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

DECISION NO: 179/00/69C

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: Ms P Kapua (Chair)

Dr F E Bennett, Mrs J Courtney, Dr R S J Gellatly,

Dr A D Stewart (Members)

Ms K G Davenport (Legal Assessor)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Whangarei on Tuesday 16 and Wednesday 17 October 2001

APPEARANCES: Ms K P McDonald QC for a Complaints Assessment Committee ("the CAC")

Mr A H Waalkens for Dr G K Parry.

The Charge

1. A Complaints Assessment Committee pursuant to section 93(1)(b) of the Medical Practitioners Act 1995 charged that Dr Parry between 3 May 1995 and 6 May 1995 acted in a way that amounted to conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioners fitness to practice medicine in that:

"There were deficiencies in his post operative management of Mrs Marinkovich namely:

(a) He failed to ensure that the doctors and/or the nurses in the Whangarei Hospital Obstetric team on duty after Mrs Marinkovich underwent a caesarean section, appropriately monitored and reported to him the progress of the disease process that had necessitated an emergency caesarean section, in particular:

(i) Mrs Marinkovich's urine output was not closely monitored.

(ii) Mrs Marinkovich's biochemical changes were not closely monitored; and/or

(b) He failed to ensure that there was urgent and appropriate medical intervention to assist Mrs Marinkovich when her renal function deteriorated."

The Plea

2. At the outset of the hearing Dr Parry, through his counsel, pleaded not guilty to the charge.

Burden And Standard Of Proof

3. There was agreement between Counsel that the burden of proof is on the Complaints Assessment Committee which had the onus of proving the charge.

4. It is also accepted that the appropriate standard of proof is the civil standard, namely, the Tribunal must be satisfied on the balance of probabilities that the material facts are proved. It is equally well established that the standard of proof will vary according to the gravity of the allegations, and the level of the charge. The facts must be proved to a standard commensurate with the gravity of what is alleged: *Ongley v Medical Council of New Zealand* [1984] 4 NZAR 369, pages 375 - 376.

The Evidence

5. The Complaints Assessment Committee called three witnesses, namely:

   (a) The complainant, Christine Louise Marinkovich.

   (b) The complainant's husband, Michael Karl Marinkovich.

   (c) Dr Kenneth Clarke, an obstetrician and gynaecologist practising in Palmerston North who gave evidence as to his opinion on the appropriate post operative management of Mrs Marinkovich.

6. Dr Parry called four witnesses, namely:

   (a) Himself.

   (b) Ms Sheilah Frame Singleton, who is a registered midwife who provided some post operative care to the complainant.

   (c) Christine Lorna Read, a registered nurse. From November 1997 until June 2001 she was maternity coordinator at Whangarei Hospital, involved in reviews and amendments to the protocols and systems that have arisen as a result of deficiencies in the care of Mrs Marinkovich.

   (d) Dr Graeme Henley Overton, a registered medical practitioner, now retired, has

experience as the obstetrics and gynaecological registrar at Dunedin and National Womens Hospital. Dr Overton gave evidence as to his opinion on the appropriate post operative management of Mrs Marinkovich.

7. The evidence established that Mrs Marinkovich first saw Dr Parry late in 1994 when she was pregnant with twins. She saw Dr Parry at that stage as a private patient. Mrs Marinkovich's own doctor and a midwife also provided antenatal care.

8. On 26 April 1995 Mrs Marinkovich was admitted to Dargaville Hospital by her own doctor as Dr Parry was overseas. Her blood pressure was raised and she had oedema. Dr Parry was contacted on his return on 1 May 1995 and at that stage Dr Parry advised that Mrs Marinkovich should continue to be monitored in Dargaville. On the evening of 1 May 1995 Mrs Marinkovich was transferred to Whangarei Hospital as there was some concern that she may be in early labour. She was under Dr Parry's care from that point.

9. On 3 May 1995, because of concerns relating to pre-eclampsia, Dr Parry determined that Mrs Marinkovich should have a caesarean section and at 6.23pm and 6.25pm on 3 May 1995 Mrs Marinkovich's twins were born.

10. It is accepted by all parties that by virtue of the caesarean section Mrs Marinkovich was no longer a private patient but came under the public hospital system at the time of the operation.

11. At 5.30am the next morning Dr Parry travelled from Whangarei to Auckland to undertake his regular National Womens Hospital ultrasound clinic. During the 12 to 18 hours following the caesarean section Mrs Marinkovich had difficulty passing urine and had been vomiting and clearly feeling very unwell.

12. On his return from Auckland that evening Dr Parry visited Mrs Marinkovich around 5.00pm. She appeared to him to be asleep and he did not wake her. He was unable at that time to locate her notes. He states that he was aware that Mrs Marinkovich had been catheterised and that there had been 500 mls of concentrated urine passed. That catheterisation had taken place at midday on 4 May 1995.

13. Without locating the notes Dr Parry left the hospital and was contacted by Nurse Singleton at 2.00am on the morning of 5 May 1995. Ms Singleton gave evidence that she expressed serious concern about Mrs Marinkovich's condition and the lack of urine output and Dr Parry gave instructions at that time for a fluid challenge, to re-catheterise and for blood tests to be done in the morning.

14. At 7.00am in the morning Dr Parry was contacted again and he instructed that Mrs Marinkovich be given IV Lasix. At 8.00am Mrs Marinkovich was transferred to the intensive care unit.

15. Mrs Marinkovich remained in the intensive care unit at Whangarei from 5 May until 23 May 1995 and at that stage she had significant renal failure along with other complications including an enlarged heart and serious fluid overload and sepsis. On 23 May she was transferred to National Womens Hospital in Auckland because of ongoing renal failure and concern about peripartum cardiomyopathy.

16. The Tribunal accepts the evidence of all the medical witnesses that the condition that developed following the caesarean section with Mrs Marinkovich is an extremely rare condition and one that would be difficult to diagnose by even the most experienced of consultants. The Tribunal also acknowledges the lengthy suffering endured by Mrs Marinkovich but in its assessment of the evidence before it, while there is an issue as to the timing of the intervention, the Tribunal recognises and accepts the evidence that during the period in question there was no action possible that would have averted the onset of this condition.

17. However, the Tribunal is charged with assessing the actions of Dr Parry, recognising that the thrust of the evidence on his behalf has been to identify aspects of the public system that were responsible for the deficiencies in the post operative management and care of Mrs Marinkovich. Further, that evidence asserted that Dr Parry was entitled to rely on the hospital staff for Mrs Marinkovich's care and post operative management and in the absence of any contact he could assume that there were no concerns.

18. The Tribunal is certainly concerned at deficiencies in the post operative management of Mrs Marinkovich and the lack of medical intervention in the first 24 hours after she had undergone surgery. The Tribunal has been pleased to hear evidence indicating that improvements in the systems and protocols have been put in place aimed at ensuring that this does not happen again.

19. However, the Tribunal accepts Dr Parry's own evidence that he was responsible for the care of Mrs Marinkovich even though she had by virtue of a caesarean section become a public rather than a private patient. Dr Parry had delivered a sick patient, a high risk patient in the view of Dr Clarke, and there is no question that potentially she may have been at further risk. Despite having performed the caesarean section Dr Parry did not communicate with any medical staff, not with the house surgeon nor the consultant on call, even though he knew he was going to be out of Whangarei for the whole of the following day. In the view of the Tribunal that was a deficiency that fell short of an acceptable standard.

20. At 5.00pm on 4 May 1995 Dr Parry returned to Whangarei Hospital and called in on Mrs Marinkovich. Because she was sleeping at the time, he did not wake her and he was unable to locate the notes although Ms Singleton made it clear that the notes would not have left the ward. Dr Parry had received no information at all about Mrs Marinkovich and having gone to the hospital specifically to check on her did not take any steps except to apparently read her fluid chart. Dr Parry felt reassured that Mrs Marinkovich had passed 500 mls of concentrated urine and had noted that there had been no urine passed for 5 hours. The Tribunal considers that that information alone should have prompted a desire to seek further information in the form of Mrs Marinkovich's notes and should have raised some concerns with a specialist of Dr Parry's seniority.

21. In terms of the contact at 2.00am in the morning the Tribunal considers that it was appropriate to instruct a fluid challenge be undertaken and that Mrs Marinkovich be re-catheterised but at that stage further steps should have been taken to gather further information or to have Mrs Marinkovich seen by the consultant on call or the house surgeon. The urgency and significance of Mrs Marinkovich's condition was not perhaps so obvious to Dr Parry because he had not himself taken steps to have all the information

necessary to discharge his obligation as the doctor responsible for Mrs Marinkovich. The fact that Dr Parry was contacted and responded confirms the impression the Tribunal had of the hospital team's view of Dr Parry's role in Mrs Marinkovich's care. The hospital team considered Dr Parry to be in charge. Dr Parry himself accepted he had some responsibility and that he did not disabuse the hospital team of this view.

22. The Tribunal was assisted by having the independent medical evidence of Dr Clarke and Dr Overton. It was Dr Clarke's opinion that Dr Parry's post operative management of Mrs Marinkovich was deficient both in terms of ensuring appropriate monitoring of her clinical condition and in terms of his response once significant deterioration in her condition was apparent. Dr Overton was of the view that Dr Parry's involvement in the post operative management of Mrs Marinkovich was at a late stage as he had not been contacted by hospital staff prior to 2.00am on the morning of 5 May 1995. Dr Overton acknowledges that while the monitoring may have been appropriately undertaken particularly in relation to Mrs Marinkovich's urine output the problem lay in the fact that the monitoring was not effectively translated into appropriate responses by staff on duty. Dr Overton considers Dr Parry's visit at 5.00pm on 4 May 1995 to Mrs Marinkovich to be a "courtesy visit". Dr Overton says the first contact was at 2.00am on 5 May and considers that the actions taken by Dr Parry at that stage were appropriate. The Tribunal agrees that the response given by Dr Parry at 2.00am was appropriate although the notes record that bloods were to be taken in the morning when clearly the facility was available to have them done immediately and should have been urgently assessed and there was no evidence of any request or direction by Dr Parry that he be contacted any time after 2.00am.

23. The Tribunal accepts that the caesarean section was an appropriate response to the pre-eclampsia and the symptoms that were apparent at that stage but accepts Dr Clarke's evidence that the disease does not end at delivery *"and it is well known for 48 to 72 hours after delivery the disease process may worsen"*. It is that period up to 72 hours after delivery during which Mrs Marinkovich's care was deficient.

Legal Considerations

24. The issue for the Tribunal is whether the deficiencies that occurred were deficiencies of Dr Parry and if so whether they were deficiencies of such a degree as to qualify as conduct unbecoming a medical practitioner.

25. In turning to the issue of the responsibilities of Dr Parry the Tribunal wishes to reiterate the position that the actions of Dr Parry were not responsible for Mrs Marinkovich suffering renal failure. As already stated the progress of the disease in this way is a rare condition and development could not reasonably have been expected to be identified or anticipated at the time that Mrs Marinkovich underwent the caesarean section. The Tribunal is however concerned to note that there was no medical assessment undertaken of Mrs Marinkovich during the 24 hours following the operation. Over 6 years after the event it is difficult to reconstruct why that did not occur and it may be that some assumptions were made by hospital staff about Dr Parry's role which meant there was an expectation that Dr Parry would be making arrangements for her care. Whichever way the Tribunal looks at the evidence it is clear that had Dr Parry discussed or contacted any staff member or the on call consultant then it is unlikely Mrs Marinkovich would have been ignored by medical staff during the whole of 4 May. It is the Tribunals view that this lack of handover or communication in any way to any medical staff is a deficiency of Dr Parry's that falls short of acceptable standards of practice.

26. The next matter is the 5.00pm visit on 4 May 1995 and while the Tribunal acknowledges that many doctors do not like to wake a resting patient, the fact that it was 23 hours following surgery and Dr Parry had had no information about Mrs Marinkovich since the operation would have encouraged a prudent surgeon to, at the very least, read Mrs Marinkovich's notes or discuss her condition with somebody. The Tribunal was not satisfied that Dr Parry could feel reassured by information showing that 5 hours earlier Mrs Marinkovich had passed, by catheter, 500 mls of concentrated urine and had been vomiting.

27. In determining what is meant by "conduct unbecoming" both counsel for the Complaints Assessments Committee and Dr Parry referred to the judgment of Elias J in *B v Medical Council* HC 11/96 where it is stated at page 15:

> *"There is little authority on what comprises "conduct unbecoming". The classification requires assessment of degree. But it needs to be recognised that conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards. That departure must be significant enough to attract sanction for the purposes of protecting the public. Such protection is the basis upon which registration under the Act, with its privileges, is available…. a finding of conduct unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard, which it is unfair to impose. The question is not whether error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations. The threshold is inevitably one of degree. Negligence may or may not (according to degree) be sufficient to constitute professional conduct or conduct unbecoming."*

28. It is this Tribunal's task to determine whether Dr Parry is guilty of conduct unbecoming a medical practitioner and whether that conduct reflects adversely on his fitness to practise medicine.

29. There is no question that consideration of what occurs in this situation is done in hindsight and that for all people matters could be handled differently with the benefit of review. The issue in this case is whether there was conduct on the basis of the evidence before the Tribunal that departs from acceptable professional standards. It is the Tribunal's view that the lack of any handover or instructions or communication to any other staff and Dr Parry's lack of any examination or assessment of Mrs Marinkovich at 5.00pm on 4 May 1995 departed from acceptable professional standards. These departures are in the Tribunal's view significant enough to attract sanction for the purpose of protecting the public.

30. While the Tribunal has expressed reservation about not directing blood tests to be done immediately at 2.00am on the morning of 5 May 1995 or ensuring at that time that there was some medical assessment or that Dr Parry would be informed of any developments,

those actions, on their own, while less than optimal, do not qualify as a significant enough departure to attract sanction for the purpose of protecting the public.

31. The factual situation is that Mrs Marinkovich was a high risk patient who had undergone surgery as a result of a condition and symptoms known to Dr Parry. In the absence of any notes or information the lack of action on the part of Dr Parry in Mrs Marinkovich's post operative management fell well short of Dr Parry's professional obligations and of acceptable professional standards. His stated expectation that he would be called if there was a problem is not a satisfactory discharge of his professional obligations and the evidence clearly shows that both he and the medical staff at Whangarei Hospital assumed that he was the specialist responsible for Mrs Marinkovich. It is acknowledged that the obstetric and gynaecological medical staff at Whangarei Hospital had considerable commitments at peripheral hospitals and the Tribunal is aware that this incident has resulted in Whangarei Hospital obstetric and gynaecological team examining its practice and ensuring there are protocols in place to apply in such situations.

Charges

32. The charges will be dealt with in respect of each part. The first part states that there were deficiencies in Dr Parry's post operative management of Mrs Marinkovich namely:

> ***(a) He failed to ensure that the doctors and/or nurses in the Whangarei Hospital obstetric team on duty after Mrs Marinkovich underwent a caesarean section appropriately monitored and reported to him the progress of the disease process that had necessitated an emergency caesarean section, in particular:***
>
> ***(i) Mrs Marinkovich's urine output was not closely monitored.***

33. In respect of this particular part of the charge the Tribunal accepts that Mrs Marinkovich's urine output was monitored, although it is noted that there are reasonably lengthy periods where the notes do not record the monitoring. While there are regular references to urine output there is no record of action or interpretation of those references being undertaken and certainly there was no process by which the results or issues relating to the urine

output were reported to Dr Parry. The Tribunal considers monitoring to include more than merely recording data and that it requires interpretation and reporting.

(ii) "Mrs Marinkovich's biochemical changes were not closely monitored".

34. The Tribunal is clearly of the view that the biochemical changes were not closely monitored and it would appear from the notes that there were no blood tests taken at all during the period in question.

35. In respect of these two matters it is the Tribunal's view that Dr Parry is guilty of conduct unbecoming a medical practitioner in that he failed to ensure that the doctors and/or nurses in the Whangarei Hospital obstetric team on duty after Mrs Marinkovich underwent a caesarean section appropriately monitored and reported to him the progress of the disease process that had necessitated an emergency caesarean section in particular Mrs Marinkovich's urine output was not closely monitored and Mrs Marinkovich's biochemical changes were not closely monitored.

36. In essence the Tribunal is unanimous that the proven conduct covered by particulars (a)(i) and (ii) departed from acceptable professional standards and to an extent significant enough to attract sanction. That conduct was not an acceptable discharge of the practitioner's professional obligations. Unbecoming conduct is therefore proven.

37. Because of the wording of section 109(1)(c) of the Act it must also be proved that the conduct, as well as being unbecoming a medical practitioner, reflects adversely on the practitioners fitness to practise medicine. This was set out by the District Court in *Complaints Assessment Committee v Mantell* NP 4533/98 where the Court stated:

"The text of the rider in my view makes it clear that all that the prosecution need to establish in a charge of conduct unbecoming is that the conduct reflects adversely on the practitioner's fitness to practise medicine…. The focus of the enquiry is whether the conduct is of such a kind that it puts in issue whether or not the practitioner whose conduct it is, is a fit person to practise medicine…. The conduct will need to be of a kind that is inconsistent with what might be expected from a practitioner who acts in compliance with the standards normally observed by those who are fit to practise medicine. But not every divergence from recognised standards will reflect adversely on a practitioner's fitness to practise. It is a matter of degree."

38. The Tribunal has no doubt that the proven conduct covered by particulars (a)(i) and (ii) are of such a kind as to be inconsistent with conduct that might be expected from a practitioner who acts in compliance with standards normally observed by those who are fit to practise. The Tribunal therefore finds that such conduct, as well as being conduct unbecoming a medical practitioner, reflects adversely on the practitioner's fitness to practise medicine.

(b) Dr Parry failed to ensure that there was urgent and appropriate medical intervention to assist Mrs Marinkovich when her renal function deteriorated.

39. At the time that Dr Parry became aware of the possibility of renal function deterioration in Mrs Marinkovich he did make appropriate medical intervention which is set out in his instructions at 2.00am on 5 May 1995. As stated he could perhaps have insisted on the bloods being done immediately, an examination being undertaken and receiving a further report from nursing staff but such an omission does not amount to conduct unbecoming a medical practitioner.

40. Therefore in terms of this part of the charge the Tribunal finds that Dr Parry was not guilty of failing to ensure that there was urgent and appropriate medical intervention to assist Mrs Marinkovich when her renal function deteriorated.

Decision

41. For these reasons the decision of the Tribunal in respect of parts of the charge laid against him by the Complaints Assessment Committee is that Dr Graham Parry has been guilty of conduct unbecoming a medical practitioner and that conduct reflects adversely on his fitness to practise medicine.

42. The Tribunal requests submissions from counsel as to appropriate penalty. Counsel for the Complaints Assessment Committee is requested to file submissions with the secretary of the Tribunal and serve a copy on counsel for Dr Parry within 14 days of the date of receipt of this decision. Counsel for Dr Parry is requested to file his submissions with the secretary of the Tribunal and serve a copy on counsel for the Complaints Assessment

Committee no later than 14 days after receipt of submissions on behalf of the Complaints Assessment Committee.

DATED at Auckland this 16th day of November 2001

.....

Prue Kapua

Deputy Chair

Medical Practitioners Disciplinary Tribunal