MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 139/00/62D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Sections 102 and 109 of the Act against **GRAHAM KEITH PARRY** medical practitioner of Whangarei

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Mr R W Jones, Dr F McGrath, Dr B J Trenwith, Mrs H White (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Auckland on Thursday 7 September 2000 and resumed hearing held at Paihia on Monday 9, Tuesday 10 and Wednesday 11 October 2000

APPEARANCES: Mr M F McClelland and Ms T W Davis for the Director of Proceedings

Mr C J Hodson QC and Mr H Waalkens for Dr G K Parry.

1. THE CHARGE:

1.1 **BY** an amended charge dated 31 August 2000 the Director of Proceedings pursuant to sections 102 and 109 of the Medical Practitioners Act 1995 ("the Act") charged Dr Parry with disgraceful conduct in a professional respect, and that the particulars of the charge either separately or cumulatively were particulars of disgraceful conduct in a professional respect.

1.2 **THE** charge contained three particulars:

1. He failed to carry out an adequate clinical assessment and examination of his patient on 22 August 1997; and/or
2. Performed an unnecessary and/or clinically unjustified cone biopsy on his patient on 19 January 1998; and/or
3. Despite receiving a pathology report on or about 9 January 1998 confirming the diagnosis of invasive carcinoma he did not refer his patient to the Oncology Unit

at National Women's Hospital, Auckland for further treatment until 9 February 1998.

4. The conduct alleged amounts to disgraceful conduct in a professional respect and paragraphs 1 to 3 inclusive either separately or cumulatively are particulars of that disgraceful conduct in a professional respect.

1.3 **THE** hearing of the charge was scheduled to commence on 9 October 2000. The charge arose from a complaint made by Mrs Colleen Poutsma to the Health and Disability Commissioner in April 1998, and was determined by the Commissioner in September 1999. As part of that determination, the complaint was referred to the Director, and the charge laid in July this year. Over the period of more than two years between the time of making her complaint, and the charge being brought to the Tribunal, Mrs Poutsma had being undergoing treatment for her cervical cancer, diagnosed in December 1997.

1.4 **IN** August, the Director advised the Tribunal that Mrs Poutsma's condition had deteriorated over the previous few months and an application was made and granted to commence the hearing on 7 September 2000 by way of a special sitting of the Tribunal held at St Joseph's Mercy Hospice in Auckland. At the conclusion of that special sitting, the hearing of the charge was adjourned to the hearing date originally scheduled.

1.5 **ACCORDINGLY**, the hearing which commenced in Paihia on 9 October 2000, was a resumed hearing.

2. FACTUAL BACKGROUND:

2.1 **MRS** Colleen Poutsma is a married woman who lives with her husband and three children at Paihia in Northland. In 1991 Mrs Poutsma was first referred to Dr Parry by her then GP, Dr Fenton of Moerewa, after having some mid-cycle, post-coital genital tract bleeding. Dr Parry was at that time a specialist gynaecologist and obstetrician, with a private practice in Northland. A smear test taken at the time was mildly abnormal.

2.2 **AT** that time, Dr Parry considered that the bleeding was due to a small cervical ectropian, a relatively common benign condition. Dr Parry did not consider that any treatment was required, but that if the problem persisted, Mrs Poutsma should see him again.

2.3 **IN** 1994, Mrs Poutsma's GP care transferred to Dr O'Connor at Paihia. On 18 August 1997, she presented to Dr O'Connor with another complaint of post-coital bleeding. Between 1991 and 1996, Mrs Poutsma had regular cervical smears which reported no abnormalities.

2.4 **WHEN** she presented to Dr O'Connor in August 1997, she reported that she had suffered post-coital bleeding on a number of occasions over the previous few months, but she had bled heavily the day before and had gone to the 'out-of-hours' duty doctor in Kawakawa, Dr Lawrence. Mrs Poutsma said that Dr Lawrence examined her and took a cervical smear, and he suggested that she should visit Dr O'Connor the next day so that he could refer her to a specialist.

2.5 **MRS** Poutsma followed this advice and she went to see Dr O'Connor the next day. He also examined her and took a cervical smear. He told her that he wanted an expert opinion from a specialist. He wrote a letter of referral to Dr Parry.

2.6 **IN** his letter to Dr Parry, Dr O'Connor stated:

"You saw Colleen in 1992 with some post coital bleeding which you thought was due to an ectropion of her cervix. She has remained reasonably well since then, but over the past few months has developed increasingly severe post coital bleeding. Her last cervical smear was in July 1996 and was normal.

On examination today, the cervix looked slightly inflamed and it bled to the touch. I have repeated smears and swabs, but I think their value may be diminished by blood contamination. On bimanual palpation, her uterus seems anteverted, but quite bulky.

I wonder if this merits further investigation and welcome your expert opinion and advice."

2.7 **MRS** Poutsma went to see Dr Parry on 22 August 1997. Dr Parry's appointment book for the relevant date records that Mrs Poutsma's appointment was scheduled for 1.10 - 1.30 pm, and the reason for her visit is stated to be "*bulky uterus*". This appointment and the reason for it was apparently made by Dr Parry's receptionist on advice from Dr O'Connor's receptionist.

2.8 **ON** the morning of her visit, the report on the smear taken by Dr O'Connor was received by telephone at Dr Parry's office and was available to him at the consultation. The report on the smear stated:

"Endocervical component is present.
ATYPICAL SQUAMOUS CELLS of uncertain significance [ASCUS] present.
Please repeat the smear in six months."

2.9 **AT** the consultation, Dr Parry spoke to Mrs Poutsma for a few minutes and then he carried out a trans-abdominal ultrasound scan. He did not carry out any other examination. He advised Mrs Poutsma that he did not think it was necessary to do anything further at that stage unless the bleeding became more regular or if a future smear was abnormal. Mrs Poutsma said that the visit lasted about 10 minutes.

2.10 **ON** her return to her car where her husband was waiting for her, she said to him that the visit had seemed like a waste of time. She reported that she had not even had to remove her 'knickers'. Dr Parry reported to Dr O'Connor in a letter dated that same day. He advised:

"Thank you for asking me to see Colleen with her recent post coital bleeding and a comment that the uterus was enlarged. Ultrasound today showed a slightly bulky uterus at 4.4 cms, but not significantly so. The endometrium was normal. She had normal ovaries. At this stage I wish to do nothing further unless the bleeding becomes a regular part of her life in which case we should see her again or if her smear is abnormal we should see her again."

2.11 **ON** 22 December 1997, Mrs Poutsma returned to Dr O'Connor and reported suffering a severe post-coital bleed the previous night, and several occasional episodes of bleeding since August. She had not returned to see Dr O'Connor sooner about her recurrent bleeding because she had been reassured by Dr Parry.

2.12 **DR** O'Connor referred her to Dr Parry as a matter of urgency. In his letter of referral he stated:

"This lady has an appointment to see you on Wednesday, 31 December at 10.30 am.

Colleen has had occasional episodes of spotting since you last saw her in August, but had a large bleed last night.

I wonder if this merits further investigation and am most grateful to you for seeing her."

2.13 **AT** her visit on 31 December Dr Parry, on this occasion, did carry out a vaginal examination, took another smear and also performed a large 7 x 5 mm punch biopsy. Mrs Poutsma bled heavily and fainted in the surgery. Dr Parry ascribed her fainting to the fact that it was a very warm day.

2.14 **BY** letter to Dr O'Connor Dr Parry reported:

"I saw Colleen today after her recent bleeding. The cervix looked quite different from what it did in August and looks considerably abnormal. I have repeated the smear and done a biopsy with a copy of the results to come to you."

2.15 **DR** Parry sent the biopsy tissue off for histological examination. His computer record for 8 and 9 January 1998 states:

"8.1.98 HISTOLOGY No. BIOPSY CERVIX

LAB NO 372073

MACRO: A white biopsy 7x7x5mm and wispy fragments totalling 4mm across.

MICRO: Sections show markedly inflamed cervical stroma with bands of markedly atypical squamous cells in all areas of the biopsy. I think these appearances are of infiltrating squamous carcinoma throughout the 5 mm biopsy and I have sent the slides to Greenlane (NWH) Pathology for confirmation.

9.1.98 LETTER DATES 9.1.98 FROM DR E A JOHNSON TO G K PARRY

We have received the following report from [Dr] Judith Barayani, Greenlane/National Women's Hospital "I agree these biopsies show invasive poorly differentiated SCC of cervix. I will hold slides pending referral to us for further treatment."

2.16 **ON** 19 January 1998 Dr Parry performed a laser cone biopsy. Following this, Mrs Poutsma suffered a severe post-operative haemorrhage, she had to undergo emergency surgery which involved a total abdominal hysterectomy.

2.17 **THE** histology report dated 6 February 1998 on the cone biopsy tissue reported:

"DIAGNOSIS: INVASIVE MODERATELY DIFFERENTIATED SQUAMOUS CELL CARCINOMA STAGE 1B2."

For the uterus the diagnosis is reported as:

"SQUAMOUS CELL CARCINOMA EXTENDING INTO THE ISTHMUS BUT NOT INVOLVING THE ENDOMETRIUM OR MYOMETRIUM."

2.18 ON 9 February 1998 Dr Parry referred Mrs Poutsma to the Oncology Unit at NWH for treatment. In his letter of referral he stated:

"I would be grateful if you could see Colleen with an invasive squamous cell carcinoma. She presented in August with one episode of post-coital bleeding and a smear with cells that they were unable to interpret. She presented again in January of this year with a further episode of post coital bleeding. The cervix looked completely different. The smear showed invasive cells and the cone biopsy confirmed squamous invasive carcinoma. Unfortunately at the time, she bled considerably from the cone biopsy and we then had to proceed to a hysterectomy. The histology confirmed extensive squamous cell carcinoma. The histology is from Diagnostics on specimen HO 98/2276 for the cone biopsy. This showed no lymphatic or vascular invasion. I would be grateful if you could see her for further treatment."

2.19 **MRS** Poutsma has received ongoing care and treatment both in Auckland and Whangarei. In March 1998 she made her complaint to the Health and Disability Commissioner and the chronology of that complaint has already been referred to.

2.20 **THE** Tribunal also records that it regards the period of time it took to bring this charge to it, over two years, as unacceptable and harsh for both Mrs Poutsma and Dr Parry. Also, given the nature of the issues raised in this case which are referred to later in this decision, such delay also meant that there were potential risks for the health and safety of patients referred to Dr Parry which should have been addressed much sooner than they have been.

2.21 **AT** the commencement of the hearing at the special sitting on 7 September 2000, Mr Hodson, on behalf of Dr Parry, admitted the factual situation alleged in the charge, and the matters of fact set out by way of background were not at issue in the hearing of the charge.

3. EVIDENCE FOR THE DIRECTOR OF PROCEEDINGS:

3.1 **THE** witnesses for the Director of Proceedings were Mrs Colleen Poutsma and her husband, Mr Jack Poutsma; Dr David Cook, a specialist obstetrician and gynaecologist of Palmerston North; Dr O'Connor; Dr John Whittaker, a specialist gynaecologist/oncologist of Auckland; and Dr Amanda Sampson, an Obstetric and Gynaecological Sub-specialist (by written statement only).

Mrs Poutsma

3.2 **MRS** Poutsma gave evidence regarding the facts and circumstances giving rise to her complaint, which are set out above, and which are largely uncontested. At the time Mrs Poutsma gave evidence she was gravely ill and being cared for at St Joseph's Mercy Hospice in Auckland. Her statement of evidence was read for her by her husband, Mr Jack Poutsma, despite being under heavy medication for pain she was lucid and responded to questions asked of her by Mr McClelland, Mr Hodson, and members of the Tribunal.

3.3 **IN** addition to the matters of fact already described, Mrs Poutsma gave evidence that when she visited Dr O'Connor on 22 December 1997 following a severe post-coital bleed the previous night and previous episodes of spotting, he expressed surprise when she told him that Dr Parry had not examined her when she was referred to him in August 1997.

3.4 **DR** O'Connor's surprise was because Dr Parry had not mentioned in his reporting letter to Dr O'Connor that he had not examined Mrs Poutsma's cervix at the time.

3.5 **MRS** Poutsma also gave evidence that after he took the punch biopsy in his surgery, he recommended to Mrs Poutsma that she should have a laser cone biopsy and he made an appointment for this to be done at Whangarei Hospital. At the time she had the cone biopsy, she had not been told the results of the punch biopsy. It was not until she was recovering from the emergency surgery following the cone biopsy that she learned that she had a tumour on her cervix.

Mr Jack Poutsma

3.6 **MR** Poutsma gave evidence which essentially corroborated Mrs Poutsma's, and he confirmed that Mrs Poutsma's statement of evidence was consistent with his recall of the events giving rise ultimately to this charge.

Dr David Cook

3.7 **DR** Cook was asked by the Health and Disability Commissioner in April 1999 to provide an independent report on Dr Parry's management of Mrs Poutsma's case. He had subsequently prepared two reports, dated 16 April 1999 and June 2000 respectively. He referred to those reports and his evidence was given in conjunction with those reports which were provided to the Tribunal in the agreed bundle of documents provided to it.

3.8 **IT** was his view that Dr Parry provided *"rather cursory management"* of Mrs Poutsma's inter-menstrual bleeding and mildly abnormal smear in March 1991.

3.9 **IN** relation to Mrs Poutsma's referral in August 1997, Dr Parry's remit as a specialist gynaecologist was to evaluate the gynaecological health and sometimes extended health of the patient. This will entail consideration of the referring GP's concerns but also often the identification of other concerns or potential diagnosis. Many GP's do not have particular skills or an interest in gynaecology and would expect a holistic gynaecological assessment on referral. In terms of whether or not Dr Parry carried out an adequate clinical assessment and examination of Mrs Poutsma, he made a number of comments:

(i) the clinical scenario was sufficiently suspicious for cervical disease to dictate urgent follow-up of the smear result either during the consultation or in its aftermath and then, appropriate action;

(ii) there were substantial indicators of possible cervical disease:

- a previous history of abnormal smears
- an abnormal appearance of the cervix (inflamed) reported by the GP
- contact bleeding reported by the GP
- significant post-coital bleeding, a symptom usually associated with lower vaginal tract disease (ie, disease of vulva, vagina or cervix) due to coital trauma.

(iii) At the age of 45 (as Mrs Poutsma was) significant pathology is more common;

(iv) Rather than an isolated, minor episode of bleeding, several bleeding episodes (at least one of which was heavy) had already occurred, suggesting the likelihood of significant disease;

(v) Important causes of inter-menstrual bleeding and post-coital bleeding are endometrial hyperplasia and endometrial and cervical neoplasia. Such pathology is

often not obvious and further evaluation of the endometrium and cervix is always required.

3.10 **THE** implication is that Dr Parry did not fully appreciate the significance of low grade smear changes, particularly against a background of post-coital bleeding and an abnormal appearance of the cervix. His focus appears to have been on excluding endometrial disease.

3.11 **INTER-MENSTRUAL** bleeding and post-coital bleeding can be difficult to distinguish and may be due to cervical or endometrial disease. The logical approach is, and should have been, that rather than assume one or the other, to investigate potential causes of both.

3.12 **IN** view of Mrs Poutsma's age, the symptoms, the (albeit slightly) abnormal smear and Dr O'Connor's description of an abnormal cervix, urgent further examination of the cervix and uterus were required. With such an investigation pending omission of a pelvic examination would be acceptable. However, without the prospect of further appropriate investigation (and not simply a trans-abdominal scan) a pelvic examination and inspection of the cervix would be mandatory, although this would still fall far short of sufficient management in this case. Relying solely on the examination findings of a GP (and an ultrasound scan) is "*clearly unacceptable since it was the uncertainty regarding these that was the principal reason for the referral*."

3.13 **DR** Cook stated that he "*never*" orders ultrasound scans to investigate cervical disease in his gynaecological practice. While he was sure that some information could be gleaned

from such an examination, this is not a generally recognised method of evaluating the cervix since the cervix is directly accessible to examination and investigation via the vagina.

3.14 **PELVIC** ultrasound best evaluates the upper genital tract (the uterus and the ovaries) but not the lower genital tract to which the presenting symptoms would most usually be attributed. He gave evidence regarding the use of ultrasound to identify gynaecological disease to explain why the trans-abdominal ultrasound carried out by Dr Parry was quite inadequate as the sole method of assessment in Mrs Poutsma's case, and also gave evidence regarding other examinations and investigations which could have been undertaken.

3.15 **IT** was Dr Cook's view that:

"The combination of an ASCUS smear, post-coital bleeding and an inflamed cervix which "bled on touch" make a compelling argument for colposcopic assessment. Colposcopies, like so many tests, have a significant error rate. They are certainly more suitable to cervical assessment than trans-abdominal ultrasound however, and at least in my practice, are always combined with cervical smear and usually cervical biopsy. This trio, often repeated if there is any doubt, reduces the subjectivity of one test alone and is the accepted method of evaluation when cervical disease is suspected."

3.16 **DR** Cook considered that Mrs Poutsma's abnormal smear should have prompted at least a repeat smear particularly since the validity of the original smear was rightly questioned by Dr O'Connor in his referral letter, due to "*blood contamination*".

3.17 **IN** relation to the cone biopsy carried out by Dr Parry in January 1998, Dr Cook considered that there was no need for this procedure to be carried out, regardless of what might have been done in previous cases. The size of the tissue obtained on the punch

biopsy was large and paid off by clearly demonstrating invasive cervical cancer throughout the 7 x 5 mm biopsy. The diagnosis was expeditiously achieved. Once the diagnosis was achieved by the reports of 8 and 9 January 1998, *"the cone biopsy was unnecessary and ultimately counterproductive as dangerous haemorrhage resulted in a simple, rather than radical, hysterectomy. … Following the performance of the simple hysterectomy, the opportunity for optimal care was lost as the options of radiotherapy as a treatment or the performance of a lymph node biopsy were compromised by the surgery."*

3.18 **IT** was Dr Cook's view that:

"The cone biopsy was the most questionable aspect of Dr Parry's management leading as it did to the inadequate hysterectomy and compromised tertiary oncology treatment. Failure to consider and investigate cervical disease in August 1997 can be tenuously understood by the mistaken focus on endometrial disease. The performance of a cone biopsy when a biopsy had already clearly established the diagnosis is incomprehensible and suggests a lack of understanding of cervical cancer management principles."

3.19 **DR** Cook was also critical of Dr Parry's delay in referring Mrs Poutsma for tertiary oncology care at NWH. Dr Parry's "*apparent disregard*" for the recommendation for a referral *"was alluded to in a later report albeit too late to alter the unfortunate surgical outcome*".

3.20 **IN** summary, Dr Cook concluded, the failure to investigate cervical disease in August 1997, an approach strongly indicated by the presenting symptoms, may have significantly delayed diagnosis of Mrs Poutsma's cervical carcinoma. An adequate investigation should have been instigated by Dr Parry.

3.21 **THE** performance of the cone biopsy was an unnecessary intervention when urgent referral to the oncology team at NWH would be the usual management. The unforeseen need for hysterectomy following the cone biopsy prevented optimal cancer management subsequently and tertiary referral was essentially too late.

3.22 **THE** clinical picture of a possibly rapidly growing tumour and the poor differentiation on histological examination dictate a poorer prognosis in this case than many others, and a positive outcome with even the most skilful management would not have been assured. However the potential delay in diagnosis and impairment of optimal cancer management must be considered negative contributors to Mrs Poutsma's overall prognosis.

Dr O'Connor

3.23 **DR** O'Connor gave evidence of his examination of Mrs Poutsma on 21 August 1997, and his referring her to Dr Parry for further investigation of her presenting symptoms. He was concerned about the fact that Mrs Poutsma was a young lady with bleeding from the genital tract and abnormalities on examination. Abnormal bleeding does not always mean cancer, but it is a finding which in most instances merits investigation.

3.24 **THE** further investigations he would contemplate Dr Parry carrying out could have included colposcopy, biopsy and/or ultrasound. He stated:

"However, at this point my referral to Dr Parry was on the assumption he would see my patient, take her history, examine her and recommend the investigations which appeared appropriate to him in light of his expertise".

3.25 **HE** confirmed receiving Dr Parry's reporting letter, and considered that it was reassuring in its tone. When Mrs Poutsma returned to see him in December and told him that Dr

Parry had not examined her in August, he was *"taken aback"*. He was surprised because he had told Dr Parry in his referral letter that her cervix was of concern to him.

He stated that:

"I would have assumed that a specialist gynaecologist would have examined her cervix as a matter of course, but especially in light of the concerns I had expressed. I would have assumed that a gynaecologist investigating a patient with abnormal bleeding from the genital tract would examine the genital tract and included in that would be an examination of the cervix. I would have expected a gynaecologist to have examined the area I had described as being inflamed and a possible source of her abnormal bleeding."

3.26 **CONSEQUENTLY**, he referred her back to Dr Parry as a matter of urgency.

Dr John Whittaker

3.27 **DR** Whittaker gave evidence that he did not recall any telephone discussion with Dr Parry regarding Mrs Poutsma.

3.28 **IN** relation to the need for a cone biopsy, it was Dr Whittaker's evidence that:

"If there was an obvious cancer and the biopsy was of adequate size then a larger biopsy (either in the form of a wedge or cone biopsy depending on the clinical circumstances) would not be warranted. Certainly, I would not recommend a cone biopsy where a large obvious cancer is present. I would not recommend a laser cone biopsy for cancer diagnosis either, as this causes a certain amount of tissue destruction which can hamper the pathologist's ability to assess the biopsy. A cold knife cone biopsy would be the best in that scenario. .. Where there is definite clinical evidence of a cancer and a punch biopsy that tends to confirm a diagnosis I would not normally request that a cone biopsy be done."

3.29 **HE** agreed that the simple hysterectomy meant that the opportunity for optimal treatment was lost. Ideally, Mrs Poutsma should have been carefully assessed after the diagnosis was confirmed to determine the tumour stage and appropriate treatment - either a radical hysterectomy and pelvic node dissection or radical pelvic radiotherapy.

Dr Sampson

3.30 **DR** Sampson is an Obstetric and Gynaecological Ultrasound Sub-specialist practising at the Women's Imaging Centre at the Freemasons Hospital Medical Centre in Melbourne. She was unable to attend the hearing and her evidence was read into the record without objection from the respondent. The respondent's counsel had previously indicated that they did not wish to cross-examine Dr Sampson.

3.31 **IN** summary, it was Dr Sampson's evidence that there are many causes of inter-menstrual and post-coital bleeding. Once a smear was thought to be normal, standard practice would indicate that further investigation was warranted. In Australia, current standard accepted practice includes an ultrasound examination of the uterus and ovaries.

3.32 **VAGINAL** ultrasound probes have been available since the early 1990s, and since this time ultrasound has become widely used to assess bleeding disorders. Other investigations include a smear and clinical examination of the cervix. Persistent ongoing bleeding would warrant a colposcopy also because the smear is a screening test only. As a colposcopy is also not failsafe in diagnosing carcinoma of the cervix, a biopsy of any abnormal area is also indicated.

3.33 **WHILE** good images of the uterus will indicate whether there is a high chance of endometrial pathology, and good images of the pelvis will also indicate ovarian pathology, neither vaginal nor abdominal ultrasound scanning is considered reliable in the diagnosis of cervical polyps, cervical intraepitelial neoplasi or cervical cancer or pre-cancer. Vaginal scanning gives better images than abdominal scanning.

3.34 **ULTRASOUND** is not considered a diagnostic tool for carcinoma of the cervix. In Mrs Poutsma's case, it was Dr Sampson's belief that further investigation with colposcopy was indicated as Mrs Poutsma presented with persistent bleeding, i.e. significant and ongoing symptoms. It was her belief that the smear was not considered in the context of her persistent symptoms. She noted that it appeared that Dr Parry made no attempt to treat her presenting symptom.

3.35 **A** normal ultrasound result would indicate the need for further evaluation to determine other possible causes of Mrs Poutsma's bleeding. Further evaluation was also required because any form of scanning is insufficient to differentiate all possible causes of inter-menstrual and post-coital bleeding.

4. EVIDENCE FOR DR PARRY:

DR Parry gave evidence to the Tribunal, together with Dr Donna Hardie, a specialist obstetrician and gynaecologist who works with Dr Parry at Northland Health; Dr Ian Page, also a specialist obstetrician and gynaecologist; Ms Christine Read, a registered midwife, and Mrs Deborah Coddington, a journalist and former patient of Dr Parry's.

Dr Parry

4.1 **DR** Parry gave a very detailed description of his professional background and current medical practice. In 1994 he passed his Diploma of Diagnostic Ultrasound from the Australasian Society for Ultrasound in Medicine, and in 1998 he was granted his sub-specialty qualification in O&G Ultrasound. He is one of two sub-specialists in this area in New Zealand.

4.2 **AS** a sub-specialist, he is required to practise in this area of work for over 65% of practising time. He estimates that about 80% of his time is concentrated on his ultrasound practice, including amniocentisis, chrorionic villous biopsy and other fetal abnormality detection work. He works at NWH's Ultrasound Unit one day per week. During the morning sessions at the Unit he is accompanied by a radiologist, and in the afternoons by an obstetrician.

4.3 **THE** only gynaecology work he currently regularly undertakes is on Tuesdays at Whangarei Hospital. He operates in the morning, and in the afternoon conducts an outpatients gynaecology clinic. He also undertakes a gynaecology clinic at Kaitaia on alternate Wednesdays and is on call for emergencies on Mondays and one weekend in five. There are currently five gynaecologists employed at Whangarei Hospital.

4.4 **HE** has ceased doing gynaecology work or consultations for patients with abnormal smears or post-coital bleeding. This cessation was as a result of a process of review of how this work could best be carried out which was undertaken by Northland Base Hospital and nationally around late 1998/early 1999.

4.5 **HE** also referred to his participation in continuing education programmes and the Competence Review Programme which he is required to complete as a result of the Competency Review Report prepared for the Medical Council, as recommended by the Health and Disability Commissioner as part of her determination of Mrs Poutsma's complaint in 1999. Dr Parry considers that the Programme is working well and that he is deriving benefit from it.

4.6 **DR** Parry described the ultrasound equipment he has available to him, and the process he follows when examining patients and reporting to referring GPs.

4.7 **HE** accepts that his care and management of Mrs Poutsma fell below the standard to be expected of a specialist gynaecologist. He rejected any suggestion that he willfully or deliberately failed to provide her with medical care that was not up to standard, or that he was uncaring or unconcerned for her. He apologised to Mrs Poutsma and her family for what had happened.

4.8 **HE** accepted that with his sub-specialty interest, he had a higher reliance on ultrasound than perhaps other gynaecologists might have. When Mrs Poutsma was referred to him in August he was influenced by the fact that he had seen an ectropian on her cervix in 1991; he was aware that Dr O'Connor, whom he regarded as a careful and accurate GP, had repeated a smear and swabs, and his impression of the letter of referral was that Dr O'Connor was concerned that Mrs Poutsma might have an infection. He referred in this regard to the reference to a "*bulky uterus"* and the "*slightly inflamed*" cervix.

4.9 **HE** confirmed that he had the laboratory report on the smear available to him at the consultation, and that he interpreted the report as "*not abnormal enough to look for more dysplastic cells*". As a result of the lab report and the fact that Dr O'Connor in particular, had carried out a vaginal examination within the previous week, he "*did not consider it necessary for me to conduct such an examination*". He performed a trans-abdominal ultrasound which provided an excellent view without difficulty in reading or

interpretation. Had this not been the case, he would have proceeded to do a vaginal ultrasound.

4.10 **HE** stated:

"*I was unable to ascertain any pathology to explain Mrs Poutsma's bleeding and reported accordingly in a letter to Dr O'Connor on the same day."*

4.11 **WHEN** Mrs Poutsma was referred back to him in December 1997 he did perform a vaginal examination and noted the abnormal appearance of the cervix, and he was concerned by what he saw. He commented to Mrs Poutsma to the effect that her cervix showed "*sinister changes*". He confirmed taking the punch biopsy, and that Mrs Poutsma fainted in the surgery. He had not had a patient faint in the surgery before but it was a particularly hot afternoon.

4.12 **THE** factual background and chronology has already been described and Dr Parry confirmed all of this. In relation to his decision to carry out the cone biopsy, he believed that it was likely that he had telephoned Dr Whittaker at NWH to discuss Mrs Poutsma's case, as it was his usual practice to do this; "*certainly I had the belief that the appropriate management was to perform a cone biopsy. I have had other cases where this treatment is recommended by NWH"*, he said.

4.13 **HE** considered that the cone biopsy was warranted because the punch biopsy was only to a 5mm depth and a cone biopsy would provide more information for assessing the staging of the cancer. He accepted that it should not have been done, but it was his belief that it was the proper investigative step to take before referring Mrs Poutsma down to NWH.

He confirmed that it was his intention to refer Mrs Poutsma to NWH once the cone biopsy result was received.

Dr Page

4.14 **DR** Page is a specialist obstetrician and gynaecologist and Clinical Director of Obstetrics and Gynaecology at Whangarei Area Hospital, positions he has held since June 2000. He is also currently Dr Parry's supervisor pursuant to the Medical Council's competence programme, which commenced on 1 August 2000.

4.15 **DR** Page did not appear at the hearing and his statement of evidence was read into the record of the hearing. He was aware that Dr Parry accepted that his care and management of Mrs Poutsma did not meet the appropriate and accepted standards, and he agreed with that assessment.

4.16 **HOWEVER**, in the four months since he has taken up his position, he has not had any concerns made known to him by any of Dr Parry's colleagues about his management of cases. He confirmed that Dr Parry is highly regarded by midwives and nurses and health professionals generally, including his medical colleagues.

4.17 **HE** stressed that Dr Parry's work in ultrasound or fetal abnormality scanning practice has not, to his knowledge, been the subject of any criticism. He realised that Dr Parry's reliance on ultrasound was criticised by the Competence Review Committee, "*and we are working to address this*", as is Dr Parry's poor note keeping, also identified by the Competence Review Committee.

4.18 **HE** confirmed that Dr Parry is a willing participant in the competence programme and that *"he plainly has a keen desire to improve."* He is confident that his twice-weekly review of cases which Dr Parry manages does ensure that the women of Northland are currently being appropriately managed. He considers that at the end of the one year programme Dr Parry will be practising as well as any other obstetrician and gynaecologist in New Zealand.

Dr Hardie

4.19 **DR** Hardie also works with Dr Parry at Whangarei Base Hospital. Her evidence principally addressed Dr Parry's decision to carry out the laser cone biopsy notwithstanding that a firm diagnosis of invasive cervical carcinoma had already been made and NWH were awaiting a referral for Mrs Poutsma by Dr Parry.

4.20 **IT** was her experience that she could remember only one occasion when she referred a patient to NWH on the strength of a punch biopsy only. It was, to her knowledge, common practice to obtain a larger tissue biopsy before referral. She confirmed in oral evidence that she had checked the figures available at the Hospital for cervical cancer referrals to NWH over the past year.

4.21 **IN** 1999 there were 9 referrals for cervical cancer to NWH from Whangarei, of these, there were 4 cone biopsies performed prior to referral. As she had undertaken the review only the day before, Dr Hardie was unable to provide any details of the circumstances of the cases. Dr Hardie confirmed that a 7x7x5mm biopsy tissue sample (such as was obtained by Dr Parry from the punch biopsy) was "*large*".

4.22 **DR** Hardie confirmed that she had never seen a laboratory report written in the terms of Dr Barayani's report to Dr Parry dated 9 January 1998. She confirmed that the report indicated that Dr Barayani had identified invasive cancer, and was awaiting referral. She agreed that most gynaecologists would "*individualise*" the situation, and she agreed that, in the circumstances, she would have referred Mrs Poutsma on the basis of the report from the punch biopsy coupled with the clinical observations which Dr Parry had reported.

4.23 **IT** was Dr Hardie's practice to obtain a sufficient tissue biopsy to make a diagnosis, usually this would be a wedge biopsy because "*you only have a 2mm biopsy from a punch. … I would tend to do a cone biopsy if I couldn't clinically see a lesion.*"

4.24 **DR** Hardie stated that she admired Dr Parry for his dedication to his work and his profession. She regarded him as a competent obstetrician and gynaecologist and his complication rates were, to the best of her knowledge and belief, "*within the normal parameters*". Dr Hardie also stated that Dr Parry is "*plainly exceptionally talented*" in regard to his ultrasound sub-specialty because he is one of only two such sub-specialists in New Zealand, and that in his ultrasound and fetal abnormality scanning practice in particular, he provides a service which is desperately needed in Northland.

4.25 **IT** was Dr Hardie's understanding that the Competence Review Committee had a lot of queries regarding "*…Dr Parry's documentation of his practice rather than his clinical practice per se*". She stated that she would be surprised if there were references to his clinical judgment in the competency review.

Ms Read

4.26 **MS** Read is a registered midwife who has worked with Dr Parry since approximately 1980. She considers that Dr Parry brought a *"commitment to improve the quality of care for women in Northland and an infectious enthusiasm for his work. He has been an integral part of the development of obstetric services in Northland through a time of enormous change. He has also contributed much to the development of gynaecology services in the area."*

4.27 **MS** Read spoke of her high regard for Dr Parry, and stated that he was well-respected for his skills and his tireless enthusiasm for the well-being of patients. In the context of his obstetrical practice, she did not consider his complication rate *"is out of the ordinary at all"*.

Ms Coddington

4.28 **MS** Coddington gave evidence as a former obstetrical patient of Dr Parry's. Throughout the period of his care, extending over three miscarriages and ultimately a successful delivery of a daughter fifteen years ago, Ms Coddington found him to be supportive, kind and patient.

5. THE DECISION:

5.1 **THE** Tribunal has very carefully considered all of the evidence submitted at the hearing of the charge. It was not possible for the Tribunal to commence deliberations immediately after the hearing concluded and accordingly, the Tribunal subsequently reconvened to

deliberate and to determine the Charge, which afforded the members ample opportunity to re-read and reflect on all of the evidence presented to it at the hearing.

5.2 **HAVING** now carefully considered all of the evidence, and counsels' very helpful submissions, and having had the opportunity to assess the credibility of each of the principal witnesses at the hearing, the Tribunal is satisfied that the Charge is established and that Dr Parry is accordingly guilty of disgraceful conduct in a professional respect.

6. REASONS FOR DECISION:

Legal issues - The Standard of Proof

6.1 **THE** standard of proof in disciplinary proceedings is well-established. The standard of proof is the civil standard, the balance of probabilities. However, 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. In this present case, the charge was laid at the most serious of the levels of charges of misconduct, disgraceful conduct in a professional respect.

6.2 **ACCORDINGLY**, in its deliberations the Tribunal applied a correspondingly high standard of proof, that is, very close to the criminal standard of proof, beyond reasonable doubt, bearing in mind that the standard of proof may also vary within a single case, such as this one, where the charge contains several particulars, and alleges that the particulars, either separately or cumulatively, constitute the charge at the most serious level.

6.3 **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

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

Disgraceful Conduct in a Professional Respect

6.5 **THERE** being no significant contest regarding the factual background to the Charge, the central issue for determination by the Tribunal was the level of culpability on the part of Dr Parry in terms of the hierarchy of professional disciplinary offences available to the Tribunal under section 109 of the Act.

6.6 **ALTHOUGH** the charge was laid at the most serious level, Mr Hodson in his closing submissions, accepted that, in this case, the full range of the grounds upon which the Tribunal could find Dr Parry guilty of a professional disciplinary offence were available to the Tribunal and he did not submit that the charge should stand or fall at the level of the charge laid by the Director. Dr Parry expected an adverse finding; he admitted that his conduct fell below the standard expected of a practitioner in his position. However, he denied that Dr Parry's conduct constituted disgraceful conduct in a professional respect.

6.7 **MR** Hodson submitted that the charge had initially been properly laid at the level of professional misconduct. However, the Director of Proceedings had amended the charge to elevate it to one of disgraceful conduct, without amending the Particulars of the charge in

any way, and without disclosing any valid reason for the change. It should be recorded that the level at which the charge is laid is (except for certain exceptions prescribed in the Act) a matter for the prosecutor of the charge.

6.8 **THE** Tribunal has the power to amend a charge "*during the hearing of any charge*" (clause 14, First Schedule of the Act), subject to the requirement to observe the rules of natural justice (clause 5(3), First Schedule). In practice, the Tribunal, and its predecessors, and indeed the courts generally, have taken the approach that the determination as to the level at which a charge is proven is entirely a matter for the disciplinary body or court, after conducting a hearing on the charge before it, as is provided for in section 109 of the Act.

6.9 **ON** Dr Parry's behalf, Mr Hodson and Mr Waalkens characterised this case as a case of a missed diagnosis; Dr Parry made a mistake, and, the defence argued, findings of disgraceful conduct should be confined to misconduct involving sexual misconduct or abuse; fraud; or to "*those who act deliberately knowing their errors or so grossly negligent as to be beyond understanding, …*". A number of cases involving findings of professional misconduct and disgraceful conduct were submitted to the Tribunal in support of that submission.

6.10 **HOWEVER**, the Tribunal is satisfied that comparisons with other cases and the factual circumstances within which they arose are helpful only as a guide, or a framework, which can assist the Tribunal to put this case, and its factual circumstances, into the general context of the cases which come before it. Ultimately, the Tribunal must confine its

considerations to the present case, and the factual and evidential situation it presents, guided and informed by its collective knowledge, experience and expertise.

6.11 **AS** noted on previous occasions, the Tribunal is a specialist Tribunal and, on this occasion, comprises two lay persons, a specialist radiologist, a public health specialist and a specialist gynaecologist. It is therefore a specialist Tribunal comprised of a mix of lay persons and medical practitioners with relevant skills and experience.

The Test for Professional Misconduct

6.12 **THE** test for professional misconduct most often cited is that contained in *Ongley v Medical Council of New Zealand*, [1984] 4 NZAR 369, per Jefferies J:

"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."

The Test for Disgraceful Conduct in a Professional Respect

6.13 **WHAT** might constitute disgraceful conduct in a professional respect under the present Act has not been considered by either of the High Court or the District Court on appeal. However, under the 1968 Act, the High Court did consider findings of disgraceful conduct in a number of cases, most notably in *Brake v Preliminary Proceedings Committee* [1997] 1 NZLR 71. The Full Court held:

"The test for "disgraceful conduct in a professional respect" was said by the Court of Appeal in ***Allison v General Council of Medical Education and Registration*** *[1894] 1 QB 750, 763 to be met:*

"If it is shown that a medical man, in the pursuit of his profession, has done something with regard to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency … ."

It is apparent from this test, and from the later cases, in which it has been adopted, that it is an objective test to be judged by the standards of the profession at the relevant time.

…

The Privy Council adopted the following passage from the judgment of Scrutton LJ in ***R v General Council of Medical Education and Registration of the United Kingdom*** *[1930] 1 KB 562, 569:*

"It is a great pity that the word "infamous" is used to describe the conduct of a medical practitioner who advertises. As in the case of the Bar so in the medical profession advertising is serious misconduct in a professional respect and this is all that is meant by the phrase 'infamous conduct'; ***it means no more than serious misconduct judged according to the rules written or unwritten governing the profession*** *(emphasis added)."*

In our view the same test should be applied in judging disgraceful conduct.

…"

6.14 **BOTH** of these tests defined the conduct under review by reference to what the practitioner's peers might reasonably regard as either 'unprofessional conduct' or 'disgraceful or dishonourable'.

6.15 **IN** this regard, the tests pre-date modern medico-legal jurisprudence developed in Canada; *Reibl v Hughes* (1980) 114 DLR (3d) 1, *et al*; by the High Court of Australia in *Rogers v Whitaker* (1992) 175 CLR 479, *Chappel v Hart* (1998) 72 ALJR 1344, and *Naxakis v Western General Hospital* (1999) 73 ALJR 782; and in New Zealand, *B v Medical Council* (unreported) High Court 11/96, 8/7/96 per Elias J, to the effect that, while the evidence of what other doctors would have done, or how they assess Dr Parry's

conduct, or of acceptable practice generally in circumstances such as present in the case under review, is a useful guide, perhaps even the best guide, it is not more than that.

6.16 **WITH** this in mind, the Tribunal does not unhesitatingly adopt the opinions expressed by those practitioners who give evidence as 'expert witnesses'. Nor does it necessarily measure the practitioner's conduct against what other doctors might have done in similar circumstances; these matters are no more than a guide.

6.17 **IN** assessing the evidence the Tribunal also kept in mind that it is not entitled to substitute any special knowledge or expertise it may have for the evidence presented to it, ref: *Lake v Medical Council of New Zealand* (unreported, HC123/96), High Court, Auckland, per Smellie J, at p 35). The nature of its constitution as a specialist Tribunal, and the experience and expertise of the members should be limited to informing its objective assessment of the evidence, and its conclusion as to whether or not, having heard the expert evidence and accepted it or not, it concludes that the level of care given by Dr Parry to Mrs Poutsma fell below what the protection of the public and the maintenance of appropriate professional standards requires.

6.18 **THE** test is objective; the conduct under review is measured against the judgment of the practitioner's professional peers of acknowledged good repute and competency, *"bearing in mind the composition of the tribunals which examine the conduct"; Ongley v Medical Council"* (supra).

6.19 **IN** *Ongley*, perhaps presaging later development of the relevant legal principles, Jefferies J held that:

"The structure of the disciplinary processes set up by the Act which rely in large part upon the judgment of a practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standards applied by competent, ethical and responsible practitioners."

6.20 **IN** the now very familiar statement from *B,* (and in the context of a charge of 'conduct unbecoming') Elias J held:

"There is little authority on what comprises "conduct unbecoming". The classification requires assessment of degree. But it needs to be recognised that conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards. That departure must be significant enough to attract sanction for the purposes of protecting the public. Such protection is the basis upon which registration under the Act, with its privileges, is available. I accept the submission of Mr Waalkens that a finding of conduct unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which it is unfair to impose. The question is not whether error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations. The threshold is inevitably one of degree. Negligence may or may not (according to degree) be sufficient to constitute professional misconduct or conduct unbecoming: Doughty v General Dental Council [1988] 1 AC 164, Pillai v Messiter (No. 2)(1989) 16 NSWLR 197; Ongley v Medical Council of New Zealand (1984) 4 NZAR 369. The structure of the disciplinary processes set up by the Act, which rely in large part upon judgment by a practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standards applied by competent, ethical, and responsible practitioners. But the inclusion of lay representatives in the disciplinary process and the right of appeal to this court indicates that usual professional practice, while significant, may not always be determinative; the reasonableness of the standards applied must ultimately be for the court to determine, taking into account all the circumstances including not only usual practice but also patient interests and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards."

6.21 **THUS,** the assessment is one of 'degree'. As was stated in *Brake:*

"Obviously, for conduct to be disgraceful it must be considered significantly more culpable than professional misconduct. … or as was put in Pillai v Messiter (No 2) (1989) 16 NSWLR 197, 200, ***a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference*** *and*

an abuse of the privileges which accompany a registration as a medical practitioner. These are the approaches which have been taken in our courts." (emphasis added)

6.22 **IN** *Pillai v Messiter* the Supreme Court of NSW held that it is still necessary, in every case, to prove *"misconduct in a professional respect"* that goes beyond mere negligence by the civil standard. In a statement which echoes the language of the Act under which this case falls for determination, the court went on to say:

"In giving meaning to the phrase "misconduct in a professional respect" in the context within which it appears, it must be kept in mind that the consequence of an affirmative finding is drastic for the practitioner. And that the purpose of providing such a drastic consequence is not punishment of the practitioner as such but protection of the public. The public needs to be protected from delinquents and wrongdoers within professions. It also needs to be protected from seriously incompetent professional people who are ignorant of basic rules or indifferent as to rudimentary professional requirements …".

6.23 **THE** court then went on to consider the facts of the case to determine whether or not the drastic step of removing the practitioner from the register was warranted. On the facts, which involved an error of transcription, said to be *'a terribly unfortunate one but nonetheless an accidental one which could be made in busy practice without misconduct'* resulting in over-prescription by others which was not detected by the practitioner. The latter error *'may have been careless but it was carelessness shared by very many others who, in this respect, were also responsible for the care of the patient'* the court determined that the facts did not warrant the removal of the practitioner from the medical register.

6.24 **IN** terms of the 'assessment of degree' which the Tribunal must make, the decisions of the High Court of Australia in *Rogers v Whitaker* (supra), approved by Elias J in *B v Medical Council* (supra), *Chappel v Hart* (supra) and *Naxakis v Western General Hospital*

(supra) are also helpful. In all of these cases, the Court referred to the so-called 'common sense' test of causation. In *Rogers v Whitaker*, Gaudron J expressed the test in the following terms:

"The matters to which reference has been made indicate that the evidence of medical practitioners is of very considerable significance in cases where negligence is alleged in diagnosis or treatment. However, even in cases of that kind, the nature of particular risks and their forseeability are not matters exclusively within the province of medical knowledge or expertise. Indeed, and notwithstanding that these questions arise in a medical context, they are often matters of simple commonsense. And, at least in some situations, questions as to the reasonableness of particular precautionary measures are also matters of commonsense. Accordingly, even in the area of diagnosis and treatment there is, in my view, no legal basis for limiting liability in terms of the rule known as the "Bolam test" which is to the effect that a doctor is not guilty of negligence if she or he acts in accordance with a practice accepted as proper by a responsible body of doctors skilled in the relevant field of practice. That is not to deny that, having regard to the onus of proof, the "Bolam test" may be a convenient statement of the approach dictated by the state of the evidence in some cases. As such, it may have some utility as a rule of thumb in some jury cases, but it can serve no other useful function."

6.25 **GAUDRON J** again referred to the 'commonsense test' in *Naxakis* (supra) in circumstances where the overwhelming body of evidence pointed to the conclusion that a neurosurgeon was not at fault in persisting with his diagnosis of traumatic subarachnoid haemorrhage -

"*In Rogers v Whitaker, I pointed out that, at least in some situations, "questions as to the reasonableness of particular precautionary measures are ... matters of commonsense". In this case, the first question to be determined is, in essence, whether it was unreasonable for the hospital and Mr Jensen not to have taken the precautionary measure of excluding other causes of the appellant's symptoms. And assuming there was some evidence that there were steps that could have been taken to exclude other causes, it was for the jury to form their own conclusion whether it was reasonable for one or more of the steps to be taken. It was not for the expert witnesses to say whether those steps were or were not reasonable. Much less was it for them to say, as they were frequently asked, whether, in their opinion, the hospital and Mr Jensen were negligent in failing to take them." (p785, para 21)*

6.26 **THE** Tribunal has proceeded on the basis that the 'commonsense test' is consistent with the formulation of the 'assessment of degree' test referred to in *Ongley* (supra), *Brake* (supra), and *B* (supra). Such a test seems to the Tribunal to be a practical and useful test, and it is also consistent with the composition of the Tribunal comprising as it does a mix of practitioners and lay persons.

6.27 **SIMILARLY**, the issue as to whether or not the outcome might have been different had the practitioner's management of the patient's care been different will not determine whether or not the charge is proven. The central issue for the Tribunal's inquiry is to ascertain whether or not the practitioner's conduct and management of the case, at the relevant time, constituted an acceptable discharge of his or her professional and clinical obligations. In this present case of course, Dr Parry has accepted that, in this regard, his treatment of Mrs Poutsma was deficient and it was the Tribunal's task to determine the degree of deficiency in terms of the sanction the Tribunal is satisfied is warranted.

6.28 **ON** that basis, and against the legal background referred to above, the Tribunal was required to determine whether or not Dr Parry's conduct, as particularised in the charge, constituted more than 'mere negligence'. It is satisfied that findings of 'disgraceful conduct' are not limited to sexual misconduct, exploitation of patients for personal gain, fraud or dishonesty. 'Disgraceful conduct in a professional respect' may encompass conduct involving clinical care and/or clinical issues, without any element of 'moral turpitude', particularly in circumstances where the doctor's conduct exposes patients to risk and/or he or she ignores fundamental rules or clinical management principles; see for example, *Brake,* where the court expressly rejected any such limitation.

6.29 **IN** considering this charge, the Tribunal has taken into account all of the relevant legal principles referred to above, and the cases referred to it by counsel, and it has followed the approach of previous Tribunals, and their predecessor, the Medical Council (in relation to 'disgraceful conduct' charges), that a 'high degree' of culpability is required.

6.30 **ADOPTING** that approach, the Tribunal considered each of the Particulars of the charge, and then the charge in its totality.

7. PARTICULAR 1: [Dr Parry] failed to carry out an adequate clinical assessment and examination of his patient on 22 August 1997.

7.1 **WHEN** Mrs Poutsma attended for her consultation with Dr Parry on 22 August 1997 it was on the basis of her referral to him by her general practitioner for specialist care and advice. It is perhaps significant that Dr Parry's appointment book produced at the hearing records that the reason for Mrs Poutsma's attendance was "*bulky uterus*", and this symptom appears to have been uppermost in Dr Parry's mind, notwithstanding the contents of the letter of referral from Dr O'Connor.

7.2 **IT** is also significant that the letter of referral is addressed to "*Mr G Parry, Gynaecologist*"; making it quite clear that Mrs Poutsma was being referred for a specialist gynaecological consultation. In fact, it was Dr O'Connor's evidence that if he had thought that Mrs Poutsma might require an ultrasound examination, he would have referred her to Northern Radiology, as was his custom. He was aware that Dr Parry 'has always' done ultrasound examinations as part of his obstetrical and gynaecological practice, and it did not surprise him that ultrasound was mentioned in Dr Parry's reporting letter. However, he

had considered Mrs Poutsma's symptoms sufficiently serious to merit a full investigation of her genital tract, and it was that reason he had referred her to a specialist gynaecologist.

7.3 **NOTWITHSTANDING** that in his letter, Dr O'Connor refers first to the symptom he regards as most serious, *"on examination today, the cervix looked slightly inflamed and it bled to the touch*," and to the fact that, while he has taken a smear and swabs, he thinks that "*their value may be diminished by blood contamination*", Dr Parry's explanation for not carrying out a vaginal examination of the cervix and genital tract was that Mrs Poutsma had had two previous vaginal examinations within the past week, and he was reassured by Dr O'Connor's description and the report received from the laboratory on the smear and swabs.

7.4 **DR** Parry seems not to have taken into account at all the fact that when the two previous internal examinations had been undertaken by general practitioners, both GPs had been sufficiently concerned by what they had seen to refer Mrs Poutsma to a specialist gynaecologist (Dr Lawrence having advised Mrs Poutsma to go to see Dr O'Connor the next day in normal business hours so that he could refer her to a specialist, and Dr O'Connor to Dr Parry).

7.5 **FURTHER**, Dr Parry did not have any report from Dr Lawrence of his findings, and without carrying out his own examination, he had no way of assessing the accuracy of Dr O'Connor's assessment. The Tribunal accepts Dr Cook's implication that Dr Parry did not fully appreciate the significance of Mrs Poutsma's symptoms and that his focus was solely on excluding endometrial disease.

7.6 **IT** was Dr Parry's belief that because Dr O'Connor had not seen any causes of bleeding other than slight inflammation, the most appropriate investigation that might be performed was the ultrasound investigation. But he ignored the several and significant indicators of possible cervical disease which were present, and, as a specialist gynaecologist, this is totally unacceptable.

7.7 **IT** was also Dr Parry's evidence that it was "*totally new to me*" that it is possible to obtain an ASCUS report in the presence of cervical cancer. The Tribunal were very concerned by this admission. He was however aware that there is a false negative rate for smears. It was Dr Cook's evidence that the false negative rate for smears is significant "*so we must be suspicious*". There was also the added complication that Dr O'Connor was concerned about the reliability of the smear as its value could be diminished by blood contamination. Notwithstanding, Dr Parry regarded the ASCUS smear report as "*innocuous*".

7.8 **AS** a result of the Health and Disability Commissioner's determination of Mrs Poutsma's complaint, the Medical Council commissioned a Competency Review Report, which report was provided by a Committee comprising two very experienced gynaecologists and a lay person. This Report was referred to in evidence at the hearing. One of the findings of that Report was that the Review Committee was concerned that Dr Parry has an "*excessive reliance on ultrasound in cases of genital tract bleeding."* Dr Parry rejected this criticism. He considered that their interpretation that his reliance on ultrasound is ""*excessive" may be because the use of ultrasound in New Zealand has yet to be accepted as an investigative tool in investigation of abnormal genital bleeding. … I think that my practice as from my sub-specialty is based on*

ultrasound. I would be remiss if I did not use my clinical skills and my ultrasound skills in assessing as best I can any abnormal genital tract bleeding."

7.9 **HOWEVER**, it was Dr Sampson's evidence that in a sexually active woman a vaginal scan is indicated as this scan produces clearer images in the vast majority of women, and, most importantly in view of Dr Parry's ranking of differential diagnoses (referred to in para 7.13 below), Dr Sampson stated that "*neither vaginal nor abdominal scanning is considered reliable in the diagnosis of cervical polyps, cervical intraepithelial neoplasia, or cervical carcinoma. These are all causes of inter-menstrual and post-coital bleeding*." It is standard practice amongst ultrasound sub-specialists in Australia to perform both scans to enhance the diagnostic outcome. Dr Parry did have vaginal ultrasound equipment available to him when he saw Mrs Poutsma in August 1997.

7.10 **IT** was Dr Cook's evidence that:

"At the age of 45, as Mrs Poutsma was, significant pathology is more common. Rather than an isolated, minor episode of bleeding, several bleeding episodes (at least one of which was heavy) had already occurred, suggesting the likelihood of significant disease."

7.11 **ALTHOUGH** he agreed that it was in Mrs Poutsma's best interests to exclude all possible causes of genital tract bleeding and other symptoms, Dr Parry felt that the most appropriate investigation that might be performed was the ultrasound because Dr O'Connor had not seen any other causes or bleeding other than slight inflammation of the cervix. But he also conceded that the abdominal ultrasound examination was only adequate to exclude causes of endometrial bleeding. By doing only an abdominal ultrasound examination he was not excluding causes of cervical bleeding.

7.12 **ALSO**, on the basis of Dr Sampson's evidence, in terms of standard accepted practice within Dr Parry's sub-specialty and quite apart from his obligations solely as a specialist gynaecologist, Dr Parry should have gone on to investigate the cause of Mrs Poutsma's post-coital bleeding because he was unable to ascertain any cause for it as a result of the trans-abdominal scan. In the absence of any clinical findings of 'significant pathology', or indeed of any pathology at all to explain the presenting symptoms, further investigations and/or examinations were mandated.

7.13 **IT** was unacceptable for Dr Parry to carry out only a 'cursory', even partial, inquiry and to send Mrs Poutsma away with her primary, potentially very serious, symptoms unresolved. It is relevant in this context that, in response to a question from the Tribunal, Dr Parry listed the differential diagnoses for post-coital bleeding. He stated that, in order of importance, not necessarily in order of frequency, "*then cancer of the cervix has to be top of the list*".

7.14 **HE** accepted that his failure to take all steps to exclude cervical cancer in August 1997 was a "*fundamental breach*" of Mrs Poutsma's rights as a patient. Dr Parry also accepted that his statement to Dr O'Connor in his reporting letter of 31 December 1997, after Mrs Poutsma had again been referred to him following a severe post-coital bleed, that "*The cervix looked quite different from what it did in August and looks considerably abnormal*", was grossly misleading as it implied that he had examined Mrs Poutsma at the consultation in August.

7.15 **IN** the circumstances which the Tribunal is satisfied are established, and which are largely accepted by Dr Parry, the Tribunal is satisfied that Dr Parry's failure to undertake what is possibly the most basic investigation required of him as a specialist gynaecologist (and, on Dr Sampson's evidence, also as a gynaecological ultrasound sub-specialist) in the circumstances of Mrs Poutsma's referral, was grossly negligent, and is conduct that the Tribunal considers to be significantly more culpable than professional misconduct.

7.16 **IT** was an omission by Dr Parry that was reckless and it disregarded his responsibilities both to Mrs Poutsma, as his patient who was relying on him to ensure that her symptoms were properly investigated to exclude any serious illness or condition requiring further care, and to Dr O'Connor, who referred his patient for specialist care and advice in good faith and in the belief that Dr Parry would respond appropriately to his request for expert advice and assistance.

7.17 **IN** failing to adequately examine Mrs Poutsma, Dr Parry's conduct constituted such a significant departure from accepted standards that it cannot, on any measure, be characterised as 'mere negligence' or a 'mistake'. Perhaps most significantly in terms of most cases of this sort, none of the professional witnesses sought to excuse or condone Dr Parry's failure to examine Mrs Poutsma at the consultation on 22 August 1997.

7.18 **AS** Dr O'Connor said in answer to a question from the Tribunal, *"before this case I would have considered it inconceivable that I could refer a patient to a gynaecologist with post-coital bleeding and [she would not have had] her cervix examined. It simply would not have crossed my mind."* Dr Parry's failure to carry out

an appropriate examination or any investigation of his patient's principal, and potentially ultimately fatal, symptom is indefensible and inexcusable.

7.19 **IN** view of his failure to carry out an adequate examination, the Tribunal does not accept that this case can be characterised as one involving a 'mistaken' or 'missed' diagnosis. Dr Parry made no adequate or reliable diagnosis. Dr Parry made no attempt to establish or to exclude the most serious causes of post-coital bleeding. He did not record an adequate history, or carry out a proper examination and investigation of the symptoms and clinical signs referred to him by Dr O'Connor. Mr McClelland suggested to Dr Parry that "...., *it's kid's stuff that an O&G [specialist] when presented with symptoms like Colleen's does everything to exclude the possible causes of that, including cervical cancer",* a suggestion which Dr Parry conceded was "*correct*".

7.20 **THE** Tribunal is also satisfied that this case cannot fairly be characterised as 'one of those disaster cases' which might happen to every doctor in his or her career; understandable and to some degree accepted, as was suggested by Dr Parry's counsel.

7.21 **IN** making this latter proposition, Mr Hodson appeared to rely on evidence given by the Director's witness, Dr Cook as evidencing a concession in relation to what had happened in this case. In cross-examination Dr Cook was asked:

> *Q: "Finally Dr Cook, is it the case that when you look at any - I am generalising here - O&G's practice you are inevitably going to get cases of great persistence and great work and then every now and again you are going to get a disaster case, is that so?*
>
> *A: That's true.*
>
> *Q: Lapses and errors and things do actually occur in medicine, like they do no doubt in law and other areas of our community?*

A: Correct.

Q: And do you regard that as understandable as well as acceptable?
A: I regard it as understandable and I think to some degree it has to be accepted.
Q: And your report …".

7.22 **IT** is the Tribunal's view that this exchange falls well short of any concession of the sort Mr Hodson suggests; Dr Cook did not suggest that this case fell into that unfortunate category of 'disaster' cases, which might occur to any specialist practising in a 'high risk' specialty.

7.23 **FURTHER**, the proposition confuses *the nature of the conduct* which is the subject of the Tribunal's inquiry, and *the outcome for Mrs Poutsma*, which is not the subject of the inquiry, and is not relevant in that context. In terms of a 'disaster' case for Dr Parry, it is a case that was brought about solely as a result of Dr Parry's failure to observe a minimum acceptable standard of care at the relevant time.

7.24 **ACCORDINGLY**, the Tribunal is satisfied that Particular 1 is established at the level of disgraceful conduct in a professional respect. This finding by the Tribunal is unanimous.

Particular 2: [Dr Parry] performed an unnecessary and/or clinically unjustified cone biopsy on his patient on 19 January 1998;

7.25 **DR** Parry's justification for carrying out the cone biopsy was that it was 'normal practice' to do a cone biopsy before referring patients from Northland down to National Women's Hospital in Auckland for treatment. Because they have to travel away from their home area for treatment, it is preferable that all of the preliminary investigations and 'work up' is done in Whangarei, so that the length of time they have to be away from home is minimised.

7.26 **DR** Parry stated that he believed that the depth of the invasion at 5 mm needed to be further investigated for staging of the disease. The Tribunal found it disturbing that Dr Parry did not appear to understand that a visible cervical cancer did not require a further diagnostic biopsy. In fact, a cone biopsy was contra-indicated.

7.27 **IN** Mrs Poutsma's case, Dr Parry confirmed that when he did examine the cervix in December 1997 he could see the lesion, and when he took a punch biopsy, he had a "*high suspicion*" then that Mrs Poutsma had invasive carcinoma of the cervix. When he performed the punch biopsy, a very large tissue sample was obtained, some 2 - 3 times larger than normal.

7.28 **ON** 9 January 1998 he received the report from the local laboratory that the smear he took indicated cancer, and all of the tissue slides were referred to NWH, which confirmed the diagnosis. NWH told Dr Parry that the slides would be held pending referral to NWH for further treatment. There was no clinical need for any further diagnostic tests to be done after 31 December 1998, and certainly after the laboratory reports were received back by Dr Parry. Notwithstanding, Dr Parry did not immediately refer Mrs Poutsma to NWH. Instead, 10 days later, he carried out the cone biopsy.

7.29 **IN** the context of this clinical picture, Dr Parry's decision to proceed to carry out the laser cone biopsy on 19 January 1998 is inexplicable.

7.30 **DR** Parry's explanation is supported, he says, by his belief that he spoke to Dr Whittaker by telephone, and that Dr Whittaker told him to go ahead with the cone biopsy. Dr

Whittaker recalls no such telephone discussion, and, in view of the established diagnosis and the potentially adverse outcome in relation to her options for further treatment at NWH, Dr Whittaker stated that he would not have given such advice.

7.31 **AS** described above, Mrs Poutsma suffered a severe post-operative haemorrhage and it was necessary to perform an emergency simple hysterectomy. The consequence of the simple hysterectomy operation was that the clinical options for treating Mrs Poutsma's invasive carcinoma were curtailed. Far from contributing anything to Mrs Poutsma's treatment, it compromised it. The inferences which the Director suggested could be made from Dr Parry's decision to proceed with this procedure, in the absence of any sufficient clinical reason for doing so, are disturbing.

7.32 **DR** Parry's evidence that in 24 years of experience he had not realised that a cone biopsy was not appropriate if a clear diagnosis had been made, was clearly not accepted by the Director. Mr McClelland also referred Dr Parry to the letter of referral he had written to Dr Whittaker. That letter is dated 9 February 1998. It states:

"I would be grateful if you could see Colleen with an invasive squamous cell carcinoma. She presented in August last year with one episode of post-coital bleeding and a smear with cells that they were unable to interpret. She presented again in January of this year with a further episode of post-coital bleeding. The cervix looked completely different. The smear showed invasive cells and the cone biopsy confirmed squamous invasive carcinoma. Unfortunately at the time, she bled considerably from a cone biopsy and we then had to proceed to a hysterectomy. The histology confirmed extensive squamous cell carcinoma. …. I would be grateful if you could see her for further treatment."

7.33 **MR** McClelland suggested to Dr Parry that this letter was misleading, a suggestion which Dr Parry accepted. However, Dr Parry denied that it was his intention to deliberately mislead Dr Whittaker/NWH. He denied that he was seeking to cover up the fact that his

treatment and management of Mrs Poutsma's case had been "*way below*" acceptable standards. Dr Parry stated that he "*did not expect that the situation would arise that certainly in January 1998, that I would be putting information in a letter to protect myself from an inquiry. I certainly would not have done that deliberately …*".

7.34 **HOWEVER,** there can be no doubt that Dr Parry did misrepresent the circumstances in several significant respects. As Mr McClelland put to him, Dr Parry could have set out the factual situation in more accurate terms, for example,:

Q*:* *"… if in fact you said in your letter to Dr Whittaker she presented in August, she had recurrent bleeding for several months, her smear was ASCUS, I didn't perform a vaginal examination, I didn't do a colposcopy or any other form of examination except for an ultrasound abdominal examination, I took no further action, I then took a punch which showed clearly invasive cancer, I could see the lesion, I then did a cone, if Dr Whittaker had read that he would fall of his perch, he wouldn't believe that possible because it is plain bad, bad management of a patient isn't it?*

A: *I certainly accept at this stage, with the criticism that has been made, that I have made errors of judgment. I certainly have not done that deliberately nor have I written letters to try to obviate that."*

7.35 **THE** Tribunal agrees that Dr Parry's letter to Dr O'Connor was 'grossly misleading', and his letter to Dr Whittaker similarly so.

7.36 **HIS** decision to perform the cone biopsy may have been an attempt to retrieve the situation; to treat the carcinoma, or even he may have thought that it might be possible to remove the lesion entirely by laser cone biopsy. However, Dr Parry was questioned as to all of these possibilities, and he denied them.

7.37 **IN** the absence of any satisfactory justification for performing the cone biopsy and the misleading terms of the letters to Dr O'Connor and NWH, the inference that was raised by the Director was that Dr Parry knew that he made serious errors in his management of Mrs Poutsma's case. As soon as he saw her on 31 December 1997 and carried out a vaginal examination he realised the extent of his mismanagement and his failure to provide an adequate standard of care to Mrs Poutsma and that he had attempted to 'cover up' the extent of the deficiencies in his care and treatment of Mrs Poutsma.

7.38 **IN** view of the gravity of an adverse finding in relation to the inferences raised, the Tribunal has determined that in relation to his motives for undertaking the cone biopsy Dr Parry exercised poor judgment but the Tribunal is unable to establish, to the requisite standard of proof, whether he was deliberately attempting to 'cover-up' his mismanagement of Mrs Poutsma's case, or to mislead anyone. However, in relation to the contents of the correspondence, the Tribunal is satisfied that Dr Parry did deliberately mislead Drs Whittaker and O'Connor regarding his management of Mrs Poutsma's case.

7.39 **THE** Tribunal is not satisfied that there was a telephone discussion between Dr Parry and Dr Whittaker regarding Mrs Poutsma's case in January 1998. Accordingly, it does not accept that Dr Parry proceeded to carry out the cone biopsy on advice from Dr Whittaker.

7.40 **THE** Tribunal accepts Dr Cook's assessment:

"Even less comprehensible was his later decision, despite a clear diagnosis established with a generous and entirely appropriate biopsy of the cervix, to apparently disregard the invitation for tertiary referral and perform an unnecessary cone biopsy. Again this implies a lack of understanding of the ***then*** *current*

principles on cervical malignancy management which would dictate expert tertiary assessment usually with recourse to radical hysterectomy or intra-cavity radiotherapy. Unfortunately neither of these treatment options were feasible following the emergency hysterectomy prompted by the complicated cone biopsy procedure."

7.41 **DR** Parry's conduct in electing to carry out the cone biopsy in the absence of sound clinical need, even if he thought that a cone biopsy was required as 'usual practice', was at the least a grave error of judgment on his part. At best, given that Dr Parry is an experienced specialist gynaecologist, his conduct, considered both in relation to this Particular only and in the context of Mrs Poutsma's clinical care in its totality, raises serious issues regarding his competency to practise as a specialist gynaecologist.

7.42 **ACCORDINGLY**, the Tribunal is satisfied that in relation to Particular 2, Dr Parry is guilty of disgraceful conduct in a professional respect. This finding by the Tribunal is made by a majority of the Tribunal members.

Particular 3: Despite receiving a pathology report on or about 9 January 1998 confirming the diagnosis of invasive carcinoma he did not refer his patient to the Oncology Unit at National Womens' Hospital, Auckland, for further treatment until 9 February 1998.

7.43 **THE** issues raised in this Particular have already largely been covered in relation to the previous Particulars. It is the Tribunal's view that Dr Parry was in breach of his duty of care to Mrs Poutsma by delaying referral after he received the report from NWH on 9 January 1998, and the advice from Dr Barayani that NWH were holding the slides "*pending referral*". It is the Tribunal's view that NWH/Dr Barayani made it quite clear to Dr Parry that they were expecting a referral.

7.44 **AS** already stated, the reasons for Dr Parry's inaction are inexplicable in clinical terms, and his conduct in delaying referral is unacceptable, especially given his experience and his professional obligations to Mrs Poutsma as her specialist gynaecologist. He was responsible for ensuring that she received appropriate, expert care as soon as possible. He failed to do that.

7.45 **ACCORDINGLY**, the Tribunal finds this Particular is established at the level of professional misconduct. This finding by the Tribunal is unanimous.

8. GENERAL CONCERNS REGARDING DR PARRY'S PRACTICE:

8.1 **THERE** are a number of aspects of Dr Parry's care of Mrs Poutsma that raise concerns about his practice as a specialist gynaecologist generally. First, his clinical notes of his consultations with Mrs Poutsma and his operating notes are grossly inadequate.

8.2 **SECOND,** while he accepted that the facts upon which the charge was based were correct, and that his care of Mrs Poutsma fell below acceptable standards for a practitioner in his position, he sought to justify his decision not to carry out a vaginal examination of Mrs Poutsma when she presented with the primary symptom of post-coital bleeding, and advice from the referring GP that the cervix "*bled to the touch*" when he examined her and took smears and slides, in order to reduce the level of his culpability.

8.3 **THIS** justification by Dr Parry was made in part on the basis that he considered a trans-abdominal ultrasound examination was sufficient in the circumstances, and in part because

he relied on Dr O'Connor's description of the cervix as 'slightly inflamed', and the ASCUS smear.

8.4 **IF** that is correct, then the Tribunal agrees with Dr Cook's assessment made in his Report dated 21/7/00 (submitted to the Tribunal to be read in conjunction with his evidence), that "*fundamental errors of judgment were made in this case*".

8.5 **THE** Tribunal is concerned that Dr Parry does have an "*excessive*" and inappropriate reliance on ultrasound in the context of his gynaecological practice. If his treatment of Mrs Poutsma is typical and Dr Parry does not carry out basic, virtually mandatory, examinations of patients referred to him for specialist gynaecological advice, then that is a matter of great concern to the Tribunal.

8.6 **IN** relation to Dr Parry's practice and the issues generally raised in this case, two statements in particular, made in exchanges between Dr Parry and members of the Tribunal, give rise to the Tribunal's concerns:

8.6.1 ***Q:*** *(Dr Trenwith) What instructions were given to Mrs Poutsma prior to her appointment since she was going to end up having an abdominal ultrasound examination?*

A: *I cannot be certain of what instructions were given to Mrs Poutsma specifically, but when patients were referred they were asked - and the standard was to ask the patient to attend with a full bladder in case I wanted to do an ultrasound.*

Q: *Would you comment on whether the bladder was satisfactorily filled in this examination?*

A: *… the bladder itself comes to 2/3rds of the way … about 2/3rds of the way to the fundus of the uterus … .I think that is a satisfactory filling of the bladder. When the bladder is over-filled, then often the uterus is pushed backwards and becomes more difficult to visualise. So I think that bladder is full enough to do an appropriate examination.*

8.6.2 ***Q:*** *(Dr Jones) Can I ask [in] what proportion of your new gynaecological referrals you rely on the GP's assessment of the lower genital tract and thereby you don't perform a vaginal examination"*

A: ***Very few. At this stage*** *I think that the vaginal examination is an important part of a gynaecological assessment and I think that certainly from the experience that I've had with Mrs Poutsma's situation that there would be very few patients that I would not do a vaginal examination on at present.*

Q: *Which ones wouldn't you perform a vaginal examination on at present?*

A: *At present, those that were bleeding at the time and felt uncomfortable about having a vaginal examination in the presence of bleeding."*

8.7 **IN** relation to the first of these; it is the Tribunal's view that this exchange highlights the extent of Dr Parry's reliance on ultrasound examination. If it is the case that patients referred to Dr Parry are advised to attend with a full bladder (and it was not possible to question Mrs Poutsma on this point as it arose late in the hearing), then it suggests that Dr Parry must not usually intend to carry out vaginal examinations, as a full bladder prevents optimum clinical examination of the pelvis.

8.8 **HIS** reliance on ultrasound examinations to the exclusion of other, fundamental, examinations (especially in the context of his gynaecological practice) is excessive and it is possible that GPs who refer, or who have referred, gynaecological patients to him are not aware of this.

8.9 **IN** relation to the second, Dr Parry appears to regard a vaginal examination as an 'option', and to leave the decision as to whether or not the patient has such an examination up to the patient. He appears to ignore the fact that even as a matter of commonsense bleeding from the genital tract may be the very reason why a vaginal examination is necessary. If

patients are uncomfortable about having such an examination in such circumstances, then Dr Parry should explain to them the important reasons why such an examination is necessary, and offer them the alternative of visiting another gynaecologist (for example, a woman), or of returning to see him as soon as the bleeding has stopped, and he should advise their GP accordingly.

8.10 **HIS** professional obligation is to carry out all examinations and investigations that are necessary to exclude serious disease. His obligation is to inform his patients adequately, so that they understand what the possible diagnoses may be, and what examinations are necessary to ascertain the reason for their symptoms. He did not demonstrate to the Tribunal any meaningful understanding of the nature of his professional obligations to patients referred to him.

8.11 **THE** Tribunal has concerns that Dr Parry's treatment of Mrs Poutsma is symptomatic of a general lack of understanding and application of fundamental principles of modern gynaecological practice and that he still may not understand the need to adequately examine women who have been referred to him with lower genital tract symptoms or abnormal smears.

9. CONCLUSION:

9.1 **HAVING** considered each of the Particulars separately and cumulatively, the Tribunal is satisfied that, the charge is established and that Dr Parry is guilty of disgraceful conduct in a professional respect.

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

9.3 **THE** Tribunal has particularly borne in mind that the charge is not one of 'disgraceful conduct' *simpliciter*, and all of the words of the charge have meaning. The charge requires that the Tribunal must be satisfied that each element of the charge must be made out.

9.4 **IT** has carefully considered all of the cases referred to it, not merely for the legal principles which they contain, but also by way of comparison of the factual circumstances present in those cases, and in this case. It has compared Dr Parry's conduct not only with the other findings of disgraceful conduct, but also with findings of professional misconduct. However, as stated above, that exercise can take the Tribunal only so far. At the end of the day the Tribunal must consider this case on its own facts, and make its judgment accordingly.

9.5 **ON** that basis, the Tribunal is satisfied that Dr Parry's failure towards Mrs Poutsma, and his breach of the trust she, and Dr O'Connor, placed in him, fell so far short of reasonable and acceptable standards for a specialist gynaecologist, that it does constitute disgraceful conduct in a professional respect. As stated on other occasions, an important part of the professional disciplinary process is setting standards. Those standards include standards relative to clinical practice. In its way, "*in a professional respect*", Dr Parry's breach of the professional obligations he owed in the circumstances of this case is 'bad enough' to warrant a finding reserved only for the most serious of such breaches.

9.6 **IN** conclusion, the Tribunal records that approximately 120 testimonials and letters attesting to Dr Parry's care of patients and long service in Northland were presented to it for consideration and were taken into account by the Tribunal.

10. ORDERS:

10.1 **THE** Tribunal orders as follows:

10.1.1 **THE** charge laid against Dr Parry by the Director of Proceedings is established and Dr Parry is guilty of disgraceful conduct in a professional respect;

10.1.2 **THE** Director of Proceedings is to lodge submissions as to penalty not later than 14 days after receipt of this Decision; and

10.1.3 **SUBMISSIONS** as to penalty on behalf of Dr Parry are to be lodged not later than 14 days thereafter.

DATED at Auckland this 31st day of October 2000

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W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal