MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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PUBLICATION OF THE COMPLAINANT'S NAME AND ANY IDENTIFYING DETAILS IS PERMANENTLY PROHIBITED	**DECISION NO:**	187/01/80C
	IN THE MATTER	of the Medical Practitioners Act 1995
		-AND-
	IN THE MATTER	of a charge laid by a Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against **GRAHAM KEITH PARRY** medical practitioner of Whangarei

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Ms S Cole, Dr J W Gleisner, Dr U Manukulasuriya,

Dr A D Stewart (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Whangarei on Monday 12 and Tuesday 13 November 2001

APPEARANCES: Mr M F McClelland and Ms C Gelston for the Complaints Assessment Committee ("the CAC").

Mr A H Waalkens for Dr G K Parry.

LEGAL ASSESSOR: Dr D B Collins QC

The Charge

1. The Complaints Assessment Committee, pursuant to section 93(1)(b) of the Medical Practitioners Act 1995 charged that Dr Parry, Obstetrician and Gynaecologist, of Whangarei, in 1995, acted in a way that amounted to professional misconduct in that there were serious deficiencies in Dr Parry's gynaecological practice, namely, that he failed to adequately assess and examine A after she presented with post-coital bleeding, by either visualisation of the cervix using the naked eye and/or the use of a colposcope.

Evidence for the Complaints Assessment Committee

2. Evidence for the CAC was given by Mrs A, the complainant; and Dr John Tait, registered medical practitioner of Wellington.

Evidence for Dr Parry

3. Evidence for Dr Parry was given by Dr Graham Parry; Dr Donna Hardie, registered medical practitioner of Whangarei; and Dr John Doig (evidence given via video link), registered medical practitioner of Christchurch.

Background to the charge

4. Mrs A was first referred to Dr Parry in May 1993 by her then general practitioner, Dr B, as she had experienced some intermittent inter-menstrual bleeding.

5. After taking a brief history Dr Parry carried out an abdominal ultrasound on Mrs A. The ultrasound examination did not disclose any abnormalities. Dr Parry did not carry out an internal examination at any time during this consultation. Mrs A thought this was unusual and asked if such an examination would be appropriate. Dr Parry told Mrs A that he did not need to examine her internally as he could see all he needed to from the scan. He advised Mrs A to monitor the bleeding and to see him again if the bleeding became more regular or got worse.

6. In his reporting letter dated 10 May 1993 Dr Parry advised Dr B that:

"... I have arranged a FSH and plasma oestradiol for her with a copy of the results to come to you. I suspect that this is probably symptoms of ovarian failure rather than anything sinister. Ultrasound was completely normal."

7. An appointment was made for Dr Parry to see Mrs A at an outpatients clinic on 20 July 1993. However, Mrs A did not attend this appointment and she did not recall being advised that this appointment had been made.

8. Mrs A continued to experience persistent inter-menstrual bleeding and she returned to see Dr Parry again on 21 September 1993. During this consultation Dr Parry discussed various treatment options with Mrs A including dilatation and curettage ('D & C'), hysteroscopy and hysterectomy. Mrs A rejected the suggestion of a hysterectomy because she thought this was 'a bit drastic' as Dr Parry had said he could find nothing wrong with her, but she agreed to a D & C and a hysteroscopy.

9. The D & C was performed on 19 October 1993 at Whangarei Hospital. A cervical smear was taken at the time of the procedure at Mrs A's request. However the hysteroscopy was not performed due to a problem with the sterilising equipment on the day of the operation that meant the equipment could not be used.

10. After the D & C procedure Mrs A was told that nothing untoward had been detected and that no further action was required at that stage. It was Dr Parry's evidence that he would have visualised the cervix in the course of carrying out this procedure. Post-operatively, he advised Mrs A that if bleeding persisted she should consult with him again after six months. Mrs A did not recall Dr Parry telling her about the need for six monthly visits, however it was her evidence that she did subsequently see mention of such visits in a referral letter. Mrs A's hospital notes indicate that there was some improvement in her symptoms without further treatment.

11. On 12 January 1995 Mrs A went to see Dr C, who had taken over Dr B's practice. At this visit, Mrs A reported bleeding after intercourse as well as late and heavier periods. Her symptoms persisted and she returned to Dr C on 28 April 1995. Dr C examined her and took a cervical smear. At the time Dr C remarked how easily Mrs A's cervix bled and that she had to repeat the smear in order to get a readable sample. Mrs A's impression was that Dr C seemed quite concerned that she had bled so briskly. Neither the CAC nor Mrs A were able to obtain copies of the report on the smear, or Dr C' letter of referral, or any other documents or records relating to the April/May 1995 consultations for this hearing as these documents cannot now be located.

12. Dr C referred Mrs A to Dr Parry and she went to see him on 15 May 1995. In her letter of referral Dr C apparently reported that Mrs A's cervix looked normal and that the smear result had also been normal. Mrs A therefore re-presented to Dr Parry complaining of occasional episodes of post-coital bleeding and pre-menstrual spotting.

13. It was Dr Parry's evidence that because of the regular cyclical nature of the bleeding he considered that its cause was likely to be hormonal in nature. At the consultation Dr Parry again carried out an abdominal ultrasound scan to exclude uterine causes of the bleeding. He did not carry out any internal examination, or any other examination, nor did he refer Mrs A for any other examination or investigation.

14. In his reporting letter dated 15 May 1995, Dr Parry advised:

"I note that the smear looked normal and that the cervix looked normal. Ultrasound showed a normal uterus with a normal endometrium for the state of the

cycle. She tells me that this is occasionally the second half of the cycle and the second half of the cycle is also now associated with pre-menstrual spotting so I am sure this relates to her hormonal status and there is nothing sinister and nothing further needs doing."

15. Mrs A's post-coital and inter-menstrual bleeding continued until 6 December 1996. On that occasion the general practitioner whom she saw, Dr Laurenson, examined her and took another cervical smear. The results reported a high grade abnormality (CIN III).

16. Subsequently Mrs A's husband made a formal complaint to the CEO of Northland Health regarding the standard of care and treatment that his wife had received. Mrs A was referred to Dr Hardie at Whangarei Hospital and she underwent a colposcopy on 19 December 1996 and a Lletz biopsy was carried out on 20 December 1996. The results of the biopsy returned CIN I on histology and confirmed no evidence of malignant disease.

17. Subsequent to this Mrs A had all of her previous smears re-read. Three of the smears that were originally read as normal came back with mild abnormalities.

The Law

18. Dr Parry was charged with professional misconduct, the middle of the range of professional disciplinary findings available to the Tribunal. The test for professional misconduct is well-established. In *Ongley v Medical Council of New Zealand* [1984] 4 NZAR 369 the test was stated in the following terms:

"[the issue to be determined is]…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."

19. In *B v The Medical Council* (High Court, Auckland, 11/96, 8 July 1996), and in the context of a charge of conduct unbecoming, Elias J (as she then was) 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. …Those standards to be met are, as already indicated, a question of degree; …*
>
> *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 of 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."*

20. Dr Collins advised the Tribunal that in this case the test as to what constitutes professional misconduct can be posed as a question – namely, has Dr Parry behaved in a professional capacity in a way that the established facts could be reasonably regarded by his colleagues and representatives of the community as constituting professional misconduct?

21. This formulation of the test, in part, differs from the *Ongley* test to the extent that it refers to representatives of the community. This reference is essential, Dr Collins advised, because not all of the members of the Tribunal are members of the medical profession – namely Ms Cole and Mrs Brandon.

22. The Tribunal's assessment of Dr Parry's professional conduct in the context of this charge should therefore reflect both the interests of the community and the expectations of the profession. Neither counsel raised any objection to the advice given by Dr Collins. The Tribunal considers that the advice given in this regard is fair and reasonable and appropriately takes into account all of the relevant interests, and the principal purpose of the Act contained in s3; "*… to protect the health and safety of members of the public…*".

23. On the basis of this advice, considered in conjunction with the relevant cases, including *B* (supra) and *Ongley* (supra), both decisions given in the professional disciplinary context and on appeal from this Tribunal's predecessors, the question as to whether Dr Parry's conduct is conduct which is culpable, i.e. is conduct warranting sanction, is a question to be determined by this Tribunal bearing in mind that it is well established that not every

error, or error of judgment on the part of a practitioner, will be culpable or warrant the sanction of an adverse professional disciplinary finding.

24. Whether or not a practitioner is guilty of professional misconduct is an objective test and is a question squarely for determination by this Tribunal. Only if the Tribunal is satisfied that a departure from acceptable standards has been proved to the requisite standard, may it then go on to determine if any such departure is significant enough to warrant sanction.

Power to amend the charge

25. Clause 14(1) of the First Schedule to the Act provides that the Tribunal may amend the charge in any way, subject to a requirement to adhere to principles of natural justice and to conduct its procedures fairly; *Director of Proceedings v M*, Decision 97/99/48D, 26/11/99.

Burden of proof

26. The CAC carries the burden of proving the charge.

Standard of Proof

27. The appropriate standard of proof is the civil standard, namely, the balance of probabilities. However the standard of proof required will vary according to the gravity of the allegations founding the charge and the level of the charge: 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 Decision

28. Having carefully considered all of the evidence presented to it and the very helpful submissions made by both counsel, the Tribunal has determined that Dr Parry is guilty of conduct unbecoming and that reflects adversely on his fitness to practise medicine.

Reasons

29. The factual basis of the charge against Dr Parry is very narrow. The charge alleges serious deficiencies in Dr Parry's management of Mrs A in that after she presented with post-coital bleeding Dr Parry failed to adequately assess Mrs A, specifically that he failed to visually examine the cervix either with the naked eye or with a colposcope, and, in effect, that he should have.

30. The test as to whether or not Dr Parry's conduct in relation to his management of Mrs A's care amounts to a professional disciplinary offence is an objective one and, in coming to its decision, the Tribunal has considered the opinions of all of the practitioners who gave evidence at the hearing of the charge, and the evidence given by Mrs A.

31. The Tribunal has therefore had the opportunity to assess Dr Parry's conduct against the practice of comparable practitioners as that was described in evidence, and in terms of the relevant legal principles, and the legislative context contained in the Act, bearing in mind that ultimately it is the Tribunal that must exercise its collective, specialist, judgment as to which of the evidence it prefers and the degree to which, if any, it considers Dr Parry's conduct to have fallen short of relevant acceptable professional standards.

32. Dr Parry did not dispute the allegation that he did not examine Mrs A's cervix visually during the May 1995 consultation. It is therefore a matter for the Tribunal to determine whether that is conduct that constitutes professional misconduct.

33. It was the thrust of Dr Parry's defence to the charge that he did not undertake a visual examination of Mrs A's cervix because he relied on the reported results of the vaginal examination carried out by her general practitioner, Dr C, whom he believed was a careful and accurate practitioner with some expertise in women's health, and Mrs A's history of normal smears. In effect, Dr Parry conceded, whether or not he carried out an examination depended upon his opinion of the referring GP and what was reported, rather than the presenting symptoms.

34. Dr Parry's good opinion of Dr C was supported by Dr Hardie. She told the Tribunal that she considers Dr C to be a competent general practitioner who has a good deal of experience carrying out vaginal examinations. Dr Hardie gave evidence that Dr C is well-respected in Whangarei. Mr Waalkens submitted that this evidence must be of significance. The Tribunal has no doubt that this evidence was sincere and that both of Dr Parry and Dr Hardie have a high regard for Dr C' ability.

35. However the Tribunal considers that it is also significant that Dr C obviously felt it necessary to have Mrs A assessed by a specialist gynaecologist. In effect, she was seeking 'a second opinion'; in this case, the expert opinion of a specialist practitioner. Also, the clinical picture had changed since Dr Parry had last seen Mrs A. Specifically, Mrs A had begun to experience post-coital bleeding, and her original presenting symptoms had persisted. Dr Parry had himself advised Mrs A to return to him if the bleeding persisted.

36. It was also submitted for Dr Parry that this case could be differentiated from others on the basis that Mrs A had not in fact developed cancer. In this regard, the Tribunal is mindful that it must resist the temptation of hindsight. Mrs A is fortunate to have not developed cancer. However, as she succinctly stated, *"I am just thankful that I did not have cervical cancer or it would have had around three years to develop. I do not believe that anyone should have to rely on luck when they visit any doctor let alone a specialist…"*.

37. The Tribunal's task is to assess the conduct of the practitioner at the time of the relevant event, in this case, May 1995. The fact of a favourable outcome for Mrs A does not excuse any poor or inadequate management of her care by Dr Parry just as an unfavourable outcome would not, *per se*, be culpable. It is well-established that the outcome for the patient must, as a matter of fairness, be put to one side for the purposes of determining a professional disciplinary charge.

38. Dr Parry did not resile from the fact that as the specialist gynaecologist to whom Mrs A was referred it was up to him to determine the cause of her abnormal bleeding and it was

his professional duty to exclude all possible causes especially those that were potentially most serious.

39. It was Dr Tait's evidence that, in 1995, it was generally accepted that performing an abdominal ultrasound was not sufficient to exclude possible malignancies of the cervix and other causes of post-coital bleeding. Dr Parry accepted that he did nothing at all personally to exclude a malignancy of the cervix and, equally, he accepted that he could have visualised the cervix either with the naked eye or by colposcope.

40. It was Dr Tait's evidence that when faced with a woman presenting with a history of abnormal vaginal bleeding, the specialist gynaecologist must invariably visualise the cervix.

41. It was also Dr Tait's evidence that:

"…an experienced gynaecologist is better able than most general practitioners to carry out and interpret a pelvic examination; this is something that a gynaecologist does virtually on a daily basis. On referral the gynaecologist is required to make a diagnosis of the cause of the post coital bleeding and in doing so must as far as possible exclude all other potential causes including of course the possible serious potential causes.

…

Pelvic ultrasound is used to evaluate the upper genital tract (the uterus and ovaries) but not the lower genital tract which is most relevant when the presenting symptom is post coital bleeding. At best, a relatively large cervical tumour might be visualised by abdominal ultrasound but certainly small tumours would not be detectable. Abdominal ultrasound would not detect any abnormal appearance of the cervix either. In other words, abdominal ultrasound would not detect cancer or pre-cancer of the cervix (unless the tumour was large).

Abdominal ultrasound is used in the investigation of uterine and adnexal diseases including endometrial polyps, fibroids and ovarian cysts.

…

In my opinion abdominal ultrasound is not an appropriate method of evaluating the cervix particularly as it is directly accessible to examination and investigation via the vagina.

…

In view of the potential risk of malignancy it is obviously important to exclude as much as is possible lesions of the cervix and vagina.

…

In my opinion, the minimal acceptable assessment of a patient with Mrs A's symptoms would be to visualise the cervix and vagina by passing a speculum. If to the naked eye the cervix did not appear normal (i.e. there were areas of ulceration or abnormal vasculature) then it would be necessary to proceed to colposcopy (as noted previously, because of the specialist gynaecologists' expertise and experience s/he is best placed to assess whether the cervix appears to be normal. It is the gynaecologist's ability to assess the cervix in that way which would be one of the reasons a GP will refer a patient with post-coital bleeding to a gynaecologist).

…

Given the fact that Mrs A had post-coital bleeding and pre-menstrual spotting in my opinion it would also have been appropriate for Dr Parry to attempt an endometrial biopsy whilst visualising the cervix (even if the cervix looked normal).

…

In my opinion, by only doing an ultrasound examination Dr Parry would not have been able to exclude the more potentially dangerous causes of post-coital bleeding nor be able to treat some of the other causes.

…

By failing to perform an assessment and examination of the cervix, Dr Parry had not done everything necessary to exclude possible potentially dangerous disease.

…

Mrs A was 41 when she saw Dr Parry. With a women of that age a specialist gynaecologist would be more concerned about the possibility of a malignancy or pre-malignancy in either the uterus or cervix. By performing an abdominal ultrasound Dr Parry was only ever going to be able to consider the uterus but not the cervix."

42. Dr Doig, also a specialist obstetrician and gynaecologist, took a different view. It was Dr Doig's evidence that Mrs A had in fact an entirely appropriate response by Dr Parry to her initial consultation in 1993, i.e. investigation by diagnostic curettage and uterine endometrial sampling, in addition to the ultrasound scan he performed at that time. Three cervical smears taken in 1991, 1993 and 1995 all demonstrated normal cervical cells and Dr

Tolk's referral letter apparently stated that the cervix looked normal. Given this background, "*the evidence far from suggesting a cervical cause of pathology is on the contrary supportive of an intra-uterine cause*".

43. It was Dr Doig's evidence that:

"Given therefore that Dr Parry was presented with a patient who had a normal cervical appearance, according to the referral note, and who had three normal cervical smears, I believe it completely reasonable that he should investigate the possibility of an intra uterine cause for bleeding.

To my view there is absolutely no evidence whatsoever that at the time of the referral in 1995 Mrs A had a cervical cause for her bleeding. Indeed the weight of evidence strongly reflects the fact that she had no such cause for her bleeding problem.

…

[Mrs A] presented with normal cervical cytology and abnormal bleeding, occurring at a specific time of her menstrual cycle and associated, at times, with a post-coital act. In that respect … it is my view … that Mrs A's minor cervical abnormality [the CIN III result] has arisen in 1996, some 18 months after her consultation with Dr Parry."

44. Dr Hardie, who was working with Dr Parry at Whangarei Hospital at the time, was similarly supportive of his management of Mrs A's presentation in the context of the referral background.

45. In response to a question from Mr McClelland, Dr Parry accepted that all he had done to exclude the major concern of the post-coital bleeding, namely a malignancy of the cervix, was to rely on the examination of the general practitioner reported in the referral letter, and the results of Mrs A's previous cervical smears. He accepted that cancer of the cervix is "*number one*" of the most serious possible causes of post-coital bleeding. Dr Parry also accepted that a cervical smear test is a screening device rather than a diagnostic tool and, when taking into account a reported negative result, the practitioner must bear in mind that there is a significant false negative rate for smears (between 10-20%).

46. The Tribunal has carefully considered all of this evidence. On balance, and in the circumstances of Mrs A's referral, the Tribunal prefers the evidence of Dr Tait and considers that it more accurately and fairly reflects an acceptable standard of care and skill reasonably to be expected of the specialist gynaecologist to whom she was referred.

47. As it has done on previous occasions, the Tribunal reiterates its approach that, while expert evidence may guide the Tribunal in establishing whether or not the conduct in question amounts to professional misconduct, the views of experts (or any of them) do not necessarily determine the ultimate outcome. The fact that another practitioner may give evidence that supports the respondent is not necessarily exculpatory, and vice versa. In *Rogers v Whitaker* (1993) 67 ALJR 47 the Australian High Court held that there was a 'comprehensive duty of care' which covers diagnosis, treatment, and the provision of information so as to secure consent. In relation to a practitioner's duty of care in the context of diagnosis and treatment, the Court determined that while medical evidence 'will have an influential, often decisive, role to play' the Court is the ultimate arbiter and may impose its view of the doctor's duty, even in the face of contrary medical evidence (at p.48, 52).

48. *Rogers v Whitaker* has been followed by the High Court of New Zealand in *B (supra),* and, accordingly, has consistently been applied by this Tribunal. Thus, the Tribunal could depart from even unanimous expert opinions if it formed the view that the expert opinion or evidence as to the usual practice of other, similar, practitioners does not reflect the professional standards which it considers acceptable, and that are of a sufficient standard to ensure that the principal purpose of the Act is fulfilled.

49. As was confirmed by Dr Collins in his advice to the Tribunal, the Tribunal has an important role to play in setting professional standards; *Farris v Medical Practitioners Disciplinary Committee* [1993] 1 NZLR 60; *Lake v The Medical Council of New Zealand* (HC) 123/96, 23/1/98. The Tribunal accepts entirely that any standards it or the Courts may set will appropriately be subject to the exercise of each practitioner's clinical judgment and the particular circumstances of individual cases. The standard that may be required is not necessarily the 'gold' standard; all standards must take into account available resources (see for example, clause 3 of the Code of Health and Disability

Consumers' Rights) and the exigencies of modern medical practice, as well as the reasonable expectations of patients, and the public generally.

50. Often the relevant standard of care and skill required may simply reflect commonsense; *Naxakis v Western General Hospital* (1999) 73 ALJR 782. However, in this case, taking into account the presenting clinical features including:

- persisting symptoms;
- a change in the nature and frequency of abnormal bleeding;
- the patient's age;
- the possibility of the presence of a cervical malignancy and the potential consequences of such disease;
- the possibility of false negative smear report/s; and
- a specialist referral

the Tribunal considers that Dr Parry's care and treatment given to Mrs A was unsatisfactory and, in the circumstances, that it does constitute a professional disciplinary offence, but at the lower end of the scale of such offences provided for in the Act.

Orders

51. Accordingly, the Tribunal has unanimously determined that Dr Parry is guilty of conduct unbecoming and that reflects adversely on his fitness to practise medicine.

52. The Tribunal invites submissions as to penalty. The timetable for submissions is as follows:

52.1 The CAC is to file its submissions with the Secretary of the Tribunal and serve a copy on counsel for Dr Parry not later than 14 working days from the date of receipt of this decision;

52.2 In turn, Mr Waalkens is to file submissions in reply on behalf of Dr Parry with the

Secretary and serve a copy on counsel for the CAC not later than 14 working days from receipt of the CAC's submissions.

53. On 26 August 2001 the Tribunal made orders pursuant to section 106(2)(a) that this hearing be held in private and, at the commencement of the hearing on 12 November 2001 the Tribunal extended the nature of those orders to prohibit publication of any part of these proceedings pursuant to section 106(2)(b) during the course of the hearing.

54. In making these orders, the Tribunal intended that its decision would ultimately be made available for publication and, accordingly, these interim orders are discharged forthwith.

DATED at Wellington this 29th day of January 2002

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W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal