Medical Practitioners Disciplinary Tribunal

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DECISION NO: 61/98/27C

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Complaints Assessment Committee pursuant to Section 93(1)(b) of the Act against **DENYS JOHN COURT** medical practitioner of Auckland

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Dr I D S Civil, Dr R S J Gellatly, Dr A D Stewart,

Mrs H White (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Auckland on Thursday 17 December 1998

APPEARANCES: Mrs D Hollings for the Complaints Assessment Committee ("the CAC")

Mr A J Knowlsley for Mr D J Court.

1. THE CHARGE:

1.1 **A** Complaints Assessment Committee, pursuant to Section 93(1)(b) of the Medical Practitioners Act 1995, charges that Dr Denys Court, Medical Practitioner of Auckland:

In the course of his management of A:

(a) Failed to perform a cervical biopsy prior to the performing of a laser procedure in about June 1996; and

(b) Failed to manage the care of A to a proper standard for the period June 1995 to December 1996 when A transferred her specialist care to Mr C

being conduct unbecoming a medical practitioner which reflects adversely on the practitioner's fitness to practise medicine.

1.2 **AT** the commencement of the hearing Mr Knowsley indicated that Mr Court pleaded guilty to both of the two particulars of the charge as framed, and also that he acknowledged that both particulars amounted to conduct unbecoming a medical practitioner which reflects adversely on fitness to practise medicine.

2. AGREED SUMMARY OF FACTS:

2.1 **MR** Court practises as a specialist in obstetrics and gynaecology in Auckland. He has held specialist registration since 20 September 1980.

2.2 **THE** complainant in this matter, Ms A (now Mrs A), was first referred by her GP, Dr B, to see Mr Court in May 1991. Dr B's letter of referral dated 24 May 1991 noted *"worsening, burning RIF pain"*.

2.3 **MR** Court saw Ms A and diagnosed *"probable PID"*. He prescribed antibiotics. Mr Court noted that he would consider a laparoscopy if there was not a marked improvement after five days.

2.4 **FIVE** days later Mr Court noted in Ms A's medical file that she was *"much improved"*.

2.5 **THE** next time that Mr Court saw Ms A was in June 1991 when there was a recurrence of pain and tenderness. Again Augmentin was prescribed by Mr Court.

2.6 **MS** A continued to have problems and saw Mr Court again in July 1991. He performed a diagnostic laparoscopy for Ms A on 22 July 1991. In his reporting letter to Dr B he noted:

"Despite her symptoms suggesting continuing pelvic pathology, her pelvis is, in fact, completely normal ... Certainly I am concerned about her general status. Her general health seems to be deteriorating but on this occasion there is no question that her pelvis remains normal".

2.7 **SUBSEQUENTLY** Mr Court was approached by Ms A and asked to write a medical certificate in January 1992.

2.8 **MS** A did not see Mr Court again until 1995.

2.9 **BY** letter dated 7 June 1995 Dr B confirmed that Mr Court would be able to see Ms A in regard to an abnormal smear result. At this stage Ms A had had two atypical smears in the last six months.

2.10 **MR** Court saw Ms A on 14 June 1995 when he took a brush specimen smear and performed a colposcopy and a biopsy. The colposcopy according to Mr Court's record showed a small area of CIN at 5 o'clock of the cervix. The cervical biopsy diagnostic histology report confirmed that cervical intraepithelial neoplasia grade 3 (CIN3) was present.

2.11 **THE** diagnostic report from the smear stated:

"The specimen is satisfactory with abundant squamous cells although evaluation is limited by the absence of endocervical or metaplastic squamous cells. Abnormal squamous cells of uncertain significance are seen. Recommendation: Colposcopy and biopsy are recommended."

2.12 **THIS** was consistent with the brush specimen taken by Dr B in mid May 1995 which had also resulted in a report from the diagnostic laboratory that a colposcopy and biopsy were recommended as abnormal glandular cells of uncertain significance had been seen.

2.13 **MR** Court advised Ms A and her GP that it would be appropriate to undertake Laser ablation and this was performed by Mr Court on 5 September 1995.

2.14 **ON** 13 September 1995 Mr Court reported to Dr B that:

"The procedure was entirely straightforward and I will see her in three or four months for review and to ensure cure".

2.15 **MR** Court advised Ms A verbally to return in three to four months but no further recall was given.

2.16 **ON** 1 May 1996 Ms A attended at the Family Planning Clinic for a smear. This again showed CIN3 cells present. She then contacted Mr Court and made an appointment for 17 May 1996. Mr Court performed a colposcopy in view of the recent smear showing a recurrence of CIN3. A further CIN lesion was in the previous area which Mr Court had treated with laser ablation.

2.17 **THE** colposcopy suggested CIN3 was present and Mr Court made arrangements for Ms A to have further cervical laser ablation which was undertaken on 4 June 1996. No biopsy was undertaken by Mr Court at this time. The second laser ablation was exceptionally painful.

2.18 **FOLLOWING** the second laser ablation Mr Court reported to the GP that:

"Hopefully this will be the end of A's problems with CIN. I will be seeing her in 3 months time for further colposcopic review".

2.19 **NO** written recall was given to Ms A. Nevertheless in early September 1996 Ms A made a further appointment herself with Mr Court for 9 September 1996 as the lower pelvic pain which had abated for about a year had returned and had again become chronic.

2.20 **MS** A saw Mr Court on 9 September 1996 when he performed a further colposcopy. According to Mr Court's notes this showed an area of squamous metaplasia which was visible

in the area where laser ablation had been performed. He also took a cervical smear (cervibroom specimen). Again no biopsy was performed.

2.21 **THE** diagnostic report in regards to the smear conducted on 9 September 1996 was received by Mr Court's office on 18 September 1996. It stated:

"The specimen is satisfactory with abundant squamous and endocervical cells. Abnormal squamous cells of uncertain significance were seen. Recommendation: Colposcopy and biopsy are recommended."

2.22 **MR** Court had told Ms A that he would telephone through the smear result. In fact this did not occur. Instead Mr Court wrote to Ms A by letter dated 14 November 1996 stating:

"*With reference to your recent smear report (11 September 1996) there were some slightly funny looking cells probably just consistent with the healing process that was going on. I think it would be wise for me to see you next March for a further colposcopy and smear test before we can assume yet that you are completely in the clear."*

2.23 **A** copy of this letter was sent to Dr B.

2.24 **MS** A was not sent a copy of the diagnostic report of 18 September 1996. She accepted the advice from Mr Court that she would not need to see him again until March of 1997. However not long after that Ms A herself felt unwell. She returned to her GP, Dr B, as her lower pelvic pain was still intermittent. Dr B referred her to Mr C, at Ms A's request, for an opinion in regard to her pelvic pain.

2.25 **MS** A saw Mr C for an initial consultation on 10 December 1996. He noted that there had been recurrent pelvic pain for many years and that she had had CIN3 smear tests and two laser treatments to her cervix.

2.26 **ON** 16 December 1996 under anaesthesia Mr C undertook a colposcopy and laparoscopy. Mr C reported:

"On examination under anaesthesia Ms A has a normal vulva and vagina, her cervix had clearly had previous laser surgery and her cervix was noted to be moderately dilated already to 5 to 6mm. There was a small cervical polyp high in the cervical canal and this was removed by avulsion. Colposcopy showed a normal ectocervix but the transformation zone was well up the canal and was not visible. The polyp was removed. The cervix was further dilated so size eight Hagar and curettage was performed".

2.27 **THE** diagnostic report dated 19 December 1996 indicated clearly that invasive squamous cell carcinoma was present.

2.28 **ON** 18 December 1996 Mr C contacted Ms A and asked her to see him urgently to discuss the histology report. Ms A saw Mr C on the same day and Mr C informed her that she needed to see Mr Andrew Macintosh for a second opinion and urgent surgery. Ms A discussed with Mr C the fact that Mr Court had advised her not to come back until March 1997 for a check-up. Mr C effectively advised Ms A that she would probably not be alive in March 1997 and hence the need for urgent surgery. Ms A asked if the surgery could be delayed so that she could try to have children immediately as at this stage Ms A and her then fiancée did not have any children. However Mr C advised her that the tumour would be terminal if it was left much longer.

2.29 **ON** 19 December 1996 Ms A attended at Mr Macintosh's rooms having been referred by Mr C. A biopsy of the cervix showed a squamous cell carcinoma. Mr Macintosh also rebiopsied her cervix with a relatively deep biopsy from the anterior lip and this showed moderately differentiated squamous cell carcinoma which extended through the full thickness of the biopsy. The biopsy was at least 5 mm in thickness and there was no vascular space invasion. Mr Macintosh advised Ms A that he was able to see the tumour with his naked eye.

2.30 **MR** Macintosh advised Ms A that the carcinoma would have to be excised and that this would have to be done by radical hysterectomy. He undertook a radical hysterectomy in regard to Ms A on 28 January 1997. In order to treat the cancer adequately fertility could not be preserved.

2.31 **MR** Macintosh had indicated that the tumour was visible at colposcopy. The size of the tumour at histology was 20 mm x 20 mm and can therefore be described as large. Ms A and her husband then inquired about the possibility of surrogacy which can only be undertaken through the United States at a cost of approximately US$80,000. They moved to Australia in order to increase earnings so that they could proceed with in vitro fertilisation and gestational surrogacy programmes. Ms A advises that this move has been at great personal cost. Her mother was recently widowed at a young age.

2.32 **ON** 23 February 1998 Mr Court wrote to the Complaints Assessment Committee in regard to the complaint by Ms A. He stated in regard to the review in May 1996 and the second laser ablation conducted in June 1996 that:

"It is apparent that in relation to the current lesion, no biopsy was done. I have never knowingly performed a laser procedure without a biopsy. I can only presume it was my intention to take a second biopsy under local anaesthetic immediately prior to the laser ablation. It is also my policy to check for a biopsy report in the notes prior to any cervical laser procedure."

2.33 **IN** regard to the inadequate and slow follow up of the abnormal cervical smear and colposcopy results in September 1996 Mr Court stated:

"The smear was technically adequate and the concurrently performed colposcopy had shown squamous metaplasia only. The recommendation of the smear report of "colposcopy and biopsy" is a computer-generated statement which accompanies all abnormal reports. I felt in view of the above, recall in March was appropriate. Subsequent events have, of course, indicated that earlier recall would have been timely"

2.34 MR Court went on to state:

"As I have acknowledged from my statements above, I accept that the care I provided Ms A fell below the standard of best practice. A biopsy should always precede cervical treatment (of whatever kind). Secondly, had I performed a cone biopsy on 4 June 1996 it is possible or likely that this would have led to earlier diagnosis of her cervical cancer. Similarly, earlier recall than March would have afforded earlier diagnosis. It distresses me to know that my management of Ms A fell below the standard that I would and should expect of myself. Whilst radical surgery may not have been avoidable. I accept that my care led to a delay in diagnosis and I sincerely apologise that I failed to meet Ms A's reasonable expectations."

2.35 UNFORTUNATELY in August 1998 Ms A experienced further suprapubic pain and a lump in the suprapubic region. She was referred to Professor Hacker, the Director of the Gynaecological Cancer Centre at the Royal Hospital for Women in Sydney. Biopsy revealed further squamous cell carcinoma. Ms A was required to be subject to a further major operation. Subsequent to the surgery Ms A underwent concurrent chemotherapy and x-ray therapy.

2.36 PROFESSOR Hacker reports that at the present time Ms A is without evidence of disease but her ovaries have ceased to function and she is on hormone replacement therapy. She has been advised that her chances of surviving and conquering her cancer is about 50%.

3. EVIDENCE:

3.1 WRITTEN briefs of evidence of two expert witnesses for the CAC and of one expert witness for Mr Court were made available to the Tribunal. However the witnesses were not called and consequently there was no cross-examination. Very brief details from the briefs of each of the three expert witnesses follow.

3.2 THE first CAC witness was to have been Andrew Ronald Macintosh, a medical specialist practising privately and at National Women's Hospital, who undertakes gynaecological and

laparoscopic surgery and gynaecological oncology. In the opinion of Mr Macintosh there were four areas where Mr Court's practice in relation to Ms A was below an acceptable standard. They were described by Mr Macintosh as failure to cone biopsy in June 1995, failure to follow up adequately in June 1995, failure to cone biopsy in 1996, and finally, failure to observe the tumour which was visible to the naked eye when he saw Ms A in December 1996. However when Mr Macintosh colposcoped Ms A the cervix had recently been dilated at the time Mr C had operated on Ms A.

3.3 **A** second expert witness for the CAC was to have been Neville Frederick Hacker, Director of the Gynaecological Cancer Centre at the Royal Hospital for Women in Sydney. Like Mr Macintosh, Professor Hacker was critical of Mr Court's management and treatment of Ms A in a number of respects. For example, by reference to the colposcopy performed by Mr Court on 17 May 1996 which revealed a CIN3 lesion in the same location as the previous lesion, Mr Hacker commented:

"The recurrence of such an apparently small area of CIN within 12 months of extensive laser ablation should have raised suspicion that a more serious underlying condition was present. To perform further laser ablation without extensive biopsy (preferably cone biopsy) would in my opinion be well below the expected standard of care."

3.4 **MR** Hacker said it was difficult to escape the conclusion that Mr Court's management of Ms A, at least in 1996, fell well below an acceptable standard of care.

3.5 **THE** expert witness for Mr Court was to be have been Howard Murray Clentworth, a Consultant Obstetrician and Gynaecologist at Wellington and Lower Hutt Hospitals, and also in private practice at the Boulcott Clinic, Lower Hutt. Mr Clentworth concluded his four page brief with an opinion that Mr Court followed absolutely conventional therapy and that he would not

be critical of his management of Ms A except for his admitted omission to perform a biopsy in May 1996.

4. MEDICAL ASSESSOR:

4.1 **PRIOR** to the hearing the Tribunal appointed Dr David Peddie to act as a Medical Assessor concerning the charge laid against Mr Court. The role of a Medical Assessor is to assist the Tribunal in understanding the effect and meaning of technical evidence.

4.2 **THE** Medical Assessor may also be consulted by the Tribunal in case of need as to the proper technical inferences to be drawn from proved facts or as to apparently contradictory conclusions in the expert field.

4.3 **IN** some respects the advice given by Dr Peddie to the Tribunal contradicted some of the evidence of the two expert witnesses, Messrs Macintosh and Hacker. For example Dr Peddie explained, if a punch biopsy had been undertaken in June 1996, it could have missed an underlying carcinoma if one had been present at that time. However Dr Peddie said he had to acknowledge, in not taking the biopsy, that the chance of making an unsuspected diagnosis was missed. Furthermore Dr Peddie explained, as a Generalist and Colposcopist, that he would find it difficult to be over-critical of Mr Court or Mr C for not seeing invasive carcinoma at their examinations. Dr Peddie explained further, at follow-up, after treatment, he personally relies on colposcopy and cytology, and usually only takes a biopsy if a lesion is apparent, either on colposcopy or suggested on cytology.

4.4 **MRS** Hollings drew to the Tribunal's attention Ms A's view, that she was concerned Dr Peddie had given his expert opinion, and that if she had known what his view was going to be, she would have preferred to have Messrs Macintosh and Hacker present to give their evidence and to comment in reply to Dr Peddie. Noted was Mrs Hollings submission, that the Tribunal could agree to ignore the statement of Dr Peddie in so far as it contained opinion evidence. Also noted by the Tribunal was Mr Knowsley's submission, that it is the role of a Medical Assessor to give an opinion on the facts. It was explained by the Chair that all of the evidence would be balanced by the five members of the Tribunal, and that the view of any one person alone would not be determinative of the outcome.

5. STATEMENTS:

5.1 **PERSONAL** statements were tendered to the Tribunal by Mr Court and Ms A.

5.2 **MR** Court's nine page statement amplified in considerably more detail the explanatory information given by him during the inquiries made by the CAC. Warranting specific mention is that all of Mr Court's patients are registered with the Cervical Screening Register. At the time of Ms A's care Mr Court explained he also maintained a manual patient recall system. Now he employs an electronic recall system whereby monthly lists of patients due for follow-up recall are produced. If these patients have not made appointments within that month they are contacted by his staff. At the time of Ms A's care, although he kept a manual follow-up register himself for ongoing audit, he relied upon the Cervical Screening Register to recall patients. Mr Court felt that he was entitled to rely upon the register to notify patients of their recall. However he did not know whether such recall did actually occur.

5.3 **A** point made by Mr Knowsley in his closing submissions was in relation to recall, particularly following the first consultation on 5 September 1995, and Mr Court's reliance on the National Register as a backup to his then manual system. Mr Knowsley submitted if such reliance is not appropriate, then the Tribunal needs to send a signal to the profession that this is not appropriate, and that practitioners should not rely on the Cervical Screening Register to recall patients.

5.4 **IN** summary Mr Court said he accepted that some aspects of his clinical management did not meet best practice standards. In particular, he acknowledged his failure to perform an intended biopsy meant that he not only failed to meet the high standards he normally would expect of himself, but also the standards that Ms A no doubt expected of him. Mr Court sincerely apologised for failing to meet those expectations. He concluded that he was distressed to think that the standards of care he would normally apply were not met in his care of Ms A, and that he could only imagine the distress experienced by her. For several months Mr Court explained he has not been accepting new gynaecology referrals, remaining in practice only long enough to be sure that all his patients had been appropriately followed up for an appropriate time. Just recently he has succeeded in recruiting a new gynaecologist to take over his practice with effect from 21 January 1999. Currently he is actively seeking non clinical or non medical employment.

5.5 **FINALLY** a personal statement was received by the Tribunal from Ms A. It is not necessary to include the detail of Ms A's statement to the Tribunal in this Decision. Suffice for us to record, that quite understandably there were points made by both Mr Court and Mr Knowsley with which Ms A did not agree. Ms A said she found it very traumatic and upsetting for Mr Clentworth to conclude that in his opinion Mr Court followed absolutely conventional therapy with the exception only of his admitted omission to perform a biopsy in May 1996.

5.6 **ALSO** Ms A expressed her opinion that it would be entirely inappropriate for Mr Court's name to be suppressed.

6. DETERMINATION:

FOLLOWING the morning adjournment the Chair indicated, based on the admissions made by Mr Court, and particularly the information contained in the briefs of evidence of Messrs Macintosh and Hacker, that the two particulars contained in the charge had been established to the required standard. It remained, then, for matters of penalty only to be addressed.

7. ORDERS:

THE following orders are made:

7.1 **THAT** Mr Court be censured.

7.2 **THAT** Mr Court pay a fine of $5,000.

7.3 **THAT** Mr Court pay 30% of the costs and expenses of and incidental to the inquiry made by the CAC, prosecution of the charge by the CAC and the hearing by the Tribunal, but not exceeding $9,500.00.

7.4 **IF** Mr Court remains in or decides to return to colposcopic practice, he is required forthwith to present himself to the New Zealand Committee of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists for the purpose of completing the module in Colposcopy and the treatment of pre-invasive cervical disease.

7.5 **IN** the interests of Ms A's privacy, particularly in regard to her health care, and bearing in mind that part of the summary of issues and submissions involve intimate and distressing details, her name and any details which may be likely to lead to her identification, are suppressed. However there will be no order for suppression of Mr Court's name, as was favoured by Mr Knowsley, although it is acknowledged that no formal application under Section 106 of the Act concerning Mr Court was made.

8. REASONS FOR ORDERS:

8.1 **THE** summary of facts and the briefs of evidence of Mr Macintosh and Professor Hacker indicate that the second particular of the charge is clearly established. Mr Court's failure to manage Ms A care was not only inappropriate in failing to perform a cervical biopsy in or about June 1996, but his general management of Ms A from June 1995 to December 1996 was below an acceptable standard in regard to what could be expected of a practitioner of similar experience and training.

8.2 **THE** general failure to carry out adequate follow-up is a particularly disappointing aspect of Ms A's care. She took the view that throughout all the relevant time that Mr Court was in charge of her gynaecological care, she had placed herself totally in his hands. Mr Court is a highly regarded specialist in the medical profession. One of the aggravating factors must necessarily be his seniority and his position as a specialist in obstetrics and gynaecology.

8.3 **FOR** Ms A, who is now married, the reality that she will not be able to have children has been devastating. Perhaps more drastically, she has been advised that she has only a 50% chance of surviving and conquering the cancer.

8.4 **HOWEVER**, as was conceded by Mrs Hollings, there are some mitigating factors which the Tribunal has been able to take into account when assessing the penalties to be met by Mr Court.

8.5 **IT** is accepted, on the advice of Mr Macintosh, that Ms A's current state of health may have been inevitable even with proper management. However, Mr Macintosh's considered opinion is that Mr Court's actions are in general terms probably 70% responsible for the position Ms A finds herself in today.

8.6 **IN** terms of clinical practice it is the CAC's view that the poor clinical practice (excluding the failure to follow-up) is limited. The evidence has established poor clinical practice in regard to colposcopy, rather than general gynaecological practice.

8.7 **IT** is accepted the fact that Mr Court elected to admit the charge should be taken into account by the Tribunal, although this was a relatively late indication. Certainly it was acknowledged by Ms A to have been a preferable course of action for her to avoid the stress of having to give evidence.

8.8 **THE** CAC accepts that Mr Court has a high reputation and this should also appropriately be a matter of credit. But for Mr Court's admission of the charge, and the other mitigating factors to which reference has been made, it is likely that both fine and costs would have been pitched at a higher level.

8.9 **WHEN** announcing its findings at the conclusion of the hearing, the Tribunal ordered that Mr Court pay 40% of the specified costs and expenses (para 7.3 refers). The reduction to 30%, but not exceeding $9,500.00 should be explained.

8.10 **A** breakdown of costs was not available when the Tribunal ordered reimbursement of 40%. When the details became available the parties were duly informed.

8.11 **MR** Knowsley's response was that total costs of $31,420.61 seemed very high. He submitted that the imposition of 40% of those costs, amounting to $12,568.24 was a very severe penalty, one which was out of proportion to Mr Court's shortcomings, and unjust in the circumstances. Mr Knowsley asked that the Tribunal be given an opportunity to review the costs level. This has now been done.

8.12 **IN** reassessing the level of costs in this case, the Tribunal has received some guidance from a recent judgment of the High Court, *J v Dental Council of New Zealand* (HC, February 1999, Potter J, Auckland, AP 40/98) Her Honour explained:

"The appellant was also ordered to pay 30% of the counsel's costs. I note that this method of awarding costs in cases under the Act is not unusual, but I do not consider it appropriate to make an award of costs when the amount of costs is not known and there is no information available to the Court upon which it can be determined whether the costs claimed are appropriate. In ***H v Auckland District Law Society*** *[1985] 1 NZLR 8, the Court stated in relation to proceedings before the New Zealand Law Practitioners' Disciplinary Tribunal that an indication of how costs claimed by the New Zealand Law Society were to be assessed, should be provided in any given case. That seems to me a fair and reasonable approach. There are many factors that may influence a Court in awarding costs including the ability to pay, of the party against whom costs are sought. The Court needs to know the amount of costs involved and the party who is to be liable for costs is entitled to be satisfied that costs claimed are fair and reasonable. In future this procedure should be followed."*

8.13 **HAVING** now established the amount of actual costs involved in this case, the Tribunal is satisfied that 40% of the total costs incurred would be excessive and not fair and reasonable in the circumstances.

8.14 **BY** reference to costs imposed by the Tribunal in comparative cases, we believe that a reduction to 30%, but not exceeding $9,500.00, would be reasonable. Total expenses were $34,101.55 of which 30% is $10,230.46. Therefore in terms of the reduced order Mr Court's liability will be $9,500.00.

8.15 **UPHELD** is Mrs Hollings submission that the order suppressing Ms A's name is in accordance with the spirit of Section 107 of the Act.

8.16 **HOWEVER**, as earlier indicated, we do not consider it is appropriate in this case that Mr Court's name should be the subject of an order prohibiting publication.

8.17 **IN** this regard it is noted that the general principle of the Act is that hearings of this Tribunal are to be held in public (Section 106). The Tribunal must be satisfied that it is desirable to make a non-publication order, taking into account the interests of any person, the privacy of the complainant and the public interest.

8.18 **GENERALLY** we consider it is appropriate that other members of the medical profession are made aware of the error of Mr Court, together with prospective and current patients. We agree with Mrs Hollings that there is nothing particularly unusual about this case that would justify a departure from the normal procedure of publication.

DATED at Auckland this 24th day of February 1999

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P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal