollis who said in his initial report that:

"The CTG was still abnormal and yet no further action was taken and labour was allowed to proceed to a spontaneous vaginal delivery."

He does not expand on that. In a subsequent report he said:

"An assisted vaginal delivery did not take place despite an abnormal CTG and meconium stained liquor."

Insofar as that statement is concerned, the evidence before us was that there was an attempt at an assisted delivery and Dr Hollis was incorrect in assuming that there had not been.

The other evidence about this matter comes from Dr Korda who was called on behalf of the doctor. Dr Korda is a gynaecologist at the Royal Prince Alfred Medical Centre. He is a member of the Royal College of Obstetricians and Gynaecologists. He is a fellow of the Royal Australian College of Obstetricians and Gynaecologists, a fellow of the Australian College of Legal Medicine. He has a number of significant qualifications and has served as an obstetrician and gynaecologist in many leading hospitals in the United Kingdom and in Australia and has an impressive curriculum vitae which has been tendered.

When he prepared a report he indicated that at 6.00am when Dr B saw the patient urgent delivery was indicated. He said at p24 of his report:

"When a baby is delivered by an emergency caesarean section it is often recommended that the time required to organise the operation and deliver the child should be a maximum of thirty minutes. Unfortunately these recommendations are often based on unaudited retrospective personal experience and anecdotal evidence

rather than on empirical evidence from large prospective studies. Evidence suggests that in modern practice in maternity hospitals in Australia only a small percentage of emergency caesarean sections were performed in less than thirty minutes..."

He went on to indicate that the median time was more likely to be more than an hour. He also indicated that there was a great deal of preparation required to perform an emergency caesarean and he outlined what those matters were, including preparing the patient, getting an anaesthetist, moving the patient into a theatre and doing the various tests that need to be done, scrubbing up and safely performing the surgery. He said that in a level one hospital such as A it might be expected that it would take sixty-nine minutes. He expressed this opinion at p25:

"As discussed above, the median times from when a decision is made to perform an emergency caesarean section to deliver a child in a level one maternity hospital is sixty-nine minutes. When Dr B saw Mrs A at 5.55am on 25 March 2003 Mrs A was in strong labour, the cervix was seven centimetres dilated and this was her third child. On palpitation the baby did not appear to be overly large. It could therefore be reasonably anticipated that as Mrs A was in the active phase of cervical dilatation with her third baby she would reach full dilatation in less than one hour. As it takes more than one hour to organise a caesarean section in a level one hospital it would have been totally pointless to make these arrangements, as on the balance of probabilities, Mrs A would have delivered before the caesarean section could have been started."

He gave evidence and he said that given the information that Dr B had he would have made precisely the same decision at 6 o'clock in the morning. He said that any experienced obstetrician would make and would be able to make that same judgment about the matter. If I go back to

Dr Peat's assessment of the matter, he said, as I have already indicated:

"Imagine if he had been called at 4.15am, would it still have been appropriate to await vaginal birth?"

Well of course that is a totally different situation than the situation that Dr B faced.

Dr B is an obstetrician and at that stage of about thirty-three years experience as an obstetrician he made the judgment he did make on the basis of the material that he saw and Dr Korda said he would make exactly the same judgment. Indeed it stands to reason that if he had in fact organised as a back-up, a caesarean team, it would have been necessary to take some steps to do that and that may well have interfered with the fact that a speedy birth was to be achieved. Everyone agrees that the signs that were visible at 6.00am were such as to require the earliest possible birth. There are various reasons for that. The CTG scans apparently can indicate a degree of stress. It may be unknown what that stress is. It can be because of the cord around the throat. It may be because of lack of oxygen getting to the baby's lungs. There can be a number of explanations. The solution is to get the baby out as quickly as possible. In some ways if he had stopped at any stage to organise a caesarean birth he might now be criticised for not getting on with the business of delivering the baby as soon as possible.

In my view there is no substance at all to this complaint and it should be dismissed.

The second complaint is that during the course of the

morning after he had arrived at 6 o'clock Dr B should have organised for a paediatrician to be called. To put the matter in context, Dr B had not been the treating doctor in respect of the patient. He was summoned to the hospital as the obstetrician rostered for emergency purposes on this morning. The evidence relied upon by the Health Care Complaints Commission to assert he should have called a paediatrician again comes from Dr Peat who said this in his report of 10 September:

"I cannot understand Dr B's decision not to call the paediatrician to the delivery. Meconium stained liquor was known to be present and there was an abnormal CTG. The failure to call the paediatrician suggests that Dr B did not appreciate that the combination of normal CTG and meconium stained liquor do represent a substantial risk to the baby and that the baby was in danger of dying from hypoxia. The correct standard to apply in this situation in my opinion is that there was a significant risk of a seriously ill neonate and the staff member most experienced in resuscitation should be present. In this circumstance that should have been the on-call paediatrician. I am critical of Dr B for declining to call the paediatrician when it had been suggested by the midwifery staff. His decision not to call the paediatrician invites my severe disapproval, especially in the situation in which he denies any responsibility or skill in this area."

Dr Hollis who had been asked to comment in the early stages of this inquiry had also addressed this issue and he said:

"Despite the abnormal CTG and the copious pea soup meconium a paediatrician was not summoned to be present at time of delivery."

His criticism then is directed at the period after 6.30 when the thicker meconium was noted. Dr Peat's criticism appears to go back to the earlier stage at 6.00 o'clock when the doctor first arrived.

The paediatrician who was called was Dr McDonald and Dr McDonald had prepared a protocol for calling in the paediatricians and that protocol included the observation of meconium. He gave evidence before the tribunal and in his evidence he was directed to the events that had occurred on this morning and it appears from the evidence that we have otherwise heard that Mrs A was having a difficult time in the labour ward. She was in a lot of pain and she was not reacting in the way the doctor and nursing staff wished her to. Dr McDonald said this, that he would not be particularly critical of the doctor for the decision for the paediatrician not to be called. He went on to say that pea soup meconium is generally not life threatening. He said there was no clear and present danger mandating him being called and that most of these babies did not require a paediatrician at birth. He said that he understood the decision not to allow a midwife to leave because of the need to have the midwives there to assist in the delivery of the baby. His evidence is very clear, that it was not necessary for him to have been called and that he would not criticise Dr B for the decision that he made, that is in spite of the fact that his guidelines indicate that it is prudent in the presence of meconium for the paediatrician to be present at birth just in case the paediatrician is needed.

On that issue Dr Korda gave evidence and was cross-examined. Dr Korda said this at p 27:

"In a level one setting where delivery is imminent and could occur with minutes the calling of a paediatrician that could take

anything between twenty minutes to half an hour would be fruitless and certainly would not be disapproved by the general body of my obstetric colleagues."

He also said:

"Without the benefit of hindsight, no reasonable obstetrician in Dr B's position would have called a paediatrician where arranging to call a paediatrician would have required him to lose one of his midwife assistants and it would have taken at least twenty minutes for the paediatrician to arrive."

There is then, clearly, a conflict of views, between the views expressed by Dr Peat and the view expressed by Dr Korda, who is supported in his view by Dr McDonald. One of the arguments that has emerged here about these conflicting opinions is that Dr Peat has practised in his career in a level three hospital. A level three hospital is a hospital where paediatricians are standardly on hand and can be called in to a labour ward at a minute's notice. A level one hospital, such as A Hospital was, does not have any of those facilities.

Dr Korda on the other hand, in spite of his present position, has spent quite a lot of time working in level one, level two, and level three hospitals. He has been criticised by the complainant here as putting himself in the doctor's shoes and therefore being too subjective in his assessment. In my view he had to put himself in this doctor's shoes to be able to make a realistic assessment about what was reasonable in the circumstances that this doctor found himself to be in. Having done that, as I have said, he indicates that Dr B should not be criticised for failing to call in a paediatrician.

Both Dr Korda and Dr McDonald said that if there had been a third midwife present then a third midwife could have called in a paediatrician and they would be somewhat critical of a decision not to call in the paediatrician in those circumstances. What both of them said was that they readily understood that a doctor faced with the emergency situation that existed in this room at this time would want to have the assistance of two midwives. A decision had been made to assist with the delivery and preparations were put in place to attempt to do that. The patient was being clinically unco-operative and a lot of assistance was needed.

There has been some argument about whether some other course could have been taken. The first suggestion is that there might have been a third midwife there after all. That suggestion comes from the statement of one of the midwives where she said she thought there was a third midwife present. The other midwife who was present said that that was not the case, that there were just the two midwives in the room, and Dr B's evidence was that there were only two midwives in the room. It would be quite wrong for this Tribunal to come to any decision based on the fact that a third midwife was present. The overwhelming evidence is that that was not the case.

The other question that has been raised is whether or not a buzzer in the room should have been used to summon somebody else to call the paediatrician. Evidence was given that there was a buzzer in the room. There was no evidence where the buzzer buzzed once the button was

pressed. There was evidence that there was another midwife in the hospital at the time. Apparently the hospital building has a wing and there is an office in the middle and one end of it is where the delivery occurs and the other end, presumably, is where the babies are kept. The third midwife appears to have been in the other section which is on the other side of the office which is in the middle. In any event Dr B has given evidence that he did not know there was a buzzer in the room and there is no evidence that on that night anyone drew his attention to it. The overwhelming evidence about the matter is that he was fully occupied attempting to achieve an early birth of the baby because that was clearly indicated as necessary by all the signs he had seen. As soon as the baby was born, or was in the process of being born and he saw there was a cord around the neck of the baby he made immediate arrangements for one of the nurses to go and call the paediatrician. He was able to do that, firstly because at that stage he did not need the same assistance as he had before and also at that stage it was perfectly clear that a paediatrician would be needed as soon as possible. Resuscitation was done by one of the midwives until the paediatrician arrived.

I have already indicated that Dr Peat criticises the doctor in that the doctor did not intend to be involved in the resuscitation but had nonetheless failed to call a paediatrician at an earlier stage.

Again one of the difficulties about the evidence in this case is to know precisely when various things

occurred. The first difficulty is to know when the thick meconium was noticed. Was it at 6.30 or some minute or two after that. The next question is was the suggestion about having a paediatrician present asked by the nurse at 6.40 or shortly afterwards. What does appear to be the situation is that at one stage, perhaps shortly after 6.40, the doctor said "no" when asked if a paediatrician should be called. It is also clear that at some stage no later than 6.51 he said "call the paediatrician." He has expressed the view that it was only minutes after saying "don't call the paediatrician" that he said "call the paediatrician." It is not possible to come to a definitive conclusion about how many minutes exactly it was between those two things, it may have been three or four minutes, it may have been ten or eleven minutes. What is clear is that what was going on in the room at that stage was what has been described as pandemonium arising from the efforts being made to assist in the birth. It is clear that Dr B had all his attention directed at that issue.

The other matter that has to be taken into account, as I have indicated already, is that Dr B is an obstetrician who is very experienced and had about thirty-three years experience as an obstetrician at the time. His judgment about a number of the matters that occurred on this night has been vindicated significantly by Dr Korda and by Dr McDonald. Another matter that is relevant to bear in mind is that we are here in the calm atmosphere of a tribunal hearing attempting to assess and

dissect what occurred in a real situation of some degree of panic and urgency in a hospital labour ward and any judgment which was made about these things has to be made bearing in mind those realities.

Dr Peat has expressed a view that is difficult to disagree with in one sense, namely that every precaution possible should be taken to care for the mother and baby in a circumstance of birth, but that has to be done within the context of what is reasonable and available in the particular circumstance. There is no doubt that the doctor could have arranged for a paediatrician to come when he saw the CTG results and the light meconium at 6 o'clock. Two quite experienced doctors had said that that was necessary. There is material in the guidelines to indicate that a very cautious practitioner might do so. Whether to do that or not to do it is the sort of judgment that any professional person faces on a daily basis. This doctor decided in the circumstances of this case not to do it.

What we have to look at is that conduct in the context of these complaints which are brought under ss 36 and 37 of the **Medical Practice Act**. Section 36 defines unsatisfactory professional conduct as:

"Any conduct that demonstrates a lack of adequate knowledge, skill, judgment, or care, by the practitioner in the practise of medicine."

Section 37 which is also pressed upon us by the complainant is the section that deals with professional misconduct and it defines professional misconduct as

meaning:

"Unsatisfactory professional conduct of a sufficiently serious nature to justify suspension of the practitioner from practicing medicine or the removal of the practitioner's name from the Register."

In my view the material that has been put forward does not establish professional misconduct and so far as that aspect of this particular complaint is concerned, I would dismiss it.

The only question that arises in my view is whether it could be categorised as unsatisfactory professional conduct and in that context I should refer to the decision of the Court of Appeal in **Daskalopoulos v The Health Care Complaints Commission** (2002) NSWCA 200 and I refer in particular to the judgment of Hodgson JA at p59 where he said this:

"The question then for this Court is whether this amounted to 'conduct that demonstrates a lack of adequate knowledge, skill, judgment, or care'. I think the conduct could be characterised fairly as an error of judgment but that does not necessarily mean that it demonstrates either a lack of adequate judgment or any of the other alternatives I have mentioned. Persons who do not lack 'adequate judgment' do from time to time make errors of judgment. On the whole I am not comfortably satisfied that the appellant's error of judgment in this case demonstrated a lack of adequate knowledge, skill, judgment, or care, and I would not make a finding that the appellant has been guilty of unsatisfactory professional conduct."

No doubt there are cases where an individual mis-judgment is so egregious that it demonstrates there is a lack of adequate knowledge, skill, judgment, or care. On the other hand there may be many mis-judgments made in the course of emergency situations that do not constitute or

demonstrate a lack of adequate knowledge, skill, judgment, or care. Minds may differ in this case as to whether or not at an earlier stage the practitioner should have called, or could have called, a paediatrician. The weight of the evidence that has been tendered is that there was no such requirement in the circumstances of this case. Allowing for a spectrum of views about it and including the view of Dr Peat it may be that some people could come to the conclusion that this was a case where for more abundant caution a paediatrician could have been called at an earlier stage. If that conclusion were reached however, in my view it would not constitute unsatisfactory professional conduct because in the circumstances of this case it would merely demonstrate a mistaken judgment on a particular issue.

From my own point of view I do not believe there was such a mistake and the evidence does not support it, but if there were it is not such a mistake as could possibly be categorised as unsatisfactory professional conduct. Accordingly I would dismiss both complaints.

BENNETT: I agree.

SPEAKER: I agree.

CHAIRPERSON: That then is the decision of the Tribunal that both complaints be dismissed.

The Hon Justice R O Blanch
Chairperson

on behalf of the members of
the Tribunal