MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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PUBLICATION OF THE NAME OF THE COMPLAINANT OR ANY DETAILS LEADING TO HER IDENTIFICATION IS PROHIBITED

DECISION NO: 194/01/81C

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: Miss S M Moran (Chair)

Mr P Budden, Dr G S Douglas, Dr M G Laney, Dr J M McKenzie (Members)

Mr B A Corkill (Legal Assessor)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Whangarei on Tuesday 20 and Wednesday 21 November 2001

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

Mr A H Waalkens for Dr G K Parry.

The Charge

1. The Complaints Assessment Committee pursuant to section 93(1)(b) of the Medical Practitioners Act 1995 charges that **Graham Keith Parry**, Obstetrician and Gynaecologist of Whangarei on or about 30 November 1988, acted in a way that amounted to professional misconduct in that:

   (a) **Patient L**, the complainant, had given informed consent for only a minor procedure, namely an assessment under anaesthetic, including a cystoscopy, but Dr Parry proceeded to a major operation, namely an attempt to repair the vesico-vaginal fistula with no prior consent or discussion of the implication of this action with his patient, and/or

   (b) Consultation with a urologist was only sought very late in the management of the vesico-vaginal fistula.

   (c) The conduct alleged amounts to professional misconduct and paragraphs (a) and (b) inclusive either separately or cumulatively are particulars of that professional misconduct.

The Plea

2. Dr Parry denied the charge.

Onus of Proof

3. The onus of proof is borne by the CAC.

Standard of Proof

4. With regard to the standard of proof, the Tribunal must be satisfied that the relevant facts are proved on the balance of probabilities. The standard of proof varies 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 at 375 to 376.

Brake v Preliminary Proceedings Committee (Full Court, High Court, Auckland, 169/95, 8 August 1996 at page 8).

Evidence for the CAC

5. The CAC called three witnesses:

5.1 The complainant patient L.

5.2 The complainant's daughter.

5.3 Dr John David Tait, Consultant Obstetrician and Gynaecologist of Wellington, as to his opinion on the issues of informed consent and referral to an urologist.

Evidence for Dr Parry

6. Dr Parry gave evidence himself.

7. Dr Howard Murray Clentworth, Consultant Obstetrician and Gynaecologist of Wellington, gave evidence as to his opinion on the issues of informed consent and referral to an urologist. Dr Clentworth's evidence was given via video link.

8. Dr David Frank Cadman Mason, Urologist of Hastings gave evidence as to his opinion on the issue of informed consent in general and as it was practised in Whangarei at the

material time and on the issue of a referral to an urologist. Dr Mason's evidence was also given via video link.

Background Events

9. On 5 July 1988 patient L consulted her GP, Dr A of Whangarei, complaining of years of stress incontinence and low back pain. His examination revealed prolapsed anterior/posterior vaginal walls.

10. The same day Dr A wrote to Dr Parry referring patient L to him for management of those complaints.

11. On 9 August 1988 Dr Parry initially saw patient L at his clinic at Northland Hospital.

12. The same day, Dr Parry wrote to Dr A and stated that he was going to arrange *a vaginal repair, plus or minus hysterectomy.* He wrote that Patient L appeared *"to be wandering around in a bit of a daze"*. It appears that at the time Patient L was taking oxazepam, an anti-anxiety medication.

13. On 12 October 1988 patient L was admitted to Northland Hospital for surgery. The form of consent signed by her recorded *vaginal repair & ? vaginal hysterectomy* to be performed by Dr Parry.

14. The surgery actually performed was a vaginal hysterectomy and anterior and posterior repairs. During the procedure, the bladder was inadvertently opened. This was recognised by Dr Parry at the time and repaired.

15. During her stay in hospital, patient L became aware that she was beginning to leak urine from her bladder and through her vagina.

16. On 18 October 1988 patient L was discharged home from hospital. Patient L stated it had become apparent to her that she was continuing to leak urine through her vagina. She was wearing sanitary pads and tampons to control the leakage and noticed that the problem was especially bad when she was mobile and standing up.

17. On 15 November 1988 Dr Parry wrote to Dr A confirming the surgery she had undergone. He confirmed that the bladder had been opened and repaired easily and that her post-operative course was uneventful and that she was discharged well.

18. On 22 November 1988 patient L returned to Dr Parry for a further consultation. What precisely was discussed between them at this consultation is in dispute. We refer to this in more detail later. Suffice to say at this juncture, patient L said she understood that she was to be readmitted to Northland Hospital for a cystoscopy only and one night's stay. Dr Parry said he understood that he had patient L's consent to undertake the cystoscopy and that if a fistula were present (which Dr Parry had created when he had inadvertently opened the bladder during the first operation on 12 October 1988) that he would proceed to repair it.

19. The same day, 22 November 1988, Dr Parry wrote to Dr A stating that he had seen patient L that day. His letter continued in the following terms:

> *"she now complains of leaking all the time. I could not demonstrate any leakage on coughing. I am going to bring her in for a cystoscopy in case the fistula that I created has recurred, or she has a ureteric one."*

20. On 30 November 1988 patient L was admitted to Northland Hospital to undergo a second surgical procedure.

21. Patient L said she did not see Dr Parry prior to the surgery.

22. Dr Parry said that it was his normal practice to visit and speak with the patient in the anaesthetic room before the patient was anaesthetised and that the only time this varied was in an emergency or if he did not have his regular anaesthetist who may not have been aware of his practice. He said that he expected he would have spoken with patient L before she was anaesthetised prior to the surgery.

23. Patient L did see a Ms B who apparently was the House Surgeon at that time.

24. The purpose for which Ms B saw patient L was to have the consent form for surgery completed and signed.

25. The form of consent signed by patient L was in the following terms:

> *"I, [patient L] of ... hereby consent to the operation of cystoscopy to be performed upon myself.*
>
> *I acknowledge that the nature and effect of the operation have been fully explained to me, I also consent to such further or alternative operative measures as may be found necessary during the course of such operation or during the treatment period subsequent thereto and to the administration of a local or other anaesthetic for the purpose of such operation or operations.*
>
> *I acknowledge that no assurance has been given that the operation will be performed by any particular surgeon.*
>
> *I acknowledge that I have been instructed not to drive a motor vehicle for 24 hours because I have been given a general anaesthetic and/or narcotic agent.*
>
> *Dated the 30th day of November 1988*
>
> *Signed: [patient L]*
>
> *This consent was read over by me to the signatory who acknowledged having understood it fully and signed the same in my presence.*
>
> *Witness: J B"*

26. Dr Parry stated that it was his normal practice to see the consent form before surgery.

27. Dr Parry said he thought that the consent form gave appropriate consent for the cystoscopy procedure (which was to check whether the repaired fistula had not been successful or effective) and for further or alternative operative measures as he considered necessary.

28. On 30 November 1988 Dr Parry carried out the cystoscopy and saw that the fistula was clean, in good condition and at an appropriate tissue state for repair.

29. At that point Dr Parry sought to make contact with Dr C, the sole urologist in Whangarei, but was unsuccessful.

30. Dr Parry stated that he considered the repair was necessary and in the best interests of patient L. He stated that he thought he had obtained from patient L her consent and that the consent form itself gave him appropriate authority. He stated that in the belief he had such consent he proceeded to repair the fistula from an abdominal approach and was confident in his ability to perform that procedure.

31. Dr Parry also stated that he had considered that if he were not able to repair the fistula at the time this would have left patient L incontinent over the heat of the summer which would have been most unpleasant for her.

32. Patient L said that in waking from the anaesthetic following the operation she was in considerable pain and that her emotions ranged from confusion, shock and then anger when she discovered the extent of her surgery. She said a nurse had informed her that not only had she had a cystoscopy but that she had also had a laparotomy and that the vesico/vaginal fistula had been repaired via an abdominal incision.

33. On 1 December 1988 patient L spoke with Dr Parry when they discussed surgery.

34. Patient L said that she made her feelings known to Dr Parry during this discussion which he acknowledged in evidence. Patient L said that Dr Parry did not have her consent to any operation other than the cystoscopy. Dr Parry said that at the time he understood that patient L was unhappy because of the fact that she had had the surgery rather than because of a lack of consent.

35. Patient L stated that following the second procedure on 30 November 1988 until 7 December 1988 she experienced quite severe bladder spasms which had not been previously present. She stated she was in continual pain and required medication to manage it. She stated that each day following the second operation she saw and spoke with Dr Parry but was not satisfied with the extent of their communications.

36. On 6 December 1988 Dr Parry consulted Dr C while patient L was recovering in hospital. The purpose of this consultation was to discuss the further appropriate management of patient L in the long term, the position as regards in-dwelling catheters, and any further definitive surgery. The advice Dr Parry received was that the catheter should remain in situ until further definitive surgery could be performed, that Dr Mason, the locum Consultant Urologist, would be arriving in Whangarei during the January/February 1989 period and that he would be the appropriate person to effect the next repair.

37. The same day Dr Parry spoke with patient L about his consultation with Dr C.

38. On 7 December 1988 patient L signed another consent form consenting to Dr Parry performing a cystoscopy and a supra pubic catheter insertion in an effort to stop the spasms.

39. On 13 January 1989 patient L signed a further consent form for another cystoscopy operation to enable the removal of a broken piece of the catheter.

40. On 18 January 1989 patient L signed another consent form consenting to a cystoscopy and the insertion of a new supra pubic catheter.

41. On 11 February 1989 patient L was readmitted to Northland Hospital where she met Dr Mason for the first time. They discussed the next operation which patient L would undergo.

42. On 12 February 1989 patient L saw Dr Mason again who informed her that he would carry out the repair operation which they had discussed the day before.

43. On 2 March 1989 patient L was admitted to Northland Hospital where Dr Mason, assisted by Dr Parry, undertook the surgery to repair the vesico-vaginal fistula and, on 17 March 1989, patient L was discharged from hospital by Dr Mason with no apparent vaginal leaks or discharge.

44. Although patient L said Dr Parry did not have her consent to carry out anything other than a cystoscopy on 30 November 1988, she made no complaint to that effect at the time or subsequently.

45. She told Dr A Dr Parry had treated her in a caring and considerate manner.

46. She consulted Dr Parry again in 1995 for a prolapsed bowel.

47. In 2000, patient L made contact with Brookfields, solicitors, who prepared a schedule of complaints by a number of women (including patient L) and lodged it with the Medical Council.

48. As then formulated, that complaint drafted for her by Brookfields, related not to the absence of informed consent regarding the second operation on 30 November 1988 but rather the unfavourable outcome patient L sustained as a consequence of the bladder being punctured during the first operation for hysterectomy performed by Dr Parry on 12 October 1988.

The Consultation of 22 November 1988

49. This consultation took place 13 years before the hearing. The only written record was a brief note by Dr Parry. There was some divergence between patient L and Dr Parry as to what took place. Inevitably such a lapse of time made it difficult not only for the Tribunal but for all concerned.

50. Patient L stated in evidence-in-chief that during this consultation and while she was lying down Dr Parry asked her to cough to see if there was any urinary leakage. She said given that she was lying down, when she coughed there was none. She said the problem was most evident when she was standing up, but that Dr Parry did not ask her to do so. She said he elected to readmit her to Northland Hospital for a cystoscopy and that he was concerned that the fistula he had created during her hysterectomy had recurred. She referred to the letter Dr Parry had written to her general practitioner advising there was a possibility she had a ureteric fistula. She said Dr Parry explained to her generally what a cystoscopy was at this consultation although not in any detail and that she did not

completely understand the nature of the operation which was being undertaken. She recalled his saying to her that he would be having just a "*wee look*" and she thought that he would go in through her belly button to have a look. She said that when she went into surgery on 30 November 1988 she had only a vague idea of what was going to happen to her.

51. In answer to a question from Dr Parry's counsel as to what Dr Parry told her at this consultation, patient L said words to the effect that they were medical terms that she did not really understand; and when asked by the Tribunal to elaborate on this patient L said "*probably the word laparotomy but I still don't know what a laparotomy is*". She said that Dr Parry did not say that he was *going to cut [her] open* but that he had just said to bring in her toothbrush and that she would be in and out and they would have a look.

52. Following the surgery, and her shock and anger at the extent of it, she said that she started to write a diary to record everything that was happening to her and that she started this on the day of her second operation (30 November 1988). She created this diary by notes on old scraps of paper but for ease and convenience of reading the diary she transcribed them word for word into a format for the Tribunal. The first line in the entry for 30 November 1988 read "*… supposed to come in one night, signed a paper for parry to do laparotomy*" When asked about this by Dr Parry's counsel, patient L said she wrote the word *laparotomy* because that was what the nurse told her the next morning that she had had.

53. Dr Parry in his evidence said he believed he would have talked to patient L about the fact that there may still be a vesico-vaginal fistula and that it would have been possible to repair it from below.

54. Dr Parry explained that the cystoscopy and the vesico-vaginal repair are different procedures which require different arrangements for surgery. To carry out the repair he explained that one needs the instruments prepared and the appropriate amount of time to carry out the procedure on the operating list. He said that a cystoscopy including anaesthetic and surgery may take about 20 minutes whereas a repair and further procedure

could take up to 1 ½ hours. It was his view from his consultation with patient L regarding the leakage that she wished to be dry.

55. Dr Parry conceded, in questions from counsel for the CAC, that the recollection of patient L of what Dr Parry allegedly said to her during the consultation of 22 November 1988 was consistent with her belief that she was going in for a cystoscopy. Dr Parry, when answering further questions, said he remembered a discussion he had had on an earlier occasion with patient L regarding the proposed hysterectomy that she was anxious to avoid a scar above her bikini line. When asked whether he thought it was a fair inference from the earlier discussion that patient L would not have agreed to a vesico-vaginal repair being undertaken, Dr Parry answered that it was a fair inference to imply that if the intention was to do an abdominal approach then his understanding was that the fistula itself at the time was going to be or could easily have been a vaginal repair and at the time that he proceeded to do the laparotomy he had not remembered the discussion about the scar on her abdomen or patient L's fear of it.

The Law

56. Dr Parry has been charged with professional misconduct, the test for which is well-established. A repeatedly cited test is to be found in *Ongley* (above) at pages 374 to 5 where Jeffries J stated:

> *"To return then to the words "professional misconduct" in this Act. In a practical application of the words it is customary to establish a general test by which to measure a fact pattern under scrutiny rather than to go about and about attempting to define in a dictionary manner the words themselves. The test the Court suggests on those words in the scheme of this Act in dealing with the medical practitioner could be formulated as a question: Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would reasonably be regarded by his colleagues as constituting professional misconduct? With proper diffidence it is suggested that the test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the composition of the tribunals which examine the conduct. Instead of using synonyms for the two words the focus is on the given conduct which is judged by the application to it of reputable, experienced medical minds supported by a layperson at the committee stage."*

57. In *B v The Medical Council* (High Court, Auckland, 11/96, 8/7/96), (in the context of a charge of conduct unbecoming), Elias J stated:

> *"In the case of diagnosis or treatment, conduct which falls short of the mark will be assessed substantially by reference to usual practice of comparable practitioners. … Those standards to be met are, as already indicated, a question of degree; … I accept that the burden of proof is on the balance of probabilities. Assessment of the probabilities rightly takes into account the significance of imposition of disciplinary sanction. I accept that the court must be satisfied on the balance of probabilities that the conduct of the practitioner is deserving of discipline."*

58. The applicable principles to be taken from these statements are:

    58.1 A finding of professional misconduct or conduct unbecoming is not required in every case where a mistake is made or an error proven.

    58.2 The question is not whether an error was made, but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations (in all the circumstances of the particular case).

    58.3 The departure from acceptable standards and/or the failure to fulfil professional obligations must be significant enough to attract sanction for the purposes of protecting the public.

59. Following the decisions of *Ongley* (above) and *B* (above) - which were given in the professional disciplinary context and on appeal from specialist tribunals - the question is whether Dr Parry's conduct was conduct which is culpable, i.e. conduct deserving of discipline.

The Decision

60. The background events, referred to above, are not a comprehensive summary of all the evidence which the Tribunal heard. Some further and relevant aspects of the evidence are referred to under this heading. However, in reaching its decision, the Tribunal has given careful consideration to all of the evidence presented to it and to the helpful submissions made by both counsel. It has also assessed the credibility of each of the witnesses. While there are some aspects in respect of which there are differing accounts as between patient

L on the one hand and Dr Parry on the other, the Tribunal has found that this can be attributed to their different understanding and to the passage of time (some 13 years from the alleged incidents to the date of hearing) which can make accurate recall difficult.

61. The charge is dealt with in respect of each part.

62. The first part states Dr Parry acted in a way that amounted to professional misconduct in that:

(a) Patient L had given informed consent for only a minor procedure, namely an assessment under anaesthetic, including a cystoscopy, but Dr Parry proceeded to a major operation, namely an attempt to repair the vesico-vaginal fistula with no prior consent or discussion of the implication of this action with his patient.

63. We have approached this issue by posing one question – can it be said that Dr Parry, in proceeding to repair the vesico-vaginal fistula, behaved in such a way that he could reasonably be regarded by his colleagues as having misconducted himself.

64. The test is objective and his conduct must be measured against the judgment of fellow practitioners of acknowledged good repute and competency.

65. The Tribunal concluded that having regard to the evidence as a whole the prosecution had not discharged the burden of demonstrating that Dr Parry was guilty of professional misconduct in proceeding to attempt to repair the vesico-vaginal fistula, given the background and circumstances.

66. In reaching this conclusion the Tribunal is mindful that Dr Parry's conduct is not to be judged by standards and attitudes which prevail today.

67. Counsel for the CAC accepted that the applicable standards were those which prevailed in 1988 when the treatment was given.

68. The Tribunal is also conscious of the difficulties which the lapse of time created for both patient L, Dr Parry, and the witnesses who were called to give evidence in respect of his alleged misconduct.

69. For the CAC, Mr McClelland submitted Dr Parry's conduct failed to reach the requisite standard because he obtained no informed consent to any operative procedure apart from the cystoscopy which was to be undertaken for the purposes of diagnosis only.

70. Mr McClelland submitted there was no discussion with Patient L of even the possibility of further operative procedures such as the repair which Dr Parry undertook.

71. In support of this submission, the principal items of evidence on which he relied were:

71.1 Patient L stated in evidence Dr Parry had not discussed with her the possibility that he might proceed to repair the fistula should the cystoscopy confirm its presence.

71.2 Patient L gave evidence that Dr Parry told her to bring into hospital only a toothbrush as she would be there for only one night – a timeframe inconsistent with the period of hospitalisation which the repair of a fistula would have entailed.

71.3 Patient L gave evidence that on waking up from the anaesthetic following surgery she was angry on discovering the extent of the surgery that Dr Parry had performed – a reaction inconsistent with her having given informed consent to the operation.

71.4 The contemporaneous hospital notes recorded patient L did "*not seem completely happy*" with what Dr Parry had done – which again was more consistent with the absence of informed consent.

71.5 In cross examination Dr Parry conceded the laparotomy was a choice he had made for patient L without any discussion with her because he thought she would prefer to remain dry over Christmas.

71.6 Patient L gave evidence that as a result of her shock and anger on the day of her second operation she decided to create a diary on old scraps of paper.

71.7 Patient L's daughter gave evidence of conversations she had with patient L as to

patient L's understanding that she was to go into hospital for a cystoscopy only, that her stay would be brief, and that she had undergone an operation which she had not expected.

71.8 Dr Parry, in his written brief, did not claim to have had any discussion with patient L of the possibility of repairing the fistula when she consulted him on 22 November 1988 and when she agreed to undergo the cystoscopy. It was submitted that this was a belated interpolation which was inconsistent with a number of the matters noted above as well as Dr Parry's own notes of that consultation and his reporting letter to Dr A following that consultation.

72. For Dr Parry, Mr Waalkens submitted:

72.1 The CAC's approach reflected the benefit of hindsight and did not truly reflect the contemporaneous circumstances and standards against which Dr Parry's actions were to be judged.

72.2 Dr Parry's evidence that he had discussed the possibility of repairing the vesico-vaginal fistula was credible and his reporting letter to Dr A was consistent with his having discussed that possibility with patient L on 22 November 1988.

72.3 The arrangements Dr Parry made with the hospital clearly contemplated the possibility that Dr Parry would proceed to repair the fistula. The time allowed was inconsistent with a cystoscopy only. Similarly, the provision for the appropriate supporting staff and surgical instruments was consistent with the possibility that therapeutic procedure might ensue. In turn, that clearly pre-supposed there had been a discussion between Dr Parry and patient L as to the possibility of a repair of the fistula.

72.4 There were a number of inconsistencies in patient L's evidence which, when coupled with her medical history and the unfortunate experience she had in surgical procedures, made it unsafe for the Tribunal to accept her evidence that Dr Parry had not in fact discussed with her on 22 November 1988 the possibility of repairing the fistula, if need be. For example, at one point patient L suggested she would not

have wanted Dr Parry to fix the incontinence problem because she had a fear of operations, and did not like hospitals or injections, or being incapacitated and out of control of her life. This, Mr Waalkens submitted, was inconsistent not only with another part of her evidence where she agreed she wanted the incontinence fixed but also with the fact that she proceeded to have several subsequent further surgical procedures after the particular operation which she said Dr Parry had not been authorised to perform.

73. There does not appear to be any real dispute that Dr Parry proceeded to repair the fistula in order to fix the problem which patient L presented following her consultation on 22 November 1988 and what Dr Parry learned on performing the cystoscopy.

74. The Tribunal is satisfied that Dr Parry did so in what he believed were in the best interests of patient L.

75. He had no reason to proceed with the operation but that he thought patient L wanted relief from the problem the fistula was creating and that she wished to have that problem attended to then rather than continue to suffer from it for some months.

76. The Tribunal accepts that Dr Parry had nothing to gain either financially or professionally whether or not he performed the operation that day. His decision to proceed can only have been because he believed that was what patient L needed and wanted.

77. The Tribunal is not satisfied that the CAC has proved that on 22 November 1988 Dr Parry did not advert to the possibility that the cystoscopy might confirm there was a vesico-vaginal fistula which it would then be appropriate to proceed to repair.

78. There is no criticism of the fact that the bladder was inadvertently punctured when Dr Parry performed the hysterectomy on patient L. It was an unfortunate but recognised complication. He identified it and attempted an appropriate repair at the time.

79. Unfortunately, that repair was not successful and the problem proved difficult to remedy.

80. Patient L has had an unhappy medical history. In the light of the difficulties which patient L suffered in consequence, it is not surprising that she should feel frustrated and even angry at the turn of events.

81. In itself, that does not prove there was no discussion at all of corrective surgery.

82. The Tribunal accepts patient L may not have fully appreciated what was ultimately involved. Equally, Dr Parry in the consultation of 22 November 1988, may have believed he had explained enough to her of the possibility of therapeutic surgery to gain a sufficiently clear understanding she wanted the problem fixed and that if the cystoscopy confirmed the fistula, he should proceed to repair it.

83. The notes of the consultation are brief. The reporting letter to Dr A that day is equally brief. The Tribunal is not prepared to conclude from the fact that a cystoscopy only was referred to in that letter, that during the consultation of 22 November 1988 there was no discussion of the possibility of subsequent therapeutic surgery.

84. Similarly, the Tribunal is not prepared to conclude that the cross-examination of Dr Parry established he did not have any discussion with patient L of the possibility of therapeutic surgery following cystoscopy. A bare reading of the transcript does not convey an adequate impression of Dr Parry's evidence as a whole.

85. The Tribunal is satisfied Dr Parry genuinely believed he had patient L's consent to repair the vesico-vaginal fistula should the cystoscopy show it to be present, and that he made appropriate arrangements to carry out that operation should the fistula prove to be present and operable.

86. The Tribunal is also satisfied that Dr Parry, having seen patient L had signed a written consent form for a cystoscopy and "*such further or alternative operative measures as [might] be found necessary during the course of such operation*", genuinely believed he was authorised to repair the fistula.

87. It was evident to the Tribunal that patient L has seen all her problems as stemming from the unfortunate complication with her hysterectomy and has erroneously attributed them to Dr Parry. In fact, a number of patient L's problems were present prior to her consulting Dr Parry, as is evident from her documented medical history. In consequence, the Tribunal cannot be satisfied that this has not coloured her perception of what occurred.

88. Not surprisingly, the evidence from the expert medical witnesses was directed to the question of whether or not Dr Parry could be properly criticised for proceeding to repair the fistula in the circumstances.

89. Dr Tait, for the CAC, gave his opinion that without fully discussing the options and implications with patient L and without consulting with a surgeon who was experienced in such surgery, Dr Parry's actions did not meet the standards expected in 1988 and 1989. He said that were Dr Parry considering repair of the fistula he should have discussed this fully with patient L prior to the surgery and incorporated reference to it into the original consent form.

90. He stated that even in 1988, if one were contemplating moving from a diagnostic procedure such as cystoscopy/laparoscopy to treatment surgery such as a laparotomy, it would have been normal standard practice to discuss this fully with the patient and obtain that patient's informed consent.

91. It was accepted in evidence that in 1988 it was normal for a House Surgeon to complete a consent form (which is still the position today).

92. Dr Tait agreed that in 1988 there was far less awareness than there is now of the need for a doctor to take a patient through any proposed surgery.

93. Dr Tait also accepted that medical literature showed that patients had a very poor recall of what they have been told pre-operatively in terms of outcome and risks, and that this was compounded by the need for the Tribunal to try to assess what had occurred in 1988.

94. Questioned by the Tribunal with regard to the consent form, Dr Tait stated it was his understanding if one were to proceed from an investigation to a repair, one would only do so if something inadvertent happened and the patient was at risk, there was bleeding or something malignant or the like but one would not do so for an elective procedure.

95. He was questioned about the development of the issue of informed consent over the years. There was reference to the Cartwright enquiry which took place in 1988. A document was subsequently produced to the Tribunal. That document was issued by the Medical Council of New Zealand in June 1990 and was headed "A Statement for the Medical Profession on Information and Consent". The preamble commenced *"In late 1988, in the wake of the widespread debate and the variety of initiatives which followed the publication of the Cartwright Report, the Medical Council have established a small working party to prepare the basis for a statement and to offer some guidelines on information and consent."*

96. This evidence established that it was not until after 1988 that the message of informed consent, as it is now understood, was clearly put before members of the medical profession.

97. Dr David Mason of Hastings, Urologist, gave evidence on behalf of Dr Parry.

98. On the issue of informed consent he stated that he well remembered that the practice in 1988 was "*much less rigid than it is today*".

99. He stated it was his understanding that in this case Dr Parry obtained consent expressly for an assessment under anaesthetic including a cystoscopy but that he proceeded to repair the vesico-vaginal fistula without express prior consent.

100. Significantly, he stated that when he was in practice in Whangarei in 1989 (January to June) he recalled that this was generally how the written consent forms were obtained. He said a written consent form for the exploratory procedure would be obtained and it was assumed as being reasonable to then proceed to repair if, during the exploratory process, the need was identified and time to do so was available.

101. He said that he well appreciated in today's climate that would not be accepted practice. However, he said that was a common practice in 1989 when he was in Whangarei and, he expected it would have been the same in November 1988 when Dr Parry performed the surgery

102. When asked by the Tribunal whether, given the findings on the cystoscopy, he would agree that, in 1988, to repair the fistula without waking the patient up was a reasonable thing to do, Dr Mason replied "*… in that environment and the type of concerns we had which was very open I think it would be very reasonable*".

103. Dr Clentworth, Consultant Obstetrician and Gynaecologist of Wellington, also gave evidence on behalf of Dr Parry. He has practised both in public and in private since 1981. He stated that while he was acquainted with Dr Parry he did not know him well. He said that they were both Registrars in Wellington in the early 1970s. Dr Parry was the more senior. He knew him as a colleague at that time. He has had occasional contact with him since then at professional conferences but knows him only as a professional colleague.

104. He stated it was particularly important to address matters as they existed in 1988 and referred to the considerable and very significant change which has occurred in respect to matters of informed consent since that time.

105. He referred to the greater awareness by the profession since that time of patient rights and in particular matters of informed consent. He said since then there have been numerous practice recommendations and medico legal opinions which have clarified and continue to set precedents for current and future medical practice. He also referred to the Health and Disability Commissioner's Code of Patient Rights which was promulgated in 1996 and emphasised that matters were quite different in 1988.

106. Dr Clentworth said he could fully understand how a practitioner such as Dr Parry would have believed in November 1988 that the pre-operative discussion on the indications for the cystoscopy that a vesico-vaginal fistula was likely and the general nature of the consent document signed in Northland Hospital at that time would have enabled him to proceed

from a diagnostic to a therapeutic procedure during the same anaesthetic, believing he was acting in the best interests of the patient.

107. Dr Clentworth concluded from Dr Parry's prepared statement that Dr Parry had proceeded to a major surgical procedure out of a combination of a genuine concern to foreshorten the considerable pain endured by patient L (knowing the incontinence would inevitably have continued through Christmas and the New Year period if no attempt were made to repair the fistula at the time of the cystoscopy) and a perception that the general consent form then used at Northland Base Hospital provided consent for such surgery consequent upon the findings of the diagnostic procedure.

108. Dr Clentworth accepted his opinion that Dr Parry at all times acted in what he thought, at the time, were in the best interests of patient L depended on factual findings the Tribunal had to make as to what Dr Parry was considering at the time.

109. Dr Clentworth stated that in the current climate, one could not justify proceeding as Dr Parry did in 1988, but had he known the patient well and was fully prepared for the more extensive surgery, he may have taken the same action [as Dr Parry] at that time [1988].

110. Having regard to the opinions expressed by Drs Mason and Clentworth – who we prefer to Dr Tait, particularly since they both have had greater contemporary experience - and to the findings we have made to consultation on 22 November 1988 and Dr Parry's understanding when he commenced the operation on 30 November 1988 - the Tribunal is not prepared to find the charge of professional misconduct has been proved.

111. The second part of the charge states that Dr Parry acted in a way that amounted to professional misconduct in that:

(b) Consultation with a urologist was only sought very late in the management of the vesico-vaginal fistual.

112. The Tribunal had little difficulty in concluding that this part of the charge has not been proved.

113. Dr Tait, in his evidence-in-chief, stated that following the original operation for a hysterectomy it would have become apparent from patient L's symptoms, which were feeling continually wet, leaking urine and discharge, that there would be a strong suspicion that a vesico-vaginal fistula had formed.

114. It was his opinion that either at that point or certainly after making the diagnosis it would be essential to consult with an urologist or a gynaecologist who had had specific training in repairing vesico-vaginal fistulae.

115. He went on to state that the best time to repair a fistula is at the first attempt because if the repair fails then subsequent scar tissue will make further surgery more difficult, increasing the risk of failure, and possibly resulting in continual incontinence of urine, in-dwelling catheters or possibly having to perform urinary diversion.

116. He stated that the first operation should be performed by the most experienced surgeon available. The reason for this was that the operation to repair a fistula is not undertaken very frequently and the operation is relatively complicated.

117. He stated that while some gynaecologists do perform these operations it would only be usual for a gynaecologist in Dr Parry's position to perform a fistula repair if that person had had a reasonable amount of experience and training in this area and had actually completed a number of those repairs.

118. He said that prior to attempting a repair of the fistula it would be absolutely essential to discuss the situation with a surgeon with experience in this particular kind of surgery. He said it would be normal practice to make the diagnosis, consult the appropriate surgeon, discuss the situation with patient L, and then organise a plan for the definitive surgery. He said Dr Parry should have discussed the diagnosis with either an urologist or a gynaecologist who had experience and a special interest in repairing vesico-vaginal fistulae, and should have taken advice as to who should do the operation.

119. However, Dr Parry gave unchallenged evidence that he did have such experience. He was an Urology Registrar in Wellington in 1973; and when he worked at Chelsea Women's

Hospital in London for 12 months in 1976, part of his work was with a urogynaecological expert which included a period of three months when he worked full time in that sub-specialty. He stated that outside of that three month period he continued to, in part, work in that sub-specialty. He gave evidence that over the years he had performed numerous vesico-vaginal fistula repairs and that he would expect that by the year 1988 he would have performed at least 10 such procedures.

120. In questions from the Tribunal, Dr Tait said that when he wrote his statement of evidence he had not read Dr Parry's statement and was therefore not aware of his experience in these matters. He agreed that if Dr Parry had repaired the number of fistulae he said he had then that made him very experienced.

121. Dr Tait has practised in Christchurch and Wellington but not practised in nor has any working knowledge of practice in Whangarei. He was not aware of local custom in places such as Whangarei but did accept that in terms of issues of what a gynaecologist would do regarding a surgical procedure much might depend on what the local custom was.

122. Dr Tait himself has never attempted to repair a fistula.

123. Dr Parry said he and two other gynaecologists, based at Northland Hospital, covered a population in 1988 of somewhere around 160,000 people. They also visited peripheral hospitals such as Dargaville, Kawakawa, Kaitaia, Rawene, and Kaeo.

124. At that time, Dr C was the sole urologist in Whangarei and was an exceptionally busy practitioner. Where appropriate, Dr Parry said he referred patients to him including during 1988.

125. He stated that at that time it was common practice for gynaecologists to perform fistula repairs in the circumstances rather than by referrals to urologists; and that this was certainly so in Whangarei.

126. He stated if he had any concern about his ability to perform the fistula repair he would not have hesitated to refer patient L to Dr C. At the time however he considered the repair to be well within his capabilities.

127. In a question from the Tribunal, Dr Parry said that one other of the two consultant gynaecologists with whom he had worked at Whangarei [at the time] had done fistula repairs.

128. He confirmed he had a good relationship with Dr C.

129. He said there were some patients whom he shared with Dr C but as a single urologist in the area, Dr C was frantically busy with his own workload. While there were certainly some patients consultant gynaecologists would refer, generally gynaecology urology was left to the gynaecologists.

130. Dr Clentworth stated he was familiar with the clinical condition of vesico-vaginal fistula with which patient L presented in 1988 and 1989.

131. Dr Clentworth was of the view that the criticism that Dr Parry did not refer patient L to an urologist at an earlier date was harsh.

132. He stated that fistula repair follows local custom and that, to his knowledge, in 1988 the practice was common in many parts of New Zealand that repair of such injuries was performed by gynaecologists. He stated that today most Wellington urologists request the presence of a gynaecologist when they are referred a patient with a vesico-vaginal fistula; but that worldwide it is gynaecologists who repair the great majority of those unfortunate injuries. He stated that in New Zealand the most experienced local surgeon may be either an urologist or a gynaecologist though frequently they will combine for surgery of that type of operation.

133. Dr David Mason was familiar with the custom in Whangarei having previously worked there for a total of 3 ½ years. He returned to work in Whangarei as an Urology Locum

Consultant for a six month period from January 1989, which is essentially the material time to which the present charge relates.

134. He confirmed it was normal in Whangarei in 1989 for gynaecologists to perform the repair of bladder openings as well as fistulae which may have developed in consequence. As he recalled, it was not a practice exclusive to Whangarei, but also common in other parts of New Zealand, particularly in the rural regions.

135. He stated that an added factor for Whangarei was that the only urologist in practice there was Dr C who had an exceptionally busy practice and a very heavy workload.

136. He added that historically it was also the case that gynaecologists, more than urologists, attended to fistula repairs.

137. He too addressed the criticism that Dr Parry failed to consult with the urologist until very late in the management of the case. It was his opinion that whilst such a criticism might be more valid today it was a harsh criticism for an obstetrician and gynaecologist in Whangarei in 1988. He considered it was reasonable that Dr Parry attempted the repair of the fistula even though those efforts were unsuccessful.

138. On the evidence presented, the Tribunal is satisfied that Dr Parry had the relevant training and experience to perform the repair of the vesico-vaginal fistula.

139. The Tribunal accepts the evidence of Dr Parry and Dr Mason that at the material time in 1988/1989 it was accepted practice for a gynaecologist of Dr Parry's experience to perform a fistula repair in circumstances such as occurred with patient L rather than by referral to an urologist.

140. Even Dr Tait, who initially criticised Dr Parry, when he was made aware of Dr Parry's experience, agreed he had the necessary experience to perform the operation.

141. Finally, the Tribunal has considered whether Dr Parry's conduct in respect of patient L, considered cumulatively, amounted to professional misconduct. Mr McClelland pointed to no matters additional to those he had raised in respect of each of the two separate parts.

Although particular aspects of a practitioner's conduct, considered separately, may not amount to professional misconduct, considered cumulatively they may do so. The Tribunal is not satisfied this was such a case.

Orders

142. The charge of professional misconduct laid against Dr Parry is dismissed.

143. An interim order was made at the hearing on Tuesday 20 November 2001 suppressing the name of the complainant or any details leading to her identification. Having regard to the subject matter of the charge that order is made permanent.

144. An order was made on 26 August 2001 pursuant to section 106(2)(a) that the hearing be held in private; a further order was also made at the beginning of this hearing pursuant to section 106(2)(b) to prohibit publication of any part of the proceedings during the hearing; the latter order was made with the intention that once the decision was made it would be available for publication. Accordingly, the interim order made pursuant to s.106(2)(b) is hereby discharged.

DATED at Wellington this 26th day of March 2002

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S M Moran

Deputy Chair

Medical Practitioners Disciplinary Tribunal