MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 138/00/58D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against Dr H medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Dr F E Bennett, Ms S Cole, Dr R S J Gellatly, Mr M G Laney (Members)

Ms Kim Davies (Hearing Officer)

Mrs G Rogers (Stenographer)

Hearing held at xx on Tuesday 29 and Wednesday 30 August 2000

APPEARANCES: Ms D A T Hollings and Ms T Baker for the Director of Proceedings

Mr A H Waalkens and Ms K Garvey for Dr H.

1. THE CHARGE:

1.1 THE Director of Proceedings pursuant to sections 102 and 109 of the Medical Practitioners Act 1995 ("the Act") charges that on or about 8 October 1997 and 16 October 1997, whilst treating Mrs Teresa Procter, Dr H undertook to remove an approximately 2-3 cm non-specific mass in Mrs Procter's right axilla without obtaining her informed consent and/or acted in breach of Right 5 and/or Right 6(1)(b) and/or Right 7(1) and/or Right 7(7) of the Code of Health and Disability Commissioners' Rights.

1.2 THE charge was particularised in several respects:

1. H failed to inform or adequately inform Mrs Teresa Procter about her impending surgery to remove an approximate 2-3 centimetre non-specific mass in the right axilla ("the lump") or give her sufficient information on which to base her decision about removal of the lump.

   Particulars:

   The additional or sufficient information that ought to have been provided to Mrs Procter in order to base her decision about the removal of the lump are the following particulars:

   (i) Explanations as to complications, expected risks or side effects for axillary

surgery; and/or

(ii) Failure to discuss alternative options other than excision of the lump itself and the dangers, if any, of not having the excision of the lump; and/or

(iii) H's provisional diagnosis and any alternative diagnosis; and/or

(iv) Failure to advise the removal of (a) lymph node(s) could reasonably be contemplated or was a real possibility in a surgical procedure to remove an axillary mass; and/or

(v) Failure to make clear the distinction between the removal of the lump which could be felt and the removal of extra lymph nodes; and/or

(vi) Failure to explain that the lump could be a mass of lymph nodes; and/or

(vii) Failure to explain that if the lump was a mass of lymph nodes, then the whole lot would have to be taken out to get rid of the lump and to establish a firm diagnosis or the lump Mrs Procter could feel would persist.

2. Failed to inform Mrs Teresa Procter of the expected risks or side effects of the surgery. Risks or the side effects referred to are:

<u>Particulars</u>:

(i) It is the Director of Proceedings case that Dr H does not appear to have explained any of the expected risks or side effects of the surgery. Dr H indicated that Mrs Procter's surgery would be minor, would be performed under local anaesthetic and that she would be back at work the following day. Mrs Procter's evidence will be that there was no other discussion in regard to possible risks or side effects of this surgery.

(ii) Failure to inform Mrs Procter of the following risks and side effects:

(i) Seroma formation (fluid collecting in the wound) which might require aspiration; and/or

(ii) Wound infection; and/or

(iii) Damage to little sensory nerves that could result in pain, numbness or tingling over quite a wide area of Mrs Procter's armpit and the skin over the upper arm; and/or

(iv) Restriction of movement of the shoulder or reduction of the strength of muscles in that region; and/or

(v) Arm swelling.

AND/OR

3. Failed to explain to Mrs Teresa Procter that surgery to remove the lump was likely to also include removal of one or more lymph nodes.

AND/OR

4. Removed lymph nodes during the surgery against the express instructions of Mrs Teresa Procter.

1.3 **AT** the commencement of the hearing Mr Waalkens challenged a second amended version of the charge which the Director had provided to him and to the Tribunal in the week prior to the hearing. Mr Waalkens had prepared the case for the respondent on the basis of an amended charge forwarded to him, but not the Tribunal on or about 23 June 2000.

1.4 **AFTER** hearing from both counsel on this point, the Tribunal ruled that the version of the charge which was advised to Mr Waalkens in June, and on which he had relied in preparing the case for his client, should be the charge which was before the Tribunal at the

hearing. Upon closer examination it appeared that there was little or no substantive difference between the two versions, however the June version was agreed to be the charge before the Tribunal, with one change to the description of the size of the lump, and the correction of two spelling errors.

2. FACTUAL BACKGROUND:

2.1 **THE** charge laid against Dr H relates to his care and treatment of Mrs Procter after she was referred to him by her general practitioner for specialist advice and assessment of a lump which she had detected in her right breast in the upper outer quadrant peripherally.

2.2 **MRS** Procter was injured in a car accident some years ago, and as a result later had implants inserted into both breasts. In November 1992 Mrs Procter consulted a specialist plastic surgeon, Mr Stephen Gilbert, who replaced both implants. In a letter to Dr H date 6 November 1997, Dr Gilbert reported that "*When I removed these* [the original implants], *the implants had ruptured ...*".

2.3 **IN** October 1995 Mrs Procter suffered a fall and badly bruised her arms and upper chest. When pain persisted following this fall, Mrs Procter was again referred to Mr Gilbert, who in turn referred her to Dr Belinda Scott for an ultrasound investigation.

2.4 **DR** Scott reported that there "*was no obvious rupture*". A large node in the right axilla was reported and some soft nodes in the left axilla, but no distinct lumps were palpable in either breast. Dr Gilbert reported to Mrs Procter on 12 January 1996 that "*like me, she is unable to say whether or not the implants had ruptured*".

2.5 **MRS** Procter's evidence was that *"It was decided to leave the node and continue ultrasound surveillance"*. However, in his report Dr Gilbert recommended that an MRI scan be carried out as this was the only way of determining whether or not the implants had ruptured. The MRI scan was carried out on 2 March 1996.

2.6 **THE** MRI scan report concluded:

"The nodular mass lesion in the right axilla at the edge of the implant has an appearance strongly suggestive of a silicone containing granuloma or silicone within enlarged lymph nodes. Although both silicone implants appear intact there is suggestion of silicone outside the implants. This may reflect a gel bleed or a small rupture that has not been detected."

2.7 **AS** a result of this report, Mr Gilbert undertook an exploration of Mrs Procter's right breast and reported no sign of silicone leakage but 'to be on the safe side' he replaced the implant. He took a biopsy of an area of thickened capsule, but found nothing of significance. The diagnostic report confirmed there was no malignancy.

2.8 **IN** mid-1997, Mrs Procter detected a lump in her right breast. In the first instance, a 'wait and see' approach was decided upon. However, after Mrs Procter noticed some changes, her GP, Dr Beveridge, referred her to Dr H at xx. When she attended for her first appointment Dr H was not available and she was seen by Dr A, a breast physician. As Mrs Procter had been referred for an ultrasound in the first instance, Dr A examined Mrs Procter and carried out the ultrasound examination.

2.9 **ON** ultrasound, Dr A confirmed the presence of a "*a 4 - 5mm nonspecific hypoechoic mass suggestive of a solid lump."* It was her opinion, subsequently reported in a letter

to Dr Beveridge, Dr Gilbert and Mrs Procter, that "*Its features [of the lump] were not worrying but after discussion with Teresa, I have advised her that this lump should be removed and a fine needle aspirate would not really alter the outcome. Therefore we have elected not to do the FNA in view of Teresa's concern of accidental rupture by a needle and I am happy to support this decision. …*".

2.10 **AS** result of her findings, she suggested that Mrs Procter should see Dr H the following week "*for a discussion on how this lump can best be removed*." At that consultation Mrs Procter told Dr A that she has previously been treated by Dr Gilbert who had recommended against her having any mammography examinations. She suggested that Dr A obtain her records from Dr Gilbert. Dr A attempted to contact Dr Gilbert by telephone at the time, but was unable to do so, and, by facsimile, requested Dr Gilbert to forward Mrs Procter's records to xx.

2.11 **ON** 8 October 1997 Mrs Procter attended for her consultation with Dr H. Details of the consultation were the subject of their respective evidence and will be referred to later in this Decision. For present purposes, Dr H apparently had no concerns regarding the lump detected by Mrs Procter and confirmed by Dr A. However he detected another lump, of about 2 - 3 cms, apparently slightly closer to, and low down in, the axilla.

2.12 **H** left the consultation to confer with Dr A, and they confirmed that the lump which he had detected was not the lump which Dr A had detected on ultrasound, and which was the subject of her opinion reported to Mrs Procter and her doctors following her consultation with her. Dr H returned to the consultation and discussed the matter with Mrs Procter. Dr

H estimated that the consultation took approximately 1 hour in total, and this was not challenged by Mrs Procter.

2.13 **MRS** Procter was adamant that she did not want her lymph nodes removed, and she instructed Dr H accordingly. Her sister had recently been diagnosed with breast cancer and her treatment had involved surgery, chemotherapy and radiotherapy. Her surgery had apparently included an axillary clearance of her lymph nodes. The experience of her sister, together with her own several operations on her breasts, had persuaded Mrs Procter that in the event she was found to have breast cancer she did not want to go through what her sister had suffered.

2.14 **IN** his reporting letter to Dr Beveridge and Dr Gilbert, he said:

"I reviewed Mrs Procter today with respect to a lymph node in the right axilla. Essentially this lymph node is worrisome as it is firm, 1.5 cm in size and situated in the axilla close to the axillary tail and could well be either a benign enlarged lymph node or a breast cancer.

She has had several implant operations with Mr Gilbert. She is not keen to have any further surgery but in view of the rather suspicious feeling to this lymph node I think we should proceed to excise this and I have made arrangements to do so under local anaesthetic plus sedation at the xx Surgical Centre forthwith."

2.15 **THE** consultation was concluded on the basis that Mrs Procter would consider Dr H's advice that the lump should be removed; she would discuss the matter with either or both of Dr Beveridge and Dr Gilbert, and she would let Dr H know whether or not she would go ahead and have the lump removed.

2.16 **IN** any event, she apparently notified Dr H's office by telephone that she would go ahead, and the lump was removed under general anaesthetic on 16 October 1997. The lump was biopsied and the diagnostic microscopy reported that it -

"*consists of four benign lymph nodes. The lymph nodes show a prominent sinus histiocytosis with foreign body giant cell reaction. Refractile material is noted within the histiocytes. This is consistent with sinus histiocytosis secondary to rupture of a previous breast implant.*"

2.17 **MRS** Procter attended for her post-operative check on 22 October 1997. Dr H was again unavailable and Mrs Procter was seen by Dr A. Mrs Procter complained of numbness under her right armpit and down her right arm. Dr A advised her this was temporary and that it would go away over time.

2.18 **HOWEVER**, Mrs Procter says that since the operation she has suffered extensive swelling in the right arm extending to her fingers, neck and face which has prevented her from playing sport and carrying out normal personal and domestic tasks. She has difficulty sleeping and her post-operative symptoms have put a strain on her marriage and her ability to continue her employment.

2.19 **ON** 6 November 1997 Mrs Procter lodged a claim for medical misadventure with ACC, and on 11 November 1997 Mrs Procter made her complaint to the Health and Disability Commissioner. The charge was laid with the Tribunal on 24 March 2000 and, following a Directions Conference on 27 April 2000, a hearing was scheduled for 28 and 29 June 2000.

3. EVIDENCE FOR THE DIRECTOR OF PROCEEDINGS:

3.1 **THE** complainant, Mrs Teresa Procter, and Mr John Simpson, a breast surgeon of Wellington, gave evidence for the Director of Proceedings.

Mrs Procter

3.2 **MRS** Procter gave evidence of her personal background and lifestyle prior to the surgery to remove the lump. She stated that she lead a very active life, but this was now restricted due to her post-operative symptoms. She gave evidence of her medical background prior to 1997, particularly in relation to the operations which she had undergone following a car accident in 1972 which led to her having breast implants inserted in both breasts in 1979.

3.3 **IN** relation to her initial consultation with Dr A, Mrs Procter gave evidence that Dr A had suggested that she should have a mammogram examination so that the lump could be looked at on x-ray. Mrs Procter told Dr A that Dr Gilbert had said that she should not have a mammogram because of her implants. Dr A did not agree with this, and said that she would phone Dr Gilbert to discuss it. In the event, she was unable to contact Dr Gilbert and said that she would get Mrs Procter's record from him, and it would be ready for Dr H when he saw the following week.

3.4 **MRS** Procter was adamant that Dr A and Dr H did not obtain her records from Dr Gilbert.

3.5 **IN** relation to the consultation with Dr H, Mrs Procter was equally adamant that Dr H did not tell her that he had detected a second lump, different to the one she had found, and confirmed by Dr A. He told her that:

"it would be safer if the lump was removed. He said that he could not say if it was cancerous or not, but "we will remove it and see what the outcome is". He said he would then see if "we need to book you for further surgery.""

3.6 **MRS** Procter said that:

"At this stage I asked Mr H if I really needed the surgery. I explained that I had already had six operations on my breasts. I explained that I was tired and exhausted by the operations and if at all possible I did not want another one. Mr H was clearly surprised by my response. He told me it was simple procedure and that "we will book you in for a Friday, remove the lump under local anaesthetic and you will be back at work on the Monday.""

3.7 **MRS** Procter's evidence was that Dr H did not explain if there were any alternatives to removing the lump; nor did he explain the possible risks, or any adverse post-operative symptoms that she might suffer. During the time Dr H was absent from the room consulting with Dr A, Mrs Procter read her file which he left on his desk. It contained only a few pages and she was surprised that there were no notes or records from Dr Gilbert.

3.8 **SHE** said that she told him what her sister had gone through and that she had had her lymph nodes removed and she did not want that happening to her because of the side effects her sister had suffered. In cross-examination she said that she was very calm during the consultation; she denied becoming very upset when Dr H told her that she had a lump which he indicated could be cancerous. She said that she told Dr H that there was "*no way*" she would let him take out the lymph nodes, "*my body being the way it is I knew what would happen".*

3.9 **MRS** Procter said that she was surprised to hear from Dr Gilbert that there was "*leakage*" and that she was unaware that her implants had ruptured. She was aware that there could be seepage, but she believed that the implants were intact when Dr Gilbert had replaced them.

3.10 **IT** was her evidence that if Dr H had told her that he had found a different lump to that which she had found she would have returned to her GP to discuss it with him and gone from there; she thought there was one lump and one lump only. Dr H made it clear to her that because of the history of her sister's breast cancer, the lump should be removed, and she felt that when Dr H was talking to her he was railroading her to do what he wanted to do, not what she wanted. She said that he used the term *"the lump*" throughout the consultation and did not indicate that lymph nodes might be removed.

3.11 **MRS** Procter stated that:

"I went over everything with Mr H. As I went over instructions to remove the lump, do not touch my lymph nodes, my sister had been through this, I did not want this to happen to me he just was not listening. He did what he felt was right."

3.12 **SHE** left the consultation unsure of what to do. She told Dr H that she would phone back and let him know what she would do. She discussed the matter overnight with her husband and the next day she telephoned Dr H to tell him that she had decided to have the lump removed. He was not available, and she left a message with the woman she spoke to at the clinic.

3.13 **AFTER** the surgery Dr H spoke to her and told her that he removed the *"lump and some lymph nodes"*. She was very distressed at hearing that lymph nodes had been removed against her instructions. In the car on the way home she telephoned Dr Beveridge and asked to contact Dr H to ask what had been removed. Dr Beveridge subsequently confirmed that the lump and some lymph nodes had been removed.

3.14 **THE** operation had been carried out under general anaesthetic rather than a local as while waiting to go into theatre she could hear what was happening in theatre and became very nervous. The anaesthetist had recognised that she was 'stressed out' and worried and he had asked her if she would prefer to have a general anaesthetic. She had readily agreed and thanked him.

3.15 **SHE** was sure that she had signed a consent form for the operation at the time of her visit to Dr H, but she could not recall when this was and no signed consent form has been located.

3.16 **THE** post-operative events and narrative have already been referred to earlier in this Decision.

Dr John Simpson

3.17 **DR** Simpson is a breast surgeon who is also employed by the Royal Australasian College of Surgeons as Executive Director for Surgical Affairs (NZ). He is also contracted to the Medical Council of New Zealand as Professional Standards Co-ordinator.

3.18 **IN** 1998 he was asked by the Health and Disability Commissioner to prepare a report on Mrs Procter's complaint. He reviewed all of the material provided to him and concluded that, in his view, the quality of informed consent was below the expected level but that other aspects of management appear to have been satisfactory. This is consistent with the Director of Proceedings case advised to the Tribunal at the outset that the clinical aspects of Dr H's care and treatment of Mrs Procter were not in issue.

3.19 **AS** Dr Simpson fairly conceded, without a transcript of the discussion between Dr H and Mrs Procter at the consultation on 8 October 1997 it was impossible to know what had been said at the time consent was obtained. Most accurately and succinctly, Dr Simpson stated:

"*There appeared to be a fairly large communication gap between the two parties. Mrs Procter states that she did not undergo the procedure that she considered she had consented to, and Mr H states that he removed the lump as agreed.*"

His conclusion was, on the evidence presented, that consent was "*barely adequate*".

3.20 **IT** was Dr Simpson's evidence that, in the context of Right 6 and Right 7 of the Code of Health & Disability Services Consumers' Rights and informed choice meant a decision, based on adequate information, made about treatment and chosen from a number of options.

3.21 **IN** his view, there seems to have been a failure on Dr H's part to make it clear to Mrs Procter that there was a real possibility that the lump which he could feel could in fact be a lymph node or a cluster of lymph nodes. The apparent failure to explain to Mrs Procter what the operation was actually going to do was clearly at the core of her complaint.

3.22 **DR** H, said Dr Simpson, should have made it clear that if the lump was a mass of lymph nodes then the whole lot would have to be taken out to get rid of the lump and to establish a firm diagnosis or the lump would persist.

3.23 **DR** Simpson stated that the risks which he would have advised to Mrs Procter, in addition to those Dr H stated he did advise, were wound infection, a collection of fluid within the

wound, known as a seroma, swelling of the arm was unlikely but possible, "*in the context of something that was really not a formal axillary dissection operation and some restrictions of movement of the shoulder joint is possible but not common and I would put that in the optional extra category but certainly infection, fluid collection and sensory change would be high on my list.*" He would also have mentioned post-operative pain, but not necessarily poor shoulder function in this context, such risk "*probably would be restricted to a woman having a standard axillary dissection with the intent of removing a large number of lymph nodes.*"

3.24 **DR** Simpson conceded that the decision regarding the amount of information a doctor should provide to a particularly anxious patient was difficult. On the one hand there is the obligation to discuss the problems and complications associated with an operation, on the other hand there is no doubt that spelling out a long line of complications will increase the level of anxiety.

3.25 **THROUGH** Dr Simpson, Ms Hollings sought to introduce two documents which were not included in the bundle of documents, and which had been shown to Mr Waalkens the day prior to the hearing. Mr Waalkens objected to their introduction. After hearing from both Counsel, the Tribunal ruled that the documents should not be admitted. One was a document which Dr Simpson has prepared as an information sheet for use in his own practice; the other a pamphlet prepared by the Royal Australasian College of Surgeons for patients undergoing 'breast surgery'.

3.26 **THE** Tribunal refused to admit the documents on the grounds that they could have been provided to Mr Waalkens at a much earlier time to have given him an opportunity to discuss them with Dr H and to prepare cross-examination if necessary.

3.27 **FURTHER**, it did not appear to the Tribunal that there was likely to be anything in the documents which could not be introduced by way of oral examination-in-chief or cross-examination and their relevance was not immediately apparent to the Tribunal as, in clinical terms, Mrs Procter was not a "*breast surgery*" patient. In any event, it subsequently transpired that the College document was available only very recently and it was not available in 1997. In a later response to a question from Ms Hollings regarding this document Dr Simpson stated that:

"*I don't personally use the College of Surgeons patient information leaflet. These documents I would term patient information leaflets, not guidelines. … some aspects of it are good but some of the wording is more applicable in Australia than here.*"

3.28 **IN** terms of the known risks, it was Dr Simpson's evidence that some degree of numbness would occur in 100% of cases. In most of these it would be minor and of little consequence to the individual. The swelling experienced by Mrs Procter is "*an unusual and not readily predicted complication … in this context … somewhere in the order of 3% might be an expected arm swelling rate.*"

3.29 **AS** to whether or not this would be a risk he would discuss prior to surgery, he said, **"***this would depend a little on how I saw the operation ahead of time. If I saw it as removal of a mass of lymph nodes then I think I definitely would. If it seemed to me to be a solid lump of tissue origin I might not. How likely it would be a major lymph node removal would decide my policy on that.*" If he thought there was a possibility that

he was to remove a lymph node of 1.5 cm in the axilla he would "*probably*" refer to the risk of swelling in the arm.

3.30 **IN** terms of the alternatives which might have been available and which could have been discussed with Mrs Procter, Dr Simpson sated that "*without a doubt removal of the mass and subjecting it to histological examination was the gold standard way of handling it.*" However, he was of the view that an incision biopsy was an option, especially if a lymphoma was being considered.

3.31 **THE** third possibility was to do an ultrasound cone needle biopsy. This would have required a very skilled ultrasound exponent, and this would not be the normal way of handling the situation. In cross-examination, Dr Simpson accepted that even 2 years ago when he wrote his original report, there were a small number of people who were capable of putting a needle into a comparatively small lesion under difficult circumstances. He did not resile from his earlier opinion that "*I would agree entirely with Mr H that the only way of excluding malignancy with certainty was to excise the lump.*"

3.32 **IN** cross-examination he agreed that, as a result of the several operations she had undergone, "*I think that Mrs Procter may have acquired a knowledge of general risks or complications, [but] the operation she was undergoing here was not the same as the previous ones and I think it would be unwise to make any assumptions about that and I certainly would not advise that.*"

3.33 **DR** Simpson agreed that Dr H's letter to Dr Beveridge provided adequate information to enable him to discuss the problem with Mrs Procter had she gone to him for advice. Finally, Dr Simpson said that he thought "*it was a frequent thing*" that despite his best efforts to impart information the patient did not pick up important information passed on to them, and, in relation to obtaining the patient's written consent prior to surgery, he said that it was his practice if he was doing the operation to obtain written consent himself.

4. EVIDENCE FOR THE RESPONDENT:

4.1 **IN** addition to Dr H, evidence for the respondent was given by Dr A, a breast physician of xx, and Dr B, histopathologist/cytopathologist of xx.

Dr H:

4.2 **DR** H gave evidence that he had a good recollection of the events at issue because it was a most unusual situation, for a number of reasons. In particular, he recalled that although he sees on average about 60 patients a week, it is only in two or three cases where he has a suspicion or concern regarding cancer; Mrs Procter was extremely anxious; she had had silicone implants with problems in respect of leakage and replacement, and concerns with lumps; she was opposed to undergoing any further surgery and he was concerned to persuade her that removal of the lump was, in his view, essential; she had been examined by other doctors who had apparently not detected the lump he could feel; it was shortly after the surgery that he had been asked to recall what had been said.

4.3 **DR** H said that when she presented to him, Mrs Procter appeared quite anxious and agitated. She was concerned about the lump in her breast and he understood her anxiety

to be related to other matters about which she spoke, namely that her sister had had breast cancer and the surgeons and chemotherapy had done 'terrible things' to her.

4.4 **HE** confirmed that Mrs Procter had told him she did not want her lymph nodes removed because she did not want to go through what her sister had suffered. He said that at the consultation on 8 October 1997 he had detected the lump low down in her axilla, and that it was a different lump to that found by Dr A on ultrasound. He said that he told her that because of the family history of breast cancer any lump in her breast should be treated with particular caution.

4.5 **DR** A had obtained Dr Gilbert's notes in response to her facsimile request made the week previously, and he had also received notes from Dr Beveridge. He had all of this material available to him at the time of the consultation. He could not explain why Mrs Procter's records were not now available.

4.6 **IT** was the case that, from time to time, records did go missing. It did not happen very often, and he could not say when the records had disappeared. He did make notes at the consultation (and Mrs Procter confirmed this), but he had not been able to locate any part of her record, including any signed consent form, and the only material that was available (including Dr A's brief note), had been provided to the Health and Disability Commissioner when it was requested.

4.7 **HE** said that he had told Mrs Procter that the area of 'thickening' was of no concern with respect to malignancy. He said that he "*did however make it very clear to Mrs Procter*

that I was very concerned about a mobile mass (I would estimate 2-3cm) in the area of the lower axilla. She confirmed that she had not detected this lump previously, but that she had been told she had enlarged glands in both armpits by Drs Gilbert and Beveridge."

4.8 **AT** the time he detected the lump, he thought it *"could have been an enlarged inframmatory secondary to silicone granuloma, I thought it would be a breast cancer, I thought it could be a lymphoma or it could be an area or ridge of fibrocysitc tissue*". He discussed his thoughts with Mrs Procter. He was certain of this because if he finds a lump, all patients ask him what he thinks it is "*pretty immediately - that happens with all lumps"*.

4.9 **DR** H's evidence was that Mrs Procter had been anxious from the outset, but she became particularly so when he discussed his concern regarding this further mass or lump. Mrs Procter was more alarmed and concerned than is common. He said that he spent "*considerable time*" doing his best to persuade Mrs Procter that it was in her best interests to have the lump removed. "*This discussion was entirely about removal of the lump in the armpits - not the thickening or lump in the 10/11 o'clock position…"*.

4.10 **HE** recalls discussing how the lump could be removed - by local anaesthetic or sedation as a day case. It was possible to have the lump removed under a local anaesthetic because it was superficial and close to the skin and low down in the axilla. Dr H said that he reassured Mrs Procter that he would be removing the lump only and he would not be going on to do any other lymph node surgery such as her sister had undergone.

4.11 **HE** assured her that it was minor surgery and that she could have the surgery done on a Friday and return to work on the Monday. He stated:

"*It is however the case that because Mrs Procter was so anxious and desperately concerned about the prospect that she might have cancer and given that plainly a surgical removal of the lump was in her best interests, I would not have wanted to go into huge detail of [the] risks or side effects of surgery."*

4.12 **DR** H went on to say that he respects and recognises the rights of patients to be fully informed. He said:

"*However, when one is dealing with a particularly anxious patient in circumstances as Mrs Procter was in (where surgery was obviously strongly recommended) it is very much a judgment call as to how much information or risks and so forth are provided to the patient. This is because some patients can be completely put off having surgery and scaring them in that manner is unwarranted. ... It is a difficult area of practice."*

4.13 **DR** H emphasised to the Tribunal that this was a very complex case, albeit the removal of the lump itself was not complicated. He remembered telling Mrs Procter that a risk of numbness to the tissues around the armpit was a risk. He always mentions the risks of bleeding and bruising and also wound infection which is a recognised risk. Some tenderness or pain in the post-operative period is to be expected. He always discusses these risks with patients, but generally in a 'low key' or reassuring manner so that the patients do not become unnecessarily alarmed. He considered that Mrs Procter was a *"very highly informed"* patient, "*she had seen a lot of surgeons*", and she had had six operations on her breasts in the past, she knew of some of the risks of surgery.

4.14 **IT** was his view that there were only two alternatives; "*there was either surgery or observation and I knew that she knew fully those alternatives*." Ms Hollings asked him, "*Well did you actually tell her that*?". Dr H responded, "*absolutely and she went*

away and I thought she was going to choose the observation alternative." Ms Hollings, "*Did you discuss the observation alternative with her?, Yes I did.*" He did not have a specific memory of doing this. However, he said, "… *I can't say I did exactly [discuss it with her] but in discussing surgery you always say, or the patient always says, what if we do nothing, that's a very clear discussion point."*

4.15 **HE** did clearly recall that, at the end of the discussion, Mrs Procter decided that she would most likely have the surgery, but she wanted to think about it and she would be in touch to confirm her decision to go ahead. He was aware that she was going to see Mr Gilbert and/or Dr Beveridge, and she asked for her notes to be sent to Dr Gilbert for this purpose.

4.16 **AS** was his customary practice, he dictated the letter to Dr Beveridge at the end of the consultation in her presence. It was his habit to do this, after the patient was fully clothed. The reason for this is twofold, in part so that the patient can hear for the second or third time what he has already said to them, and so that the patient can hear what he is telling their GP.

4.17 **IN** summary, Dr H said that the essential elements a surgeon should go through with a patient such as Mrs Procter to obtain proper consent were the complications which may arise from surgery; the avenues and possibilities of not performing surgery; the differential diagnosis and why surgery was recommended; where the operation would be performed; what it entails; how she should prepare for surgery by not eating or drinking; what sort of support she would need after the surgery; when she could go back to work; when the results would be available; what tissue would be removed at surgery; and who would be examining it.

4.18 **THERE** were three ways he made sure that the patient had 'actually taken on board' the information which had been given. First, a copy of all correspondence was sent to her GP. Secondly, he encouraged patients to seek another opinion and made his records available for this purpose. Thirdly, when he saw the patient pre-operatively he asked them specifically if they knew what he was going to do, and if they understood why they were there, and if they had any questions or concerns.

4.19 **ON** the day of the surgery he met with Mrs Procter and examined her to confirm that the abnormality to be removed was still present (it was). He marked the area with a black pen and also made a transverse marking on the skin of the axilla where the incision would be. This was in quite a different area to where the original lump was located. Mrs Procter has no recollection of any of this however Dr H's evidence was that Mrs Procter had "*absolutely not*" had any pre-medication at this stage.

4.20 **BECAUSE** Mrs Procter was so anxious, a general anaesthetic was offered and accepted. Dr H said that if there was to be any change of plan about the procedure (from a local to a general anaesthetic for example) then he would be advised and there would have been a three-way discussion about this between himself, the anaesthetist and the patient. Mrs Procter did not recall any such discussion taking place.

4.21 **THE** surgery went exactly as intended. Dr H said that had he intended to operate in the 10 or 11 o'clock position, it would have been necessary to replace the implants and he would have ordered new implants for that purpose; he had not done so. He was concerned that the lump might have been a lymphoma, and in keeping with his usual practice he arranged not only for histology, but also breast imprints on slides were made.

4.22 **AFTER** the surgery he visited Mrs Procter. She asked what the mass had consisted of and in particular if he thought she had breast cancer. He said that it did not look like breast cancer to him, but rather that the mass looked like two or three lymph nodes which had been grouped together. These had been sent for microscopic examination for a complete diagnosis. He reassured her that her implants were intact and there was no sign of seepage or leakage into the wound. He confirmed that there was no bleeding, ascertained she was not in pain, and gave permission for her to go home. He expected that she would be back to work on the Monday. He denied that she had made any complaint about his removing lymph nodes.

4.23 **HE** also provided Mrs Procter with postoperative sheets giving her information about the care of her wound and requested that she make an appointment to see him the following week. Mrs Procter was not advised of the physiotherapy services available at xx because *"as we not operating high in the axilla this is not a case that would require that"*.

4.24 **HE** confirmed that Dr Beveridge had telephoned later that day regarding the surgery, and said to him that Mrs Procter was upset and anxious. He understood this anxiety related to the possible diagnosis. He said that no complaint was raised about his removing lymph nodes.

Dr A

4.25 **DR** A, in essence, confirmed the evidence given by Mrs Procter regarding the consultation of 29 September 1997. She recalled that Mrs Procter did not want to have a mammogram because she said that Dr Gilbert had warned against such an examination; principally because he was concerned that there was a risk of rupturing the breast implants.

4.26 **DR** A confirmed that she tried to contact Dr Gilbert by telephone, but he was unavailable. She sent a fax message requesting Mrs Procter's records; but did not recall if the records were received at xx. She did not palpate the lump in the axillary tail found by Dr H, she thinks because she focussed on the lump found by Mrs Procter and confirmed by her GP.

4.27 **SHE** also confirmed that she had seen Mrs Procter post-operatively, most probably because Mr H was unavailable, as he did usually see his patients on their post-operative visit. She could not recall why she had seen Mrs Procter rather than Dr H but could only surmise that it was "*because he was delayed for some extraordinary reason.*"

4.28 **IN** Dr A's experience, Dr H was "*excellent*" in dealing with 'informed consent type issues when dealing with anxious patients'. On the occasions she had been present when he was discussing surgical options he was very careful to spell out in simple language and not use medical jargon regarding what was involved. She states:

"*He's very deliberate in what he says, keeps it very simple, and with women [who are] very anxious and have had bad news he's very careful about what he says.*"

4.29 **SHE** did not recall Mrs Procter making any complaint to her at the post-operative consultation regarding Dr H removing lymph nodes. It was her recollection that Mrs Procter complained only about the numbness in her arm that she was experiencing.

Dr B

4.30 **DR** B is a histopathologist/cytopathologist who is experienced in the examination and diagnosis of breast and lymph node tissue. He gave evidence of his examination and

diagnosis of the tissue/lump removed from Mrs Procter's breast by Dr H, and also a tissue biopsy submitted to Dr B's laboratory by Dr Gilbert in May 1996.

4.31 **THE** fibroadipose tissue received from Dr H "*contained enlarged lymph nodes measuring up to 22mm [2-3 cm] in greatest dimension. These would have been identified by the surgeon as a clinically abnormal mass requiring histological examination to identify the cause of the abnormality.*" It was Dr B's evidence that the clinical differential diagnoses would have included breast carcinoma in axillary breast tissue, fibrocystic change in axillary breast tissue, malignant lymphoma, metastatic carcinoma involving lymph nodes, and reactive lymphadenopathy. It was his opinion that removal of the abnormal tissue was the only correct course of action. In this instance, if an "*accurate and secure*" diagnosis was required, then he suggested that a core biopsy would have given him no comfort.

4.32 **DR** B disagreed with Dr Simpson's evidence on this point. He told the Tribunal that a core biopsy "*would have provided only a very small amount of tissue compared with the size of the pieces that we received. The potential for false negative diagnoses in this clinical situation would be very high if a core biopsy had been used.*"

4.33 **HE** explained that:

"*The core biopsy will give us a sample which is either a 14 gauge core biopsy which is about half a mm in width, and we are dealing with lymph nodes up to 22 mms so the potential for sampling error is huge if we were to use a core biopsy in this scenario. You are dealing with a process which may be focal within a lymph node and you are only looking at 1,000,000th of the lymph node by doing a core biopsy. What certainty can you have for diagnosis?*"

4.34 **THE** tissue provided to Dr B by Dr H comprised three pieces of tissue 3.5 x 2 x 1 cm, 2.5 x 1.3 x 1 cm and 2.5 x 1.2 x 1 cm. The specimen consisted of four benign lymph nodes. The lymph nodes showed a prominent sinus histiocytosis with foreign body giant cell reaction. Refractile material was noted within the histiocytes consistent with sinus histiocytosis secondary to rupture of a previous breast implant. There was no evidence of malignancy.

4.35 **DR** B also told the Tribunal that, had Dr H intended to carry out an axillary dissection for the purposes of obtaining a tissue sample for biopsy, rather than simply removing a lump or mass and submitting it for microscopic investigation, then Dr B would have required a much larger specimen (15 cms x 10 x 8 or 9 cms *vs* that taken). He did not regard the removal of the lump/tissue as being a significant dissection within the axilla. If the tissue had come to him labeled 'right axillary dissection' he would have gone back to the surgeon and said "*I don't believe you've taken an adequate amount of tissue to accurately stage this patient".*

4.36 **HAVING** worked with Dr H for approximately 11 years, he regarded Dr H's communication skills and his professional knowledge and experience very highly.

4.37 **HE** did not agree that the known presence of silicone leaks would make the diagnosis of reactive lymphadenopathy the most likely diagnosis. It was his view that given Mrs Procter's age and family history, then "*… the primary concern in a surgeon's mind would be to exclude a sinister diagnosis such as metastatic carcinoma or carcinoma arising in breast tissue."* It is the case that it is not uncommon to see malignant lymphoma in patients where the only symptom is a slightly enlarged lymph node.

5. THE DECISION:

5.1 **HAVING** carefully considered all of the evidence presented to it, and the very helpful submissions made by both counsel, and having had the opportunity to assess the credibility of each of the witnesses, the Tribunal is satisfied that the charge is not established and that Dr H is accordingly not guilty of professional misconduct in terms of section 109 (1)(c) of the Act.

6. REASONS FOR DECISION: LEGAL ISSUES

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 the charge contains a number of particulars and the credibility of the principal witnesses is in issue on certain key matters. All elements of the charge must be proved to a standard commensurate with the gravity of the facts to be proved: *Ongley v Medical Council of New Zealand* [1984] 4 NZAR 369, 375 - 376.

The Burden of Proof -

6.3 **THE** burden of proof is borne by the Director of Proceedings.

Informed Consent -

6.4 IN her closing submissions, Ms Hollings relied substantially on the Tribunal's Decision in *CAC -v- Stubbs*, Decision 116/99/54C ("*Stubbs*"), which in turn relied upon the

decisions of the High Court of New Zealand, *B -v- The Medical Council* (High Court, Auckland, 11/96, 8/7/96) and the High Court of Australia in *Rogers -v- Whitaker* (1992) 175 CLR 479.

6.5 **THE** latter two cases are significant for their statements as to the standard and content of the 'duty to inform' (referred to below), and the test against which the practitioner's conduct will be measured. In *Rogers v Whitaker*, the Australian High Court departed from the established law, defined and developed in the UK line of cases starting with *Bolam -v Friern Barnet Hospital Management Committee* [1957] 1 WLR 582. The 'Bolam test' established that the criterion against which a doctor's conduct falls to be judged by is whether it complies with the views of a 'responsible body of medical opinion'.

6.6 **IN** *Rogers -v- Whitaker* the Court held that while there is a single, comprehensive duty of care which covers diagnosis, treatment and the provision of information so as to secure consent, the content of the duty varies according to which activity the doctor is undertaking. Even in the context of diagnosis and treatment, the Court was reluctant to follow the *Bolam* approach, holding only that medical opinion evidence will have 'an influential, often decisive, role to play. But as to whether or not the patient has received sufficient information to allow her to make a reasoned choice whether or not to consent to treatment 'is not a question the answer to which depends on medical standards or practice,' that is a matter for the court to determine.

6.7 **THE** content of this aspect of the doctor's duty was that:

"… a doctor has a duty to warn a patient of a material risk inherent in the proposed treatment; a risk is material if, in the circumstances of the particular case, a reasonable person in the patient's position, if warned of the risk, would be likely to attach significance to it or if the medical practitioner is or should reasonably be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."

6.8 **IT** is of course also the case that that the duty is not limited merely to warnings about risks. It extends to information about any alternatives which may exist for the patient. This approach is consistent with the case law which developed in the USA and Canada, the leading cases being *Canterbury v Spence* (464 F 2d 772(1972)) and *Reibl v Hughes* (1980) 114 DLR (3d) 1. Both of these cases were referred to by Lord Scarman in his minority judgment in *Sidaway* -v- *Bethlem Royal Hospital* [1985] 1 All ER 643. All of these cases were referred to in *Rogers v Whitaker*.

6.9 **AS** stated in *Stubbs*, *Rogers v Whitaker* was referred to by Elias J with approval in *B v Medical Council,* and in extra-curial papers given at medico-legal conferences since that case the Chief Justice has expressed the view that *Rogers v Whitaker* is good law in NZ. It is also correct that the wording of Right 6(2) of the Code, with its focus on what a 'reasonable consumer, in that consumer's circumstances' needs to make an informed choice, follows closely the approach taken by the court in *Rogers v Whitaker*.

6.10 **IN** an earlier, influential case *F v R* (1983) 33 SASR 189, King CJ very articulately described the underlying philosophy of doctor-patient interaction as follows:

"The governing consideration is the right of every human being to make decisions which affect his own life and welfare and to determine the risks which he is willing to undertake. The presumption is clearly in favour of disclosure of the information which is relevant to the making of a decision."

6.11 **KING** CJ outlined five factors in determining what a *'careful and responsible'* doctor has a duty to disclose to a patient:

- The duty extends only to those matters which might influence a reasonable person in the patient's position.
- The nature of the treatment is important. The more serious the treatment, the greater the need to keep the patient informed about outcomes and possible risks.
- The nature of any inquiry by the patient.
- The decision as to the nature and extent of disclosure will depend upon the patient's overall medical condition. The 'therapeutic privilege' will be relevant in this regard. If a patient's mental or physical condition may be adversely affected by the disclosure, information may be withheld from the patient.
- The duty to disclose is governed by the overriding requirement that the doctor act in the best interests of the patient.

6.12 **HIS** Honour also recognised that the extent of the duty to advise and disclose will be affected by the surrounding circumstances, such as the existence of emergency conditions, the absence of an opportunity for detached reflection or calm counseling, and the existence of alternative sources of advice. King CJ also acknowledged that some patients will not want to receive information, and a doctor is not required to inflict information on patients which they do not seek and do not want. What is required is reasonable care on the part of the doctor in exercising a judgment as to the real wishes of his or her patient in relation to receiving information relating to risks. *"If a reasonable exercise of that judgment is against volunteering information, a doctor will not be negligent*."

6.13 **IN** all respects, this formulation of the duty to inform accords with the philosophy and purpose of the modern cases, and more particularly in the New Zealand context, with the requirements of the Code of Health and Disability Services Consumers' Rights.

6.14 **NEVERTHELESS**, the fundamental principle is that of self-determination, and the right of the individual to decide what happens to their body; a person has a right to know what treatment entails in order to be able to make a reasoned choice and thus, to give valid consent. What the law requires of doctors is that they provide the patient with sufficient information to make a considered decision. It does not require, nor has it been suggested, that the doctor is required to pass on to the patient everything there is to know about a condition or proposed treatment.

6.15 **THE** duty to disclose is therefore constrained by the traditional tort measure of reasonableness. A further constraint (as per *Rogers -v- Whitaker*) is that the duty is subject to the so-called 'therapeutic privilege': a doctor is absolved from the duty to inform if, by complying with it the patient would suffer more harm than good. In *Sidaway*, the Court confirmed the 'therapeutic' or 'professional' privilege to withhold information that might be pyschologically damaging to the patient. This followed the direction to the jury in *Bolam* where the judge said:

> *"You may well think that when a doctor is dealing with a mentally sick man and has a strong belief that his only hope of a cure is submission to electroconvulsive therapy, the doctor cannot be criticised if he does not stress the dangers, which he believed to be minimal, which are involved in the treatment ...".*

6.16 **THE** existence of such a privilege acknowledges the practical reality that it is simply not possible to devise or require a rigid formula for 'informed consent'; every case will be

different, and every practitioner must exercise his or her own judgment as to 'what' information is given, and 'how', subject to all of the relevant legal requirements and professional duties and obligations.

6.17 **IN** considering whether, as a matter of fact and law, Dr H did provide Mrs Procter with all of the information and advice necessary to enable her to make an informed choice the Tribunal also assessed the reasonableness of his approach.

6.18 **SINCE** the *Stubbs* case was determined, the Medical Council has published its Guide to Medical Practice In New Zealand. In that publication, the Council provides an extensive analysis of the law of informed consent, both in the context of the Code of Health and Disability Consumers' Rights, other legislative requirements of informed consent, and the common law. This analysis concludes:

"The right to make an informed choice and give informed consent, although superseded by other enactments under common law, is of fundamental importance in the provision of medical care and treatment. It is a true right, a claim that must be given effect by doctors unless it is unreasonable in the circumstances to do so. It is clearly not simply a matter of obtaining a signature on a form. Informed consent is a process, involving both doctor and patient, of communicating and discussing the information provided by the doctor so that the patient can take responsibility for making an informed choice about his or her treatment and then choose whether or not to give the doctor consent to implement it." (Page 105)

6.19 **IN** all other respects, the Tribunal agrees with all of the statements as to the content of the duty to inform contained in the *Stubbs* decision. Self-evidently, the duty to communicate the information in a appropriate and effective way is an important part of the obligation to inform. The Tribunal therefore proceeded to assess the case against Dr H within the context of this legal framework described above, and the Code of Health and Disability Services Consumers Rights.

Role of the Code -

6.20 **IT** was also submitted on behalf of the Director of Proceedings that because it is a pre-requisite to laying a charge against a practitioner the Health and Disability Commissioner must determine that the practitioner has breached the Code, then "*logically it must follow that a breach of the Code can appropriately be a charge*" .

6.21 **IN** effect, Ms Hollings argued, a breach of the Code is a disciplinary offence:

"It is important from a public policy viewpoint that the Code is enforceable in appropriate cases as conduct that warrants sanction. It is appropriate that the Code is enforceable before this Tribunal and other disciplinary tribunals involving providers of health care in order that its clear intention that "the Code gives rights to all consumers" is effective."

6.22 **WHILE** the Tribunal agrees that conduct which is determined to be in breach of the Code may well ultimately also be determined to constitute a professional disciplinary offence, and warrant the sanction of an adverse finding in this Tribunal, it does not logically follow that **because** a medical practitioner's conduct is determined to breach the Code, it is automatically also a professional disciplinary offence.

6.23 **IF** that was the case, then every breach of the Code would automatically have come before this Tribunal as a charge; in fact relatively few charges have been brought to this Tribunal by the Director of Proceedings. The submission also ignores the fact that the decision to bring a charge is not made by the Health and Disability Commissioner - the person who determines whether or not a practitioner has breached the Code.

6.24 **SECTION** 45 of the Health and Disability Commissioner Act 1994 provides that the Commissioner, having formed an opinion that the subject-matter of an investigation was in

breach of the Code, has a range of procedural options available. Those options include the right to make a complaint to any health professional body (s.45(d)) and (s.45(f)) the right to refer the matter to the Director of Proceedings '*for the purpose of deciding whether any one or more of the following actions should be taken ...* [s.45(f)(iii)] *The institution of disciplinary proceedings."*

6.25 **THUS**, the power to institute professional disciplinary proceedings in this Tribunal is entirely discretionary and may be exercised by the Director of Proceedings only. It is by no means automatically the case that a breach of the Code will result in professional disciplinary proceedings, and it must logically follow that it is equally not the case that a breach of the Code will automatically (or ultimately) constitute a professional disciplinary offence.

6.26 **IN** exercising its own discretionary powers under section 109 of the Act, the Tribunal must examine the conduct which is the subject of the charge brought to it, and its discretion to determine the charge must be unfettered by any other determinations made in relation to the conduct which is the subject-matter of the charge.

6.27 **THE** Tribunal does not accept Ms Hollings submission that it is only by way of the sanction of a professional disciplinary offence that the Code can be enforced. There are a variety of sanctions and means of enforcing the Code available to both of the Commissioner and the Director of Proceedings apart from the institution of disciplinary proceedings.

6.28 **IT** is also significant in the Tribunal's view that the Director's power is limited to the "*institution*" of disciplinary proceedings; consistent with the procedural, legal and practical reality that the determination of such proceedings is entirely a matter for the Tribunal. It is the *conduct* that the Commissioner opines was in breach of the Code, and that is the subject-matter of the charge, not the breach of the Code *simpliciter,* which is the subject of the Tribunal's inquiry.

6.29 **THIS** analysis does not derogate in any way from the enforceability of the "*rights and duties*" provided for in the Code, or "*the basic obligations and rights that are widely available to consumers and medical practitioners*" in the Code which are administered and enforced by the Health and Disability Commissioner. The Tribunal has previously agreed with the Director that standards set under the Code could be determinative in establishing whether a practitioner has departed from acceptable professional standards (*Wakefield,* Decision 85/99/42D).

7. FINDINGS IN RELATION TO PARTICULARS OF CHARGE:

Particulars 1 (i) to (vii) and 2(i) - (v)

7.1 **THESE** Particulars set out the grounds of that part of the charge that Dr H failed, or failed adequately, to inform Mrs Procter about her impending surgery, or to give her sufficient information on which to base her decision, and that he failed to explain any of the risks or side-effects of the surgery.

7.2 **THE** Tribunal is satisfied, on the balance of probabilities, that Dr H did provide the information which it is alleged was required to ensure that Mrs Procter was able to give informed consent to the surgery to remove the non-specific mass in her right axilla.

7.3 **THE** Tribunal is satisfied that Dr H did tell Mrs Procter that it was his opinion that the lump should be removed; he discussed the risks of lymphatic dissection in some detail because this was the surgery that he believed her sister had undergone and that such an operation *"was in no way shape or form"* similar to what was involved to remove Mrs Procter's lump.

7.4 **THE** Tribunal accepts Dr H's evidence that because he believed that Mrs Procter might have a breast cancer, but that she might reject any treatment because of her sister's experience, he explained that the lump might be lymph node; that it was well away from the axilla, and that the surgery could be performed under local anaesthetic plus sedation; he explained the risks and benefits of removing the lump, or not, and that the complications that she needed to be concerned about and which were common were bruising, bleeding, numbness and some post-operative pain and tenderness.

7.5 **THE** Tribunal is satisfied that he did discuss the symptoms that her sister had suffered and that Mrs Procter was concerned about, with her with the intention of explaining the difference between what was likely to happen in the circumstances of the removal of a relatively superficial lump in the axillary tail compared to a full axillary clearance.

7.6 **THE** Tribunal makes this finding on the basis that the Particulars fairly stipulate the information that Mrs Procter was entitled to receive from Dr H.

7.7 **THE** Tribunal also considers that it is likely that the way in which the content of the advice and information which Dr H gave to Mrs Procter was influenced by the following factors:

- his perception that Mrs Procter had a high level of anxiety about the possibility that she had breast cancer,
- her experience of several previous operations on her breasts, which were more extensive than the surgery to remove the lump which he had discovered, and
- that she was well informed about breast surgery,
- his clinical judgment that it was in Mrs Procter's best interests that the lump should be removed because "*she had a possibly fatal condition if left untreated and I was concerned that she needed to understand that and I was also concerned that she understand fully all of those issues*",
- his clinical judgment that removal of the mass and subjecting it to histological examination was the most appropriate and clinically acceptable option,
- the fact that the lump was superficial and low down in the axilla, and therefore the risk of post-operative symptoms was minimal,
- his knowledge that Mrs Procter "*was not keen*" to have any needle biopsies performed near her breast implants, "*she was very aware of the risks of damaging the implant",*
- the fact that at that time the option of obtaining the services of an ultrasonographer who would, or could, have directed a core needle into the mass so that a sample could be taken was either not available, would have required the insertion of a needle into Mrs Procter's breast which option she had made plain was rejected by her, or otherwise not warranted in the circumstances given the locality and size of the lump.

7.8 **HOWEVER,** the Tribunal does not consider that in imparting the information Mrs Procter was entitled to receive with these factors in mind Dr H acted unreasonably or unfairly. The Tribunal is satisfied that Dr H acted in good faith and that he did not intend to mislead or deceive Mrs Procter with regard to any of the information which was material to her decision.

7.9 **IN** this case, the Tribunal is satisfied that while the information that Dr H gave to Mrs Procter might have been imparted in such a way that took into account the factors described above, it was not the case that the Director of Proceedings established on the balance of probabilities that he deliberately withheld information from Mrs Procter, or that her ability to give informed consent was compromised.

7.10 **IN** coming to this view, the Tribunal does not find that Mrs Procter was in any way, an untruthful witness. However, having had the opportunity to observe both of Mrs Procter and Dr H give their evidence at some length, the Tribunal prefers the evidence of Dr H, particularly his evidence that he perceived Mrs Procter to be very anxious, given her own experience having previously undergone several operations on her breasts, and her recent experience nursing her sister after she had been diagnosed with breast cancer.

7.11 **DR** H's evidence that the consultation he had with Mrs Procter on 8 October 1997 lasted for approximately 1 hour was not challenged by Mrs Procter. At least part of this consultation was taken up with his leaving the consultation to discuss with Dr A his finding of lump other than that confirmed on ultrasound by her. Given his evidence about finding this lump, which had not previously been noticed by either of Mrs Procter, her GP or Dr

A, and which he suspected might be sinister, the Tribunal considers that it was unlikely that he would not have advised Mrs Procter of his finding, and his impression of it.

7.12 **THE** Tribunal is reinforced in this view by Dr H's evidence that he did not consider that the lump previously detected required any further investigation. But the Tribunal is satisfied either that, Dr H and Mrs Procter were engaged at cross-purposes, or that Mrs Procter's recall of events and discussions she had at the time is imperfect. Whatever the reason, the Tribunal is satisfied that Dr H did find a second lump at the consultation on 8 October 1997 and that he informed Mrs Procter of his findings, his differential diagnosis, his concerns, and her options.

7.13 **NOTWITHSTANDING** those findings, it was very unsatisfactory that Dr H was unable to produce any of his notes or Mrs Procter's medical records retained by xx at the hearing. However, it was also the case that a significant amount of Mrs Procter's evidence related to discussions she had with, and information she said she obtained from, third parties. For example, the discussion she had with her husband immediately following the consultation with Dr H, and discussions she had had with Dr Beveridge and Dr Gilbert at various times, none of whom gave evidence at the hearing.

7.14 **IN** many respects, Mrs Procter's inability to recall a number of key events or matters of detail is understandable given the passage of time, the effects of medication administered at the time of the surgery and the stress and frustration of being unwell and unable to pursue her usual activities as she would wish. But the gaps in her ability to recall signal events and information make it unsafe for the Tribunal to make findings adverse to Dr H, especially in

relation to matters in respect of which the Director of Proceedings bears the burden of proof.

7.15 **IN** this regard it is relevant that Dr Simpson agreed in cross-examination that there were a lot of studies reported in the medical literature about the ability of patients to recall information. In summary, patients often have a very poor recall of what they are told about risk factors and the like. The studies which Dr Simpson is aware of show that somewhere in the order of 1/3rd of information given is retained even in the medium term.

7.16 **FURTHER**, if patients have a particular concern, this can create stress which makes it more difficult for the patient to recall what they have been told after the event. Dr Simpson accepted that *"even with the best intent and best practice you don't have a 100% success rate"*. He was asked:

"Have you ever had a case where in spite of your efforts to impart information the patient has not picked up important information passed to them?"

He replied:

"I think it is a frequent thing. What one has to be aware of [is that] repetition before and after the procedure is often helpful to get the key information over to the patient, but it is not an entirely straightforward process by any means."

7.17 **IT** was Dr H's evidence that he believed Mrs Procter left the consultation on the basis that she was going to discuss the matter with either or both of her GP and Dr Gilbert. It was also Dr H's evidence that before the surgery Mrs Procter had phoned to say that she had discussed the matter with Dr Gilbert by telephone and that Dr Gilbert had told her that if Dr H was recommending removal of a lump then he would agree with Dr H's plan of action. Mrs Procter said that she did not discuss the matter with either of Drs Beveridge or Gilbert.

7.18 **MRS** Procter also denies that any differential diagnosis was discussed with her, in particular that there was any discussion regarding the possibility that the lump was related to the leakage of silicone into the breast tissue, or the rupture of her implant, that is, that it could have been an enlarged inframmatory secondary to silicone granuloma. Mrs Procter denied that either of the implants had in fact ruptured at any time, however Dr Gilbert's letter of 6 November 1997 confirms that such a rupture did occur, and the Tribunal is satisfied that the possibility of silicone leakage was an ongoing issue for Mrs Procter.

7.19 **IT** was Dr H's evidence that he had discussed the possibility of leakage or rupture of the implants with her and that:

"She was well aware that there had been ongoing concerns about the presence/absence of a ruptured implant and she was well aware that my differential diagnosis was silicone leakage or bleed from the implants".

7.20 **THERE** are a number of other differences between Dr H's evidence and Mrs Procter's evidence in relation to key issues. For example, Mrs Procter asserted that, 'as a matter of fact' she knew that Dr H did not obtain her records from Mr Gilbert; for their part, Dr H and Dr A are sure that they did request and receive that material from Dr Gilbert. Mrs Procter does not recall being examined by Dr H pre-operatively, or his marking the operation site; Dr H is sure that this occurred before Mrs Procter had received any pre-operative medication, as is customarily done, and he explained the reasons for this.

7.21 **MRS** Procter stated on a number of occasions that she felt that Dr H 'railroaded' her into having the surgery to remove the lump. However, the Tribunal is satisfied that this is not borne out by the evidence that Mrs Procter left the consultation on the basis that she would

think about Dr H's advice, and might obtain a second opinion from her GP and/or Dr Gilbert, and she would let Dr H know what she decided. It was Dr H's evidence that he was unsure if Mrs Procter would return for the surgery or not, but that, from time to time patients did decide not to have any further treatment and that it was their right to choose the 'no treatment' option.

7.22 **DR** H also gave evidence of his practice of dictating a letter of advice to the referring GP at the conclusion of the consultation, and in the presence of the patient so that the patient is aware of the advice given to her GP, and has the opportunity to ask questions or to seek clarification. He said that he followed this practice at the consultation with Mrs Procter, but Mrs Procter denied this. Mrs Procter alleged that Dr H failed to inform her that the lump which he advised should be removed, which was a different lump to that she had gone to see him about, could be a mass of lymph nodes.

7.23 **HOWEVER**, in his letter to Dr Beveridge, which Dr H says he dictated in her presence, he stated:

"I reviewed Mrs Teresa Procter today with respect to a lymph node in the right axilla.

Essentially this lymph node is worrisome as it is firm, 1.5cm in size and situated in the right axilla close to the axillary tail and could well be either a benign enlarged lymph node or a breast cancer.

She has had several implant operations with Mr Gilbert. She is not keen to have any further surgery but in view of the rather suspicious feeling to this lymph node I think we should proceed to excise this and have made arrangements to do so under local anaesthetic plus sedation at the xx Surgical Centre forthwith."

7.24 **IT** was Dr H's evidence that he prepared this letter in the terms that he did so that Dr Beveridge and Dr Gilbert (the letter was sent to both of them) would be able to discuss the

matter with Mrs Procter if she sought their advice. It was Mrs Procter's evidence that Dr Beveridge "*knows that*" she would not have wanted lymph nodes touched. "*He knows what I am like*", she stated, "*Dr Gilbert as I said before I leave total - I have so much faith in him he sits down and explains to me and goes through things thoroughly and the decision is made from there".*

7.25 **IN** response to a question from Ms Hollings that *"Dr Beveridge was aware of your clear desire not to have lymph nodes touched*" Mrs Procter responded "*absolutely. Dr Beveridge and I have talked about my sister. We just have a general chat and from time to time he asked me how she is."*

7.26 **IT** is simply the case that many of the issues in dispute cannot be resolved with certainty in the absence of either of Dr H's notes or evidence from any of the other third parties already referred to, or any other corroborative evidence which might have settled these issues unequivocally. It is not disputed that Dr H did have a file with him and did make notes at the consultation with Mrs Procter, and also that a consent form for the surgery was signed by her. But none of this material was able to be located.

7.27 **HOWEVER**, and bearing in mind that the burden of proof is borne by the Director of Proceedings, the Tribunal is satisfied that, on balance, it prefers the evidence of Dr H, and that he must be given the benefit of the doubt in relation to those issues which the Tribunal finds are not proven for one party or the other. On that basis, Particulars 1 and 2 are not established.

Particulars 3 and 4

7.28 **THESE** Particulars contain allegations that Dr H failed to explain to Mrs Procter that surgery to remove the lump was likely to also include removal of one or more lymph nodes, and that Dr H removed lymph nodes against Mrs Procter's express instructions.

7.29 **IT** appears clear to the Tribunal that the issue of the removal of lymph nodes as opposed to the removal of the lump is an irreconcilable dispute between Dr H and Mrs Procter. To the extent that Dr H may have misunderstood Mrs Procter's instruction not to remove lymph nodes, on the basis that she did not want to go through what her sister had, he made an error.

7.30 **LIKEWISE**, to the extent that Mrs Procter gave consent to the removal of "*the lump*" which might have been a mass of lymph nodes, she did not understand that the removal of the lump might entail removal of some lymph nodes in a mass which was close to the skin surface and low down in the axilla, and that this was a very different operation to that her sister had apparently undergone. Dr H appears clearly to have interpreted Mrs Procter's instructions to be that, in the event that the lump was breast cancer, she was not going to have any further treatment, or operations.

7.31 **THE** Tribunal is satisfied that, on the basis of his letter to Drs Gilbert and Beveridge, and his advice to Mrs Procter post-operatively that he had removed the lump and/or which comprised some lymph nodes, he did not intend to mislead or deceive Mrs Procter as to what the surgery involved. Had he intended to deceive her it would have been a simple matter to have made no mention of lymph nodes whatsoever, but referred only to removing "*the lump*" and sending it off for examination.

7.32 **HE** also appears to have understood her instruction that he should not remove lymph nodes solely on the basis that she did not want to go through what her sister had gone through. It was his understanding that Mrs Procter's sister was diagnosed with breast cancer and her treatment had involved radical surgery, a 'full axillary dissection', radiotherapy and chemotherapy. He understood that if he removed the lump and it was found to be malignant, Mrs Procter did not want to have any further treatment or surgery. She did not want to suffer what her sister had suffered.

7.33 **AS** has been stated on a number of occasions, not every error made by a doctor will be culpable. Dr H is charged at the level of professional misconduct. The test for professional misconduct is well-established. The most commonly cited formulation being that of Jefferies J *in Ongley -v- Medical Council of New Zealand* [1984] 4 NZAR 369:

"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would reasonably be regarded by his colleagues as constituting professional misconduct? With proper diffidence it is suggested that the test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the composition of the tribunals which examine the conduct. Instead of using synonyms for the two words the focus is on the given conduct which is judged by the application to it of reputable, experienced medical minds supported by a layperson at the committee stage."

7.34 **IN** *B* (supra), and in the context of a charge of conduct unbecoming, and most relevantly in the present context, Elias J stated:

" In the case of diagnosis or treatment, conduct which falls short of the mark will be assessed substantially by reference to usual practice of comparable practitioners. In the case of adequacy of communication of information to the patient, however, wider considerations are relevant. In particular, the communication must be such as to adequately inform the patient, taking into account the patient's capacity to understand it and the purposes for which the information is relevant. What needs to be communicated may depend upon whether the information is provided pursuant to the patient's general right to know about his or her condition, or whether it is required to inform the patient's own conduct in matters such as consent to medical

procedures, or co-operation with investigational treatment. These seem to me to be considerations which are relevant in assessing the conduct of a medical practitioner. Those standards to be met are, as already indicated, a question of degree; the practitioner is not a guarantor of the effectiveness of communication any more than he or she is a guarantor of the effectiveness of treatment. I accept that the burden of proof is on the balance of probabilities. Assessment of the probabilities rightly takes into account the significance of imposition disciplinary sanction. I accept that the court must be satisfied on the balance of probabilities that the conduct of the practitioner is deserving of discipline."

7.35 **FROM** these statements, 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 professional misconduct or 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); and, in the context of a complaint that the practitioner failed to obtain the informed consent of his patient.

(d) The patient's capacity to understand information is a relevant consideration, and it must follow that in assessing the patient's capacity to understand, the patient's past experience and knowledge of the issues under discussion will be relevant.

(e) The purpose for which the information is provided is relevant.

(f) The practitioner is not a guarantor either of the effectiveness of the communication or the treatment offered and/or given.

7.36 **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 H's conduct is conduct which is culpable, i.e. is conduct warranting an

adverse finding, is a question squarely for determination by this Tribunal.

7.37 **THAT** is the process followed by the Tribunal on this occasion. Having assessed all of the evidence presented to it against the framework of the basic and essential principles referred to above, and the Code of Health and Disability Services Consumers Rights, it is satisfied on the balance of probabilities that Dr H did provide Mrs Procter with all of the information and advice that was necessary and appropriate and that he did so in 'an appropriately effective way'.

7.38 **TO** the extent that he erred in removing lymph nodes which Mrs Procter subsequently said was against her express instructions, he is guilty of misunderstanding those instructions. As such, the Tribunal is satisfied that he made an error which does not warrant the sanction of a finding of either professional misconduct, or the lesser charge of conduct unbecoming that reflects adversely on his fitness to practise medicine.

7.39 **HOWEVER**, the Tribunal also wishes to record that it does have concerns regarding any failure to return telephone calls by Dr H, or any other practitioner. Similarly, it is Dr H's responsibility to ensure that he maintains proper systems for the safe-keeping of patients' records. As has been said previously by this Tribunal, a practitioner who fails to maintain proper records is at risk of an adverse finding if he or she is unable to provide any records of consultations, discussions, telephone discussions, medications prescribed and/or other relevant information relating to the care and treatment of patients.

7.40 **THE** Tribunal is also concerned that Dr H himself appears not to obtain his patients' consent to surgical procedures to be carried out by him, but he apparently leaves this to (possibly unqualified) support staff. In the absence of undertaking this personally, the Tribunal considers that Dr H risks patients giving their written consent to surgical procedures on the basis of an incomplete understanding.

7.41 **IN** such circumstances, Dr H also risks reducing the obtaining of consent to a merely mechanical process, robbed of meaning, and thus ineffective. His apparent uncertainty regarding the procedures for obtaining written consent at his clinic, and for the collection and storage of consent forms, is unsatisfactory. However, in the present circumstances, the Tribunal is satisfied, on the balance of probabilities, that a signed consent form was obtained from Mrs Procter.

7.42 **AS** it has determined in relation to Particular 1 and 2, the Tribunal is also satisfied that it was not unreasonable or inappropriate for Dr H to provide information to Mrs Procter on the basis that she was knowledgeable about the general risks of surgery, particularly in circumstances where he considered that the surgery to remove the lump was relatively minor surgery, which could have been done under a local anaesthetic.

7.43 **THE** Tribunal finds that it was not unreasonable for Dr H, having formed the impression that Mrs Procter was an anxious patient, (and given the background of her own experience and her sister's recent diagnosis and treatment, reasonably so) to exercise his judgment about the content of the advice he gave her about specific risks in the context of the surgery which he was recommending, and in the context of the level of risk he considered existed if she did not have the surgery to remove the lump.

7.44 **NOTWITHSTANDING**, any such exercise of judgment on the part of Dr H as to how or what information he gave to Mrs Procter, the Tribunal is satisfied that Dr H did provide Mrs Procter (and her GP) with sufficient and appropriate information for her to decide whether or not she should go ahead and have the lump removed.

7.45 **MOST** importantly, he also gave her a fair opportunity to discuss the matter with any other person or medical adviser, and to take such advice and counsel as she thought she needed before she made her decision. He left it entirely up to Mrs Procter to decide whether or not she would take his advice and have the lump removed, and when.

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

8. NAME SUPPRESSION:

8.1 **THERE** are currently in place orders suppressing publication of Dr H's name and any identifying details, and the name of xx, pending the determination of the Charge, or further order of the Tribunal.

8.2 **THE** Tribunal does not currently see any justification to order permanent suppression of Dr H's name, or any other details, particularly bearing in mind Mr Waalkens strong submissions made at the time that Dr H only sought name suppression on an interim basis. However, the Tribunal anticipates that, since the Charge is dismissed, Dr H may wish to make application for permanent orders, and the Tribunal is prepared to consider any such application, and any submissions Dr H may wish to be made on his behalf in that regard.

8.3 **THE** Tribunal will make orders accordingly, and the non-publication orders remain in place until any such application is determined.

9. ORDERS:

9.1 **THE** Charge of professional misconduct laid against Dr H is dismissed.

9.2 **THE** interim orders made by the Tribunal on 11 May 2000 prohibiting publication of Dr H's name and identifying details, and the name of xx, remain in place pending the determination of any application for permanent orders.

9.3 **ANY** application for permanent non-publication orders must be made within 14 days of receipt of this Decision. Such application to be accompanied by any affidavits and/or submissions in support.

9.4 **THE** Director of Proceedings to file any notice of opposition and supporting material and/or submissions within 7 days thereafter.

9.5 **THE** application can be considered on the papers or after a hearing by telephone conference, if Counsel could please indicate their preference in this regard.

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

DATED at Auckland this 30th day of October 2000.

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W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal