

MEDICAL DISCIPLINARY TRIBUNAL

DEPUTY CHAIRMAN HIS HONOUR JUDGE WARD, QC
MEMBERS DR G MARCAR and DR F HINDE

JUDGMENT

In re: Geoffrey Lancelot Rutter DAVIS

Complaint was made pursuant to Section 27 (1) of the Medical Practitioners Act, 1938, as amended, Secretary of the Health Department of New South Wales against Dr Geoffrey Davis, that he has been guilty of misconduct respect. The particulars related to two to as Mrs X and Mrs Y.

After a lengthy hearing before the investigating committee some of the particulars were deleted and in final form they were as follows:

As regards Mrs X

1. Dr Geoffrey Davis failed to advise and inform Mrs X of the Medical risks associated with a second trimester abortion.
2. Dr Geoffrey Davis failed to ensure Mrs X was given proper and adequate medical attention following her admission to Population Services International Clinic, Kings Cross on 16 February, 1982, in particular;
 - (ii) a medical practitioner was not present and consulted in relation to Mrs X's persistent complaints of pain after dilation
 - (iii) failure to ensure adequate post-operative assessment and care.

AS REGARDS MRS Y

1. Dr Geoffrey Davis failed to advise and inform Mrs Y of the medical risks associated with a second, trimester abortion.
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2. Dr Geoffrey Davis failed to ensure Mrs Y was medical attention following her admission to International Clinic, Kings Cross, on 16 Feb

Particular:

- (ii) A medical practitioner was not present and consulted in relation to Mrs Y's persistent complaints of pain after dilation.
 - (iii) A medical practitioner was not present and consulted in relation to distention, pain and shock.
 - (iv) A medical practitioner was not present and consulted to decide the necessity or desirability of a blood transfusion.
 - (v) failure to ensure adequate post-operative assessment and care
3. Inserting an I.U.D. in the circumstances
4. Failure to ensure that the foetal head was evacuated

Dr Davis has been carrying out terminations of pr trimester terminations at Population Services International Clinic in Sydney since 1974. Prior, thereto, he had practiced in the same field in the Untied Kingdom and other countries for some years. He has developed and used a two stage procedure for mid trimester terminations. He has performed over 100, 000 cases of terminations. The events giving rise to the charges occurred in respect of two cases on successive days in 1982 and appear to be exceptional. The conduct alleged to be misconduct relates, except for one matter, namely, failure to ensure that a foetal head was evacuated, to pre-operative advice as to the medical risks and the post- operative assessment and care.

The procedure undertaken upon the two patients is commonly known as the two stage mid trimester termination. It involves dilation of the cervix and avulsion of the foetal cord under general anaesthetic followed 24 hours later by a second stage also under general anaesthetic, when evacuation of the foetal contents of the uterus is undertaken with the use of specially designed forceps. In between the two stages the foetal contents will have undergone significant maceration. After each stage the patient is returned with a drip running to a recovery ward and then to a nursing ward in the clinic. Nursing care and pathology follows each stage and the patient is discharged

about 24 hours after completion of the second stage. Although there may be still a body of medical opinion that mid trimester abortion is a relatively hazardous surgical procedure, there was general acceptance by a large body of professional opinion given to the Tribunal that there is low mortality, no more than that of delivery at term and that the two stage method is an acceptable method of termination now used in many countries.

CASE OF MRS X

Particular I

Mrs X was born in 1942 and had trained as a nurse for two and a half years. She had had four children by 1969 and whilst a widow had an emotional upset following which she found herself pregnant, even though still menstruating regularly. She saw her doctor in Dubbo who referred her to the population Services International Clinic (hereinafter referred to as PSI clinic) in February, 1982 when her pregnancy was of approximately nineteen weeks duration. She had had difficult pregnancies including haemorrhaging after one birth. She had a normal gynaecological examination and counselling on admission to the clinic during which she was advised against a hysterectomy which, she desired and was fully informed of the details of the two stage procedure of Dr Davis. She realised there was an element of danger and risk in the procedure but desired the termination. Any risk of further surgery namely hysterectomy was what in fact desired. She was in fact told of the chances of complications of infection, bleeding and trauma and further surgical procedure and given a typed sheet "About your operation" which further warned of the sequelae such as pain, infection, bleeding and risk of heightened fertility post operatively.

The evidence does not support the particular

Particular 2 (ii) & (iii)

The first stage of the procedure was performed' on 15 February, 1982 when it was observed that Mrs X's .cervix was partially dilated. The membranes were ruptured with a 10mm dilator and the cord washed out so that Dr Davis merely pulled it out. She

was transfused overnight for mild anaemia. At 9.00am on 16 February Mrs X experienced an "exploding" pain and she was given pethidine. Under the influence of this drug which may have masked physical signs, she was seen by Dr Davis about 10.30 am when further pethidine was administered and the patient was placed earlier in the list of operations for the day. This would permit examination under anaesthesia to determine pelvic findings and is acceptable practice. During that examination it was found that the uterus had ruptured to the right and the patient had all the products of conception in her right broad ligament. Her transfer to Royal Hospital for Women into the care of Associate Professor Wren was arranged. We are not satisfied that actual dilation was done by instrument and we are satisfied that all appropriate steps in after care were taken in respect of a rupture which probably occurred spontaneously, such being, on the expert evidence, an occurrence which can take place.

The evidence does not support the particulars

AS REGARDS MRS Y

Particular 1.

Mrs Y was born in 1941 and had had a previous termination of a pregnancy of 14 -16 weeks duration in New Zealand at a public hospital in January, 1980, after having had three children. She was determined to have a termination of her pregnancy of about nineteen weeks duration in February, 1982. When she was told that a termination would not be performed in New Zealand after sixteen week of pregnancy, because it was too risky, she arranged with her doctor to be referred to the PSI Clinic in Australia for a termination. Although she was vague about some aspects of her initial interviews at the clinic by doctor and counsellor we are satisfied that she was anxious to proceed despite knowledge of risks and that she had the same advice as to complications of pain, bleeding and, infection and the risk of heightened fertility post operatively as was given to Mrs X together with being supplied with a copy of "About your operation".

We are not satisfied that the evidence supports the particular. It is inappropriate to make any observations of a general nature as to what is desirable information to be given to patients about to undergo procedures of termination of pregnancies which are

different from other surgical procedures, being very frequently associated with strong, indeed very strong, determination on the part of the patient to undergo the procedure.

Particular 2 (ii) & (iii)

It is appropriate to describe the broad layout of the PSI Clinic. The building consists of two floors. Downstairs is devoted to offices and it is there that initial medical and counselling interviews and office work take place. Upstairs consists basically of four rooms forming a square, being two wards each of four beds under the attention of nursing staff, and adjacent to the theatre and recovery room. Some of these rooms are only separated by screens. An intake history and procedure sheet is clipped with sheets for recording injections, general observation charts for pulse, blood pressure, temperature and other observations and a nurses fluid balance record and pathology records, referrals, and nurses report sheets. These accompany the patient and the surgeon, Dr Davis and the anaesthetist make entries on the procedure sheets as to observations, procedures performed and nursing care and medication to be given.

The first stage of the, procedure was completed in the early afternoon and the patient was transferred to the ward before 2.00 pm on 16 February, 1982. It had not been necessary to dilate the cervix as a small bag of waters was found already protruding through the cervix with a cord in it. The membranes were ruptured and the cord pulled out. This condition was known by Dr Davis to be not unusual in multiparous patients at or about forty years of age. At the second stage of the procedure on 7 February, 1982, it was found that the foetal lower limbs were already protruding through the cervix into, the vagina. Evacuation of the contents which had softened considerably was effected without curetting and an I.U.D, which had been requested by the patient, was inserted. It appears that the miscarriage had proceeded during the night 16 - 17 February, with some heavy bleeding and complaints of pain whilst the usual drip for the procedure was continuing. Appropriate nursing and medication was given throughout the night with good effect, but in the early morning some dizziness was recorded by the nursing sister. Routine testing for haemoglobin count in the morning led to the discovery at about 10.45 that there had been a drop from 11.5 grams percent to 7 grams percent. Although there is some confusion arising from records as to the quantities of matched blood delivered from pathology, quite properly, the complainant ultimately, having

regard to the full content of the evidence, did not press any suggestion that the patient was not properly transfused. A doctor's decision to empty the uterus when a patient is bleeding heavily as a result of a miscarriage process, to assist in controlling the bleeding, knowing that blood (already cross matched) was on the way to supplement blood being administered during the procedure is not unacceptable. The two most important steps in the situation were undertaken, namely, restoring the blood loss and emptying the uterus.

It is clear, that a portion of the foetal head was left in the uterus during the evacuation process. There is a conflict of evidence as to whether the uterine rupture (found on later surgery at the Royal Hospital for Women) occurred during the second stage procedure or at some time subsequently. There was much evidence to suggest that either a traumatic rupture or natural rupture arising from the expulsion of contents through the uterus into the left broad ligament occurred. These are sequelae which can occur even when proper care is being taken.

After the second stage procedure the nursing staff were specifically instructed by Dr Davis to advise him if the patient bled. Dr Davis saw the patient at about 2.30 -3.00 pm and left the clinic at about 3.30 pm leaving instructions that another doctor who had agreed to do so, should be on call. There is a conflict of evidence (between Dr Davis and nursing notes) as to whether Dr Davis spoke to the nurse on duty before leaving. We would be surprised if he hadn't and we cannot make a finding against his evidence - even if we had, it would seem to us that appropriate action was undertaken by the nursing staff. It appears from the clinic's nursing records that the patient had severe pains and tingling on her left side, that blood transfusion had ceased due to reaction by the patient and that pethidine was given which eased pain and that there was variable blood loss pethidine was given which eased pain and that there was variable blood loss between heavy and moderate during the two hours after the return of the patient to the ward. At approximately 5.00 pm Mrs Y was in hypovolaemic shock.

After being badly delayed by traffic conditions during a rail strike, Dr Davis telephoned the clinic at approximately 5.00 pm and ordered SPPS to be followed by whole blood. This was correct action in the emergency, awaiting clarification of the clinical situation.

In accordance with instructions, the doctor on standby was contacted shortly after 5.00 pm, while Dr Davis was still endeavouring to find his way out of traffic conditions. Further SPPS was ordered and administered. There was a phone conversation between Dr Davis and the nursing sister at about 6.00 pm when Dr Davis arrived home. The sister does not remember the contents of the conversation and we accept that Dr Davis gained the impression that the patient's condition was quite satisfactory from the nurse's report that the patient had been started on blood transfusion again and that blood pressure and pulse readings were improving and that bleeding had slackened off. The doctor had a further engagement that night at a restaurant known to the doctor who had agreed to be on call and to the nursing sister, but he rang the sister before leaving home at approximately 7.30 pm. At that stage the nursing notes show that transfusion was still taking place, that blood loss less severe and pethidine had been given. The sister was concerned as to abdominal distension and pain and the inability of the patient to pass urine. Instructions were given to catheterize the patient which was undertaken. At about 9.00 pm the sister rang Dr Davis at the restaurant to report deterioration in the patient's condition and the patient's wish to go to hospital. The doctor on call was informed and thereafter ensued telephone calls between that doctor and a Registrar at the Royal Hospital for Women and Dr Davis and Associate Professor Wren until eventually the patient was transferred to the Royal Hospital for Women at approximately 11.15 pm following ultimate agreement to accept her as a patient. At operation, commencing about 6.00 the next morning, the discovery of the ruptured uterus led to a partial hysterectomy being performed.

Although the summary of events shows that Dr Davis did not actually attend on Mrs Y between approximately 3.00 pm and 11.15 pm, when she was transferred to the Royal Hospital for Women, the evidence satisfies us that

- a. qualified nursing staff were on duty in close proximity to the patient
- b. arrangements had been made for another doctor to take calls
- c. Dr Davis had left instructions as to where he could be contacted and indeed a number of telephone conversations took place between him and the sister on duty
- d. Dr Davis discussed the patient's treatment and condition with the doctor on call and Associate Professor Wren

- e. all procedures taken were proper to be taken to meet the changing clinical situations
- f. if there were any misjudgements arising from the assessment of blood pressure and pulse recordings, or from the patient's condition, they were not unacceptable and certainly not misconduct

Particular 3

This was abandoned.

Particular 4

This particular was finally refined to an allegation that there was not a sufficient visual audit of the foetal parts evacuated so as to constitute gross negligence. Evidence showed that it is a recognised and accepted complication of termination procedures that there can be a non evacuation of a foetal part which can become trapped on rare occasions. It was contended however that the size of the calvaria found by Associate Professor Wren was such as, to make it grossly improper for Dr Davis to have missed it on audit at the conclusion of the ' second stage of the procedure. The head was described as being a 4.3cm head, which had partially collapsed consisting of the jaw and face and part of the skull with all the brain missing. The method of removal of foetal parts used in the mid trimester procedure of Dr Davis must lead to some judgment in assessing the true quantity of foetus evacuated, particularly when there has already been, as in the case of Mrs Y, some degree of miscarriage and softening of the foetus. We accept that Dr Davis did do a visual audit which is appropriate in the mid trimester termination two stage procedure. We do not find his error in missing the foetal head in this case to be professional misconduct.

We find that none of the particulars of the complaint of misconduct in a professional respect have been sustained and the complaints are dismissed.

We make the following observations, following upon the large amount of evidence available to and given before the Tribunal even though, some of it does not relate to the charges.

- a. The failure of the clinic staff to fully record blood pressure and pulse readings on all occasions on the sheets supplied is a matter of concern when a medical practitioner has control over the operation of a clinic.
- b. There appears to be an apparent dependence on verbal reports from nursing staff rather than close perusal of records.
- c. There were some disturbing inconsistencies and conflicts in evidence as to Dr Davis' activities. Although it appears to us that appropriate procedures in relation to the treatment and care of the two patients were in fact followed, we have an uncomfortable feeling that Dr Davis was at too great pains from time to time to justify and explain his conduct to a state of near perfection.
- d. The desirability of the two stage procedure of mid trimester termination as a medical treatment was not an issue in the proceedings.