MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

PO Box 5249, Wellington • New Zealand
Ground Floor, NZMA Building • 28 The Terrace, Wellington
Telephone (04) 499 2044 • Fax (04) 499 2045
E-mail mpdt@mpdt.org.nz

EMBARGOED UNTIL
9.00 AM THURSDAY
21 DECEMBER 2000

DECISION NO: 149/00/62D

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)

Dr 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.

SUPPLEMENTARY DECISION:

THIS supplementary decision should be read in conjunction with Decision No. 139/00/62D dated 31 October 2000.

1.0 THE DECISION:

1.1 **IN** that Decision, the Tribunal found Dr Parry guilty of disgraceful conduct in a professional respect. The Tribunal's Decision was made in the context of one charge of disgraceful conduct in a professional respect relating to Dr Parry's care and treatment of Mrs Colleen Poutsma in August 1997, December 1997 and January 1998.

1.2 **THIS** Supplementary Decision issues for the purpose of determining penalties in accordance with Section 110 of the Act.

2.0 THE CHARGE:

2.1 **THE** charge laid against Dr Parry by the Director of Proceedings contained three Particulars and alleged that either separately or cumulatively, these Particulars constituted disgraceful conduct in a professional respect. Dealing with each Particular separately, the Tribunal found two Particulars upheld at the level charged; the third was upheld at the level of professional misconduct. The Tribunal was satisfied that, cumulatively, the charge was established.

3. SUMMARY OF THE TRIBUNAL'S FINDINGS:

3.1 **IN** its Decision, and in addition to its findings on each of the Particulars, the Tribunal determined that there were a number of aspects about Dr Parry's care of Mrs Poutsma that raised concerns about his practice as a specialist obstetrician and gynaecologist, both in the context of his clinical management of Mrs Poutsma's presenting symptoms and subsequent care, and his clinical judgment generally.

3.2 **FOR** example, in relation to his management of Mrs Poutsma's case, the Tribunal accepted the expert evidence given to it that *"fundamental errors of judgment were made in this case"*. The Tribunal found that Dr Parry's failure to carry out an appropriate examination or any investigation of his patient's principal, and ultimately potentially fatal, presenting symptom was "*indefensible and inexcusable*". It determined that Dr Parry's care and treatment of Mrs Poutsma was grossly negligent.

3.3 **DR** Parry's negligent care of Mrs Poutsma in failing to carry out a proper clinical examination when she was initially referred to him was compounded by his subsequent

decision, in January 1998, to delay referring Mrs Poutsma to National Womens Hospital for oncology assessment and treatment and instead to carry out a cone biopsy of her cervix, which procedure was contra-indicated, and as a result of which she suffered a severe post-operative haemorrhage necessitating an emergency simple hysterectomy. As a consequence, the clinical options for treating her invasive cervical carcinoma were significantly curtailed.

3.4 **THE** Tribunal also determined that Dr Parry's correspondence to Dr O'Connor in December 1997, and to Dr Whitaker at NWH in January 1998 regarding his management of Mrs Poutsma's care and treatment, was grossly misleading.

3.5 **FINALLY** in relation to specific allegations made by the Director of Proceedings, the Tribunal found that Dr Parry did not carry out the cone biopsy procedure on advice from Dr Whitaker (NWH) as he suggested, because the Tribunal was satisfied, as a matter of fact, that there was no telephone discussion between Dr Parry and Dr Whitaker regarding Mrs Poutsma's case.

3.6 **THE** Tribunal also expressed concerns regarding Dr Parry's conduct of his professional practice generally. First, that his clinical notes of his consultations with Mrs Poutsma, and his operating notes, were grossly inadequate. His deficiencies in this regard were also the subject of criticism by the Medical Council's Competence Review Committee, which Report was made available to the Tribunal.

3.7 **SECONDLY**, while Dr Parry accepted that his care of Mrs Poutsma fell below acceptable standards, he still 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 Dr O'Connor that her cervix 'bled to the touch' when he had examined her. Dr Parry told the Tribunal that 'it was news to him' that cervical carcinoma could be present notwithstanding an "ASCUS" smear (a report of the presence of Atypical Squamous Cells of Uncertain Significance).

3.8 **THIRDLY**, the Tribunal agreed with the Competence Review Committee's assessment that Dr Parry has an "*excessive*" reliance on ultrasound in the context of his gynaecological practice and that this might not be known to GPs who refer, or who have referred, patients to him (and to Northland Health where he works as a consultant specialist).

4.0 **SUBMISSIONS ON PENALTY BY DIRECTOR OF PROCEEDINGS:**

4.1 **THE** Director of Proceedings seeks that Dr Parry's name be removed from the medical register; that a fine be imposed, and that the Tribunal order that he pay 50% of the total reasonable costs incurred.

Removal from the Register

4.2 **IT** is the Director's submission that given the serious nature of the Tribunal's finding, it is inevitable that Dr Parry's name be removed from the register. This is the only way in which the public interest can be protected effectively.

4.3 **IN** making this submission, Mr McClelland, Counsel for the Director of Proceedings, referred to the Tribunal's decision to suspend Dr Parry's registration made on 8 September 2000, and again on 3 October 2000 following the hearing of an application for revocation of the suspension order. In making the latter order, the Tribunal determined that it was necessary and desirable that Dr Parry's registration be suspended until the charge was determined "*having regard to the health and safety of the members of the public of Northland"*.

4.4 **BOTH** of the orders referred to were made after the hearing commenced, and on the basis of evidence given by Mrs Poutsma, and admissions of fact made on behalf of Dr Parry. The Tribunal considered that the nature of the issues raised as a result were serious, and that they were *"as much related to Dr Parry's professional judgment and his specialist practice generally as they are confined to part of his specialist practice only …"*.

4.5 **AT** the hearing of the application for revocation of the suspension order, the Tribunal considered whether or not it would be feasible to revoke the order and instead to impose conditions restricting Dr Parry's practice to his sub-specialty practice only. But it was not satisfied that conditions of this sort were practical or if they could be defined in any satisfactory way. The general nature of some of the Tribunal's concerns also precluded that option.

4.6 **THE** Director of Proceedings refers to a number of the Tribunal's findings and given the nature of these findings, the Director submits, Dr Parry's name should be removed from

the register. An order suspending him from practice, or permitting him to practise subject to conditions is not sufficient to protect the public interest.

4.7 **THE** errors made by Dr Parry in this case were fundamental. He demonstrated a lack of insight into the nature of those errors, and into the nature of his professional obligations generally. The Director of Proceedings submits that for reasons of public safety, Dr Parry should not be permitted to return to medical practice.

4.8 **AS** to the other orders sought, the Director of Proceedings submits that censure is also justified, and a fine should be imposed. In relation to costs, the Director refers to *Cooray v Preliminary Proceedings Committee* (unreported, AP23/94, Wellington Registry, 14/9/95, Doogue J) a decision in respect of an award of costs by the Medical Council under the Medical Practitioners Act 1968 Act.

4.9 **IN** that case Justice Doogue reviewed the relevant authorities and concluded that:

"… It would appear from the cases before the Court that the Council in other decisions made by it has in a general way taken 50% of total reasonable costs as a guide … In other cases where it has considered that such an order is not justified because of the circumstances of the case, … the Council has made a downwards adjustment."

4.10 **IN** this case, the Director of Proceedings submits, a downward adjustment is not warranted.

5.0 SUBMISSIONS FOR DR PARRY:

5.1 **ON** behalf of Dr Parry, Mr Waalkens submits that an order removing a practitioner's name from the register should be reserved for the 'worst cases'. These "*will invariably be characterised by wilful behaviour or a degree of recklessness so bad as to amount to a dissimilar level of culpability. There is no such finding here*", Mr Waalkens submits.

5.2 **MR** Waalkens rejects the Director of Proceedings' submission that the only way in which the public interest can be protected is by removing Dr Parry's name from the medical register. He submits that the Director's submission is "*that the public interest involved is such that the only way that the public interest can be protected is by an order for removal"*. Mr Waalkens says that that submission is "*misplaced"*. He goes on to state that:

"The submission confuses the public interest with public curiosity, aroused in this case by a morbid consideration of the presumed effects of Dr Parry's breaches of good service to Mrs Poutsma".

5.3 **MR WAALKENS** submits that:

"There is no evidence to suggest that had Dr Parry conducted himself differently, the result for Mrs Poutsma would have been any different. It needs to emphasised that the public interest in this case has arisen as a reflection of the extreme media hype in respect of the case. For the DP to suggest that because of this public interest, Dr Parry's name should be removed from the register, or for that matter that it be suspended … is wrong.

The Director of Proceedings misuses the characterisation of "significant public interest" …[and] infers that the significant media interest is the measure of significant public interest. This is wrong. A more indicative measure [of] public interest is the evidence which the Tribunal …received of unsolicited support from not only members of the public but also the huge support from medical colleagues, midwives, nurses and other health professionals. …

It behoves the Tribunal to approach its discretion in respect of penalty in a balanced and objective manner paying proper regard to the public interest as signalled by the huge support in the Northland region for Graham Parry."

5.4 **MR** Waalkens refers to Dr Parry's skills and expertise in the detection of fetal abnormalities and the use of ultrasound. He confirms that this work comprises around 80% of Dr Parry's practice. The value he can provide to the Northland community in this regard is such that it would be wrong to either remove his name from the register or suspend him. Two letters from Northland Health have been submitted to the Tribunal. In both of these, Dr Page, Obstetric and Gynaecology Clinical Director, and Dr Luke Henneveld, Chief Medical Officer, confirm that they are aware of the Tribunal's findings but want Dr Parry to return to work.

5.5 **DR** Page is Dr Parry's supervisor under the Council's Competence Programme, put in place as a result of the findings of the Competence Review Committee's Report, and he confirms that he will continue in this role if Dr Parry is permitted to return to work at Northland Health. Dr Henneveld advises the Tribunal that if Dr Parry is suspended or struck off the register, Northland Health would find it very difficult to recruit two O&G specialists to replace Dr Parry and another staff member who has recently resigned.

5.6 **DR** Henneveld assures the Tribunal that Northland Health would ensure compliance with any restrictions on practice and/or training/supervision requirements that might be imposed. "*Support would be given to the clinical and educational supervisors to ensure that this process will be rigourous and meaningful*", Dr Henneveld states.

5.7 **IN** relation to the specific penalties sought by the Director of Proceedings, Mr Waalkens rejects suspension as being 'counter-productive'; there is no need for the Tribunal to impose any conditions on practice because if Dr Parry is permitted to return to practice the competency programme put in place by the Medical Council will resume; it is accepted that Dr Parry will be censured; a fine is *"completely unnecessary"*; any order of costs should be moderate, taking into account Dr Parry's co-operation in the proceedings.

6.0 **THE LAW:**

6.1 **ALTHOUGH** neither party submitted any authorities in relation to penalty, and the submissions on any relevant legal principles were limited, given the seriousness of the findings made by the Tribunal, and the gravity of the penalties which it may impose, the Tribunal has reviewed relevant cases involving similar findings, and taken the penalties imposed in similar cases into account.

6.2 **THIS** case is relatively unusual (at least in New Zealand) in that it involves a finding of disgraceful conduct in a professional respect solely in the context of Dr Parry's clinical management of Mrs Poutsma's case. The authorities which the Tribunal relied upon in determining that Dr Parry's conduct was so grossly negligent as to warrant such a finding are set out in its substantive decision.

6.3 **IN** relation to appropriate penalties, in *Teviotdale v Preliminary Proceedings Committee of the Medical Council of NZ* [1996] NZAR 517, the Court held (allowing the appeal) that the Medical Council was entitled to exercise its disciplinary functions to remove a practitioner's name from the register only where there was an impact on the

public interest in the practitioner continuing to practice. In that case, the practitioner had originally faced a charge of conduct unbecoming, but in the course of the hearing had attempted to mislead the Council by presenting a forged document and lying on oath.

6.4 **A** charge of disgraceful conduct was subsequently prosecuted and upheld, resulting in the removal of the practitioner's name from the medical register. The Court determined that while such conduct struck at the heart of the disciplinary process *"it was however an offence which was acknowledged to be more directly relevant to conduct in a professional [sense] than in a clinical sense in that it affects the public interest rather than public safety."* (p.520). It was less significant than conduct affecting public safety since *"Only in isolated cases of gross negligence in clinical decisions or behavior to patients were medical practitioners suspended or removed from the register."* (p.521)

6.5 **RELEVANTLY** in the present context, the Court referred to a decision by Gresson J, *Re a Medical Practitioner* [1959] NZLR 784 at 802, in which His Honour said:

"…Though the imposition of a monetary penalty, or a suspension, or a striking off, viewed realistically, is a punishment, nonetheless the primary purpose of such domestic tribunals and the powers given to them is to ensure that no person unfitted because of his conduct should be allowed to continue to practice the particular profession or to follow the particular calling …".

6.6 **IN** *Tizard v Medical Council of NZ & Anor* (unreported, M No 2390/9, High Court (Barker J (presiding) Thorp J, Smellie J), 10/12/92) Dr Tizard had been found guilty of either disgraceful conduct or professional misconduct in relation to his diagnosis and/or management of seven patients. All of the charges in relation to his management of the patients were upheld at the level of disgraceful conduct. The Council found that the

combined effect of the separate findings justified findings of disgraceful conduct in respect of each patient on a cumulative basis. The penalty imposed included an order that his name was to be removed from the medical register.

6.7 **ON** appeal, the Court quashed two of the findings of disgraceful conduct made in relation to diagnoses, but upheld all of the other findings. Accordingly, the Court held that the penalty should not be disturbed.

6.8 **DR** Tizard was a very experienced practitioner, with an interest in homeopathic medicine and acupuncture. He had a particular interest in the identification and treatment of pesticide poisoning, which he considered was underestimated by conventional medicine. All of the charges related to his diagnosis and management of such poisoning in the subject patients.

6.9 **AMONG** the charges laid against Dr Tizard were allegations that he failed to undertake adequate clinical examinations, he failed to carry out diagnostic tests to confirm his diagnoses, and he "*clearly did not reach the levels of due care and skill, as recognised and required generally.*"

6.10 **IN** relation to one of the complainant patients, the Council found that, *"the management of this case is gravely inadequate. …He failed to a very serious degree to give this patient the care that he had a duty to provide."* In relation to a woman subsequently found to be suffering from a brain tumour, there was expert evidence that:

"Dr Tizard's treatment undoubtedly led to a delay in making the correct diagnosis and therefore definitive treatment was considerably delayed. … In my view the

delay in making the diagnosis did not improve the chances of cure and definitely worked against long term palliation."

6.11 **IN** essence, the Medical Council found that Dr Tizard had a general preference for diagnosis and treatment by means of acupuncture and homeopathic treatment. The appellate court found that the Council's comments in this regard were *"not a case of criticising the application homeopathic medicine but of failing to exercise other skills which, if used, would have indicated the need for further testing for some neurological disorder. …"*.

6.12 **THERE** are a number of similarities between the nature of the deficiencies of care identified in *Tizard*, and those present in this case, and, in Dr Parry's case there is also present the additional factor that the Tribunal made adverse factual findings in relation to his communications with other health professionals regarding his management of Mrs Poutsma's case.

6.13 **HAVING** upheld the Council's determination that Dr Tizard's name should be removed from the Medical Register, the Court had difficulty accepting the appropriateness of the Council's penalty imposed by way of a fine (the maximum of $1,000) and the order for costs ($150,000 ex GST). The Court thought the fine 'incongruous' in the context of the far greater penalties imposed. The Court preferred to consider it as part of the requirement that Dr Tizard should bear a reasonable share of the costs of the proceedings.

6.14 **HOWEVER,** and mindful that this Tribunal is bound by decisions of the higher courts, the Tribunal considers that this approach does not adequately differentiate between the

different purposes served by a fine and an order for costs respectively. It ignores the punitive purpose of a fine, compared to an order that the practitioner pay a reasonable proportion of the costs incurred by the Tribunal (funded as it is by the profession), and the prosecutor. The level of the fine is also an expression of the seriousness with which the Tribunal regards the practitioner's professional misconduct, bearing in mind that the Tribunal largely comprises the practitioner's professional peers.

6.15 **FINALLY**, it is necessary to address Mr Waalkens' submission that:

" …Dr Parry did not intend the consequences of the matters for which he has been found guilty of either disgraceful conduct or professional misconduct. There is no suggestion, nor could there be, [of] a wilful disregard of his patient's interest. There is what the law calls negligence. This lack of intention (or of a conscious omission) is a strong contraindication against either removal or suspension of Dr Parry's name from the medical register."

6.16 **TWO** decisions from the United Kingdom are helpful in relation to this submission. In *McCandless v General Medical Council* [1996] 1 WLR 167, a gynaecologist whose surgical blunders in performing 'keyhole' surgery caused serious injury to women patients (two of who died), was found guilty of serious professional misconduct by the Professional Conduct Committee (PCC) of the General Medical Council (GMC) and his name removed from the medical register.

6.17 **THE** appeal to the Privy Council concerned the test applied by the Committee when it determined what constituted 'serious professional misconduct'. As was contended for on behalf of Dr Parry in closing submissions, it was argued that such conduct must be morally blameworthy and that honest mistakes alone did not warrant such a finding. Counsel accepted that while the doctor had been negligent, something more than negligence was

required, "*Poor treatment was not enough*", as Lord Hoffman restated the argument. It was not enough to assert, as did the PCC, that it fell *"'deplorably short' of the standard which could reasonably be expected"*.

6.18 **THE** Privy Council dismissed the appeal. Lord Hoffman, delivering the advice, rejected the old formulation of 'serious professional misconduct' and stated that it was clear that since the enactment of 'serious professional misconduct' as an offence, the higher expectations of the public, the range of sanctions available, and decisions since 1960 all pointed to the conclusion that a doctor who, like Dr McCandless, had been found to have fallen deplorably short of the standard patients were entitled to expect from practitioners, could be found guilty of serious professional misconduct and his name removed from the register.

6.19 **LORD** Hoffman made three main points; the first was his rejection of the old formulation of serious professional misconduct as being only *"infamous and disgraceful conduct"*, i.e. misconduct in a professional sense rather than 'clinical' incompetence or negligence (such approach accords with that taken in the cases referred to in the Tribunal's substantive decision). Instead, Lord Hoffman preferred an objective standard, that *"'infamous conduct' means no more than serious misconduct judged according to the rules written or unwritten governing the profession"*, citing *R v General Council of Medical Education and Registration of the UK* [1930] KB 562 per Scrutton LJ.

6.20 **THE** second point was that, because the GMC could have recourse to a range of penalties, it was his view that this meant that *"the offence of serious professional*

misconduct was intended to include serious cases of negligence." In this context, Lord Hoffman also referred to *Minutes of the GMC* (Vol.CXXI, 1984, 22) in which the GMC agreed to issue more detailed guidance on *"the circumstances in which failure to provide a proper and sufficient standard of medical care might be regarded as raising a question of serious professional misconduct."* It could be implied from that resolution that negligence can amount to a professional disciplinary offence.

6.21 **THIRDLY**, Lord Hoffman went to the heart of the professional disciplinary process, and to professional self-regulation. He stated, *"the right to engage in self-regulation places a corresponding duty on governing bodies to protect the public against the 'genially incompetent' as well as deliberate wrongdoers"*.

6.22 **IN** the context of the legislation under which this Tribunal is established, with its Principal Purpose (in s.3 of the Act) being *"to protect the health and safety of members of the public by … ensuring that medical practitioners are competent to practise medicine"*, Lord Hoffman's judgment is very relevant, and apt in the present circumstances.

6.23 **IN** a more recent case, *Roylance v GMC(No2)* [1999] WLR 541, the appellant was a registered medical practitioner charged in his capacity as chief executive officer of a National Health Service Trust (Bristol Royal Infirmary). This case also was an appeal to the Privy Council from a decision of the PCC. Their Lordships upheld the PCC's finding that misconduct involving some act or omission, falling short of what would be proper in the circumstances, which was linked to the profession of medicine though not necessarily

occurring in the context of clinical practice, entitled the PCC to find Dr Roylance guilty of serious professional misconduct.

6.24 **NOTWITHSTANDING** his 'non-clinical' capacity as chief executive, he had a duty to care for the safety and wellbeing of patients, he had a power to inquire and intervene if he had a knowledge of concern and his professional duty as a registered medical practitioner which required him to take action to protect patients from harm, and to prevent a particular operation from happening and his failure to do so constituted serious professional misconduct and the PCC was entitled to order that his name be erased from the medical register.

6.25 **THE** Tribunal accordingly does not accept Mr Waalkens submissions referred to in paragraph 6.15. The Tribunal found that Dr Parry was grossly negligent in his management of Mrs Poutsma's case; particularly in relation to his failure to carry out a vaginal examination when she was referred to him in August 1997, and his decision to carry out the cone biopsy procedure in January 1998. It is relevant that no attempt to justify either of these decisions was made by any other witness except Dr Parry himself. The Tribunal was satisfied that the acts (performing the cone biopsy) and omissions (failing to properly examine Mrs Poutsma when she was referred to him for specialist care and advice) could not be characterised as 'mere errors', or as simply unfortunate, or 'adverse events' which could happen to any practitioner.

6.26 **FURTHER,** there were also the Tribunal's findings that Dr Parry's subsequent reports to Dr O'Connor and to Dr Whitaker respectively regarding these decisions, were 'grossly

misleading', and his suggestion that his decision to carry out the cone biopsy was made on the basis of a telephone discussion he said he had with Dr Whitaker, which the Tribunal found did not occur.

6.27 **THE** acts and omissions which the Tribunal found to warrant the description of 'gross negligence' were deliberate acts on Dr Parry's part; he did intend to carry out only an abdominal ultrasound rather than the vaginal examination which was clinically mandated. His failure to carry out an examination was a 'conscious omission' on his part.

6.28 **SIMILARLY**, he did intend to carry out the cone biopsy, which was clinically contra-indicated in the circumstances. It is true that he did not intend that Mrs Poutsma should undergo a simple hysterectomy procedure (which procedure effectively curtailed Mrs Poutsma's treatment options). But that procedure was made necessary only as a result of the post-operative haemorrhage which she suffered following the cone biopsy procedure.

6.29 **ACCORDINGLY,** the Tribunal did find that, in a number of respects, Dr Parry disregarded his patient's wellbeing, and/or was reckless. He fell well short of the standards of care Mrs Poutsma was reasonably entitled to expect. There is nothing special or extraordinary about what constitutes negligence in the context of professional disciplinary offences. Mrs Poutsma was referred to Dr Parry for specialist care, he owed her a duty of care to exercise reasonable care and skill, he failed to do that - and on more than one occasion.

6.30 **THE** relevant test is the standard of the ordinary skilled practitioner, exercising and professing to have some special skill. Dr Parry was not required to attain the 'highest expert skill', he did not have to be 'the best specialist gynaecologist' Mrs Poutsma could have consulted, but he was required to achieve the ordinary level of competence expected of a person in his profession, and practising in a particular specialty of the profession: *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582

6.31 **THE** Tribunal does not consider that the submission that "*there is no evidence to suggest that had Dr Parry conducted himself differently, the result for Mrs Poutsma would have been any different"* assists in any way. The purpose of this submission is unclear, but it is an inescapable fact that no-one will ever know what the result for Mrs Poutsma might have been had she received the appropriate care and treatment from the outset, and if her treatment options had not been significantly curtailed as a result of Dr Parry carrying out the unnecessary cone biopsy in January 1998.

6.32 **THIS** Tribunal has consistently taken the approach that in matters of alleged negligence, particularly in cases of misdiagnosis or a failure to treat, the outcome for the patient is largely irrelevant, it is the practitioner's conduct which is the subject of the professional disciplinary process. A practitioner may be found not guilty of professional misconduct notwithstanding a disastrous outcome for the patient. The converse may equally apply. Whether or not Mrs Poutsma's illness would have progressed any differently had she received all of the proper care she was entitled to will never be known and is not determinative for present purposes.

6.33 **IN** all the circumstances, and on the basis of the relevant legal principles referred to, the Tribunal does not accept that removal of Dr Parry's name from the register is contra-indicated.

7.0 THE DECISION:

7.1 **HAVING** carefully considered all of these submissions, all of the facts and circumstances of the charge established at the hearing, and for the reasons which follow, the Tribunal has determined that Dr Parry's name should be removed from the register, and that he should be censured, ordered to pay a fine in the sum of $15,000; he should pay 40% of the costs and expenses of the Health and Disability Commissioner's investigation, and the prosecution and hearing of the charge.

8.0 REASONS:

Removal of name from register

8.1 **THE** Tribunal is satisfied that Dr Parry should not resume medical practice. It is not sufficiently reassured that the Competence Programme put in place by the Medical Council provides a adequate safeguard in terms of ensuring that the fundamental errors of judgment, or that the deficiencies of care and skill which were found to have occurred in this case are capable of being remedied by a wider competency review, a Competency Programme, a period of suspension or the imposition of conditions.

8.2 **IT** must be borne in mind that Dr Parry is a specialist practitioner, and has been registered in that capacity since 1971. Yet the errors he was found to have made were of the most basic kind. Further, he subsequently sought to explain and to justify his clinical decisions,

he misled both Dr O'Connor and Dr Whitaker in the advice he gave them about his management of Mrs Poutsma's case, and, the Tribunal found, he demonstrated a general lack of insight about the nature of the deficiencies in his management of this case.

8.3 **IT** must also be borne in mind that this was not a 'hard case'; Dr Parry was simply required to provide care and advice which, in the context of his professional practice as a specialist gynaecologist, was straightforward and relatively uncomplicated. He admitted fundamental deficiencies and gaps in his clinical knowledge. For example, that cervical carcinoma can be present notwithstanding an ASCUS smear.

8.4 **IN** at least one respect, he failed even as a matter of common sense. For example, having carried out an abdominal ultrasound without finding any cause for Mrs Poutsma's presenting symptom, post-coital bleeding, he did not undertake any further examinations or tests, and there was no evidence that he made or tested any differential diagnoses. No reason for Mrs Poutsma's main presenting symptom and Dr O'Connor's report that her cervix 'bled to the touch' on examination were found as a result of the abdominal ultrasound, yet it seems not to have occurred to Dr Parry that any further, proper, examination was necessary in order to locate a causal nexus.

8.5 **THE** Tribunal is also concerned that the submissions made on behalf of Dr Parry argue strongly for his being permitted to resume medical practice virtually unimpeded by any conditions or restrictions beyond requiring him to complete the Competence Programme.

8.6 **WHEN** the details of this programme were discussed with Dr Parry, it was difficult for the Tribunal to ascertain exactly what "s*upervision*" entailed. It appears from Dr Parry's responses that the programme is largely self-reporting. Dr Parry and his supervisor, Dr Page are required to meet regularly to discuss cases which Dr Parry is managing, and review his work.

8.7 **HOWEVER**, Dr Parry demonstrated a tendency to mislead, or to provide less than 'full and frank' disclosure regarding his clinical management decisions. That is a matter which causes the Tribunal some concern, and it may also indicate that an unfair burden would be placed upon his supervisor who will inevitably be dependent, in large part, upon what is told to him by Dr Parry.

8.8 **IN** any event, Dr Parry has also told the Tribunal that his obstetric and gynaecology practice currently forms a very small proportion of his practice, approximately 20%. His practice is mainly in the area of his ultrasound sub-specialty. Thus, apart from reviewing general matters such as his note taking and record-keeping, the significant proportion of his practice falls outside of the Competence Review Programme monitoring. In this regard, it is relevant that the Competence Review Committee considered that Dr Parry's reliance on ultrasound in the context of his gynaecological practice, was "*excessive*". There is inevitably a substantial overlap between his clinical gynaecology practice and his ultrasound practice.

8.9 **THE** Tribunal has taken into account the letters provided from Northland Health. It is concerned to see that Northland Health are urging the Tribunal to allow Dr Parry to return

to work in the capacity of an O&G specialist because they would find it difficult to replace two such specialists because one has recently resigned.

8.10 **THIS** also indicates to the Tribunal that the approach of Dr Parry and of Northland Health is that it is neither necessary or desirable to impose any restrictions or conditions on Dr Parry's practice. The Competence Programme is sufficient. The fact neither Dr Parry or Northland Health appear to consider that there is any reason why Dr Parry should not resume his practice as an O&G specialist (albeit with support and subject to any conditions that might be imposed) is disturbing.

8.11 **THE** tenor of the submissions is that Dr Parry is the victim of a 'media beat-up'; that the public interest in this case is as a result of "*media hype*", and the Director of Proceedings is suggesting that "***because*** *of this public interest Dr Parry's name should be removed from the register"*.

8.12 **THE** Tribunal rejects those submissions. It considers that the public interest identified by the Director of Proceedings, and relied on as the reason why Dr Parry's name should be removed from the register, is legitimate. The 'public interest' referred to by the Director is the public interest in ensuring that the health and safety of members of the public is protected. That latter task is a primary function of this Tribunal.

8.13 **IT** is the Tribunal's view that the submissions made on behalf of Dr Parry do not address the central issue for the Tribunal; that is, is the Tribunal satisfied that Dr Parry is a 'safe' medical practitioner? For the reasons outlined, the Tribunal is satisfied that he is not,

especially if his returning to practise would inevitably involve his returning to work as a specialist obstetrician and gynaecologist. Accordingly, it has determined that his name should be removed from the register.

8.14 **THE** Tribunal did spend a great deal of time considering whether Dr Parry should be permitted to resume practice under conditions which would confine his practice to his sub-specialty, or to his sub-specialty and obstetrics, although this was not an option submitted to it on this occasion.

8.15 **HOWEVER,** at the time of the hearing of his application for revocation of the suspension order made by the Tribunal, a proposal that Dr Parry be permitted to practice subject to conditions which would allow him to practice within his sub-specialty only was put to the Tribunal. This proposal was carefully considered and ultimately rejected by the Tribunal on the grounds that it would be too difficult to monitor and enforce. It was not practical, and it would lead to confusion on the part of patients, potential patients and the public generally, and in Dr Parry's professional environment.

8.16 **IN** deciding that Dr Parry's registration should remain suspended, the Tribunal referred to the fact that the Competence Review Committee had found Dr Parry's competence to be "*deficient*", and the Report "*highlighted serious concerns for patient safety.*" In considering the nature of the public interest which the Tribunal was required to take into account, the Tribunal considered that, in the circumstances of this case, it was two-fold. It is clearly to the benefit to the health and safety of the women of Northland generally, to

have available a specialist gynaecologist, and a practitioner who is competent in the sub-specialty of gynaecological and obstetric ultrasound diagnostics.

8.17 **NO** doubt that it does cause inconvenience and hardship if women have to travel to Auckland, or have to wait longer, for procedures which could be done in Northland if Dr Parry was able to practise, or if they have to receive care from a less experienced practitioner.

8.18 **THE** second aspect of the 'public interest identified by the Tribunal was the requirement for the Tribunal to have *"regard to the need* ***to protect*** *the health and safety of members of the public"*, that is, to assess the risk to public health and safety if Dr Parry was permitted to resume his professional practice, even in a limited way.

8.19 **ON** balance, the Tribunal was firmly of the view that any such benefit that may be derived from permitting Dr Parry to practise, even if his practice could be limited by the imposition of conditions, was outweighed by the more general considerations and concerns which had arisen. The majority of the Tribunal members continue to hold that view.

8.20 **THE** issues which had been raised, including those identified in the Competency Review Report, relate also to Dr Parry's ultrasound practice in that his practice encompasses both obstetrical and gynaecological diagnostics.

8.21 **ACCORDINGLY**, the majority of the Tribunal are satisfied that the issues identified in the circumstances of this case regarding Dr Parry's professional and clinical judgment, and in

respect of which adverse findings have been made, relate to his professional and clinical judgment generally, rather than merely to his technical competence in discrete areas of his practice.

8.22 **IT** has reluctantly come to this view notwithstanding that a significant number of other practitioners, nurses and midwives have spoken highly of Dr Parry's kindness and dedication and his skills as an obstetrician, and, in the context of his sub-specialty, he is apparently providing a valuable service to the Northland community.

8.23 **THE** decision to remove Dr Parry's name from the register is accordingly a majority decision by the Tribunal. While the members are unanimous in their determination that Dr Parry should not resume his practice in clinical gynaecology, (indeed that he should not be permitted to practice clinical gynaecology at any time) one member was of the view that if his practice could be restricted to obstetrics and his ultrasound sub-specialty, then he could be permitted to resume his practice subject to appropriate conditions.

8.24 **THIS** member considered that the Tribunal has no evidence to indicate that Dr Parry's clinical practice in obstetrics or within his ultra-sound sub-specialty practice, is unsafe. However, for the reasons set out in paragraph 8.21 and because the four other members of the Tribunal considered that they could only determine the matter on the basis of the evidence presented to the Tribunal, in this case in the context of the charge relating to Dr Parry's care and treatment of Mrs Poutsma, the majority of the members were satisfied that Dr Parry's name should be removed from the register.

8.25 **ON** that basis, the Tribunal accepts the submissions made by the Director of Proceedings referred to in paragraph 4.7 herein. Having made the findings that it did, the majority of the Tribunal do not consider that it is either qualified or entitled to go any further than determining the penalty which it considers is appropriate in the circumstances of the charge laid before it.

8.26 **IN** the event that at some future time Dr Parry wishes to make application to the Medical Council to have his name restored to the register, in whatever professional capacity, then that will be a matter for the Council to determine according to the criteria provided for in the Act. The Medical Council therefore is the appropriate body to consider Dr Parry's fitness for registration in any other professional capacity, not the Tribunal.

Censure

8.27 **IN** relation to censure, it has long been established that an adverse finding in relation to a professional disciplinary offence will inevitably attract a formal censure. The Tribunal is satisfied that censure is warranted in the circumstances of this case.

Fine

8.28 **THE** Tribunal considers that a fine of $15,000 appropriately reflects the seriousness of the charge which has been upheld, and the circumstances of the case. In determining the level of the fine the Tribunal also took into account that in ordering Dr Parry's name be removed from the register, it is removing his ability to practice his profession.

8.29 **THE** Tribunal has not been given any information regarding Dr Parry's personal financial circumstances. As a result, it has no information regarding his ability to pay a fine, and it has taken this factor into account also in considering the quantum of costs it should order, and whether there should be any upwards or downwards adjustment of costs.

8.30 **ACCORDINGLY**, and again taking into account all of the circumstances of this case, and the purposes for which the Tribunal considers a fine is intended, the Tribunal has determined that $15,000 (the maximum being $20,000) is appropriate.

Costs

8.31 **THE** Tribunal is satisfied that an adverse finding on a charge at the highest end of the range of professional disciplinary offences may result in an upwards adjustment of the general order of costs awards, 50%, as acknowledged by the High Court in the *Cooray* case.

8.32 **HOWEVER**, the Tribunal agrees with the submissions made by Mr Waalkens that Dr Parry did co-operate in the hearing of the charge by making appropriate admissions at the outset of the proceedings, and generally. Any practitioner who is suspended from practice is entitled to apply for revocation of the suspension orders, thus the fact that Dr Parry did make such an application does not justify any upwards adjustment from the 50% starting point. Therefore, the Tribunal considers that the effect of the suspension orders and the application for revocation should be neutral.

8.33 **IN** addition, the Tribunal has determined that a relatively substantial fine is warranted. Against these considerations, Dr Parry has been found guilty of the most serious of the

professional disciplinary offences. In determining costs the Tribunal has also taken into account the fact that it has imposed the ultimate sanction for a professional person in ordering that Dr Parry's name is to be removed from the register, and that he is ordered to pay a relatively substantial fine.

8.34 **IT** has taken into account the fact that the proceedings were factually and legally relatively complex, and it was necessary for the Tribunal to adjourn the hearing to consider a number of procedural challenges. Thus while it is correct that Dr Parry did co-operate with the need to abridge the sitting times to accommodate Mrs Poutsma's reduced ability to attend at the hearing for a full day, the challenges made to the Tribunal's jurisdiction which could have been raised with the Tribunal prior to the commencement of the hearing, did extend the hearing time.

8.35 **ACCORDINGLY**, it is satisfied that an order that Dr Parry contribute $56,280.48, being 40% of the total costs incurred by the Director of Proceedings and the Tribunal, is fair and reasonable in the circumstances.

9.0 **ORDERS:**

9.1 **THE** Tribunal orders:

9.1.1 **DR** Parry's name is to be removed from the register;

9.1.2 **DR** Parry is censured;

9.1.3 **HE** is to pay a fine in the sum of $15,000;

9.1.4 **HE** is to pay costs in the amount of $56,280.48 which represents 40% of the costs of and incidental to the investigation by the Health and Disability

Commissioner into the subject-matter of the charge; the prosecution of the charge by the Director of Proceedings and the hearing of the charge by the Tribunal;

9.1.5 **THE** Tribunal orders publication of the above orders in the New Zealand Medical Journal pursuant to Section 138 of the Act.

Suspension of registration

9.2 **DR** Parry's registration as a medical practitioner has been suspended since the Tribunal's orders made the orders to that effect on 8 September and 3 October 2000. The Tribunal has now determined that he should not resume his medical practice, and that his name should be removed from the register.

9.3 **FOR** the purposes of section 117 of the Act and in the event that Dr Parry appeals this Decision and obtains a stay of the Tribunal's order that his name be removed from the register, it is the Tribunal's determination that he should not be permitted to resume practice, and that his registration should continue to be suspended pending the final determination of the Charge.

9.4 **THE** Tribunal's orders suspending Dr Parry's registration were made pursuant to section 104(1) of the Act. Pursuant to section 110(1)(b) the Tribunal may suspend Dr Parry's registration for a period not exceeding 12 months. Accordingly, the Tribunal **ORDERS:**

9.4.1 **IN** the event that Dr Parry obtains a stay of the Tribunal's order that his name be removed from the register, his registration is to remain suspended until the determination of the disciplinary proceedings in respect of which the notice of

charge was issued (by way of appeal or otherwise), pursuant to section 104(1); OR

9.4.2 **FOR** a period of 12 months, whichever is the lesser,

to give effect to the tenor of this Decision.

DATED at Auckland this 20th day of December 2000

.....

W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal