Medical Practitioners Disciplinary Tribunal

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DECISION NO: 48/98/26C

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 **BRIAN JAMES WILLIAMS** medical practitioner of Auckland

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Dr F E Bennett, Dr A M C McCoy,

Associate Professor Dame Norma Restieaux,

Mr G Searancke(Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Auckland on Thursday 3 September 1998

APPEARANCES: Ms K G Davenport for the Complaints Assessment Committee ("the CAC").

Mr C W James for Dr B J Williams.

Dr R R Ullal, Medical Assessor

1. THE CHARGE:

1.1 **DR** Williams is charged by the CAC, pursuant to Section 93(1)(b) of the Medical Practitioners Act 1995 ("the Act") that on or about 25 June 1996 and thereafter was guilty of conduct unbecoming a medical practitioner which reflects adversely on his fitness to practice medicine in:

(1) Failing to recommend or implement an active plan for managing Mr A's condition following (a) a gastroscopy and (b) histology which were at variance with the symptoms presented and described by Mr A of dysphagia;

(2) Failing to reconsider the diagnosis of oesophagitis made of Mr A's condition in the knowledge that his clinical and histological assessment and response to treatment did not reconcile with the symptoms presented and described by Mr A;

(3) Failing to provide a system for adequate monitoring and follow up of Mr A's condition, that allowed all contact and treatment to lapse prior to satisfactory diagnosis and management;

(4) Failing to specifically perform an undertaking to communicate with Mr A after he had obtained a second opinion from another specialist about the presence or otherwise of disturbed oesophageal motility; and

5) Failing to respond promptly or at all to telephone messages and messages left after personal visits to the surgery.

2. FACTUAL BACKGROUND:

2.1 **IN** June 1996 Mr A, then aged 48, presented to his general practitioner, Dr B, with a six month history of dysphagia (difficulty swallowing). Dr B referred Mr A to Dr Williams by letter dated 13 June 1996.

"13.6.96

Dear Brian

A

Recently a degree of dysphagia; not excess; but persistent

I would appreciate your advice.

H Fit and well; until last year when NIDDM diagnosed

On Allopurinol 300mg x 1

Glucophage 0.5gm x 1

Diamicron ½ daily 11 months

Yours sincerely

B"

2.2 **IN** his letter of report dated 21 June 1996, Dr Williams recorded that Mr A *"Relates that he has in the past been troubled by heartburn which goes back some years and he relates also that he was prescribed mylanta for this in the past but no other medications were required ..."*

2.3 **DR** Williams referred to Mr A's dysphagia and to some weight loss which Mr A related to an alteration in his diet since he had been diagnosed as a diabetic the year previously. Dr Williams concluded *"The point of arrest of his food is enough for a reflux problem and I think it is necessary to view this area and I will arrange to do this in the coming week"*.

2.4 **ON** 25 June 1996 Dr Williams performed a gastroscopy. In the course of this he took tissue specimens for biopsy from three sites, the oesophagus, the gastric antrum and the gastric body.

2.5 **DR** Williams' endoscopy report records inflammatory changes noted in the distal oesophagus: It goes on, *"No stricturing was seen. No other abnormal features within the oesophagus itself. The gastric fundus and body appeared normal. There was mild inflammatory change in the gastric antrum. The duodenum appeared unremarkable. No ulceration was seen. The samples have been taken from the antrum, the body and the oesophagus, to specify the changes and rule out the presence of Helicobacter."*

2.6 **THE** results of the biopsy of the three fragments of tissue were as follows:

(i) *"Histology sections show oesophageal squamous mucosa with focal slight inflammation. There is no definite hyperplasia. There is no dysplasia or evidence of malignancy. No fungal organisms are present. The appearances are probably within normal limits."*

(ii) **BIOPSY** Gastric Antrum, two fragments of tissue ... *"Summary FOCAL CHRONIC ANTRAL GASTRITIS"*.

(iii) **BIOPSY** Gastric Body, two fragments of tissue ... *"Histology Sections show partial thickness gastric body type mucosa within muscularis mocosae. The surface*

epithelium is intact. There is no intestinal metaplasia or epithelial dysplasia. There is no active epithelial inflammation. The lamina propria contains a normal complement of cells. There is no evidence of gland atrophy. There is no evidence of malignancy. No helicobacter- like organisms are present.

2.7 **DR** Williams prescribed a one month course of Losec (aka Omeprazole). This medication was at that time only available under a special authority issued by the Health Benefits Centre, located in Wanganui. Dr Williams gave evidence that in keeping with his usual practice, he completed a Special Authority Application form for Mr A's course of Losec prior to his leaving the endoscopy unit on 25 June 1996. However, no such application form appears to have been forwarded to the Health Benefits Centre at Wanganui at that time and it became necessary for Mr and Mrs A to contact Dr Williams to ask him to forward a second form to the Health Benefits Centre.

2.8 **RECORDS** obtained from the Health Benefits Centre by Mrs A disclose that a faxed form was received on 5 July 1996. Approval for the prescription was obtained finally on 17 July 1996 and Mr A commenced the course of Losec on 18 July 1996.

2.9 **IN** the period between 21 June 1996, when he first saw Dr Williams, and 18 July 1996 when he commenced his course of Losec, Mr A's dysphagia apparently worsened. He obtained no relief after commencing the course of Losec, notwithstanding that Dr Williams had apparently told Mr A that he should start to obtain some relief within one week of taking the medication.

2.10 **IN** response to telephone calls from Mr A, Dr Williams spoke to Mr A approximately eight days after he commenced taking Losec. Mr A indicated that his symptoms had not changed, but it was Dr Williams' opinion that the time span was too short to enable any conclusions to be drawn as to the effectiveness of the Losec and he asked Mr A to continue with the medication for the one month period of the prescription.

2.11 **MR** and Mrs A were scheduled to travel to Australia on holiday on 21 August 1996, returning on the evening of 27 August 1996. Dr Williams was absent from Auckland for the period 19-26 August 1996.

2.12 **ALTHOUGH** there was some confusion about the dates, it was common ground that Mr A contacted Dr Williams again immediately prior to his travelling to Australia and he again advised Dr Williams that there had been no improvement in his symptoms. By this date Mr A had completed his one month course of Losec. As a result of this advice Dr Williams undertook to discuss the matter with Dr C, a consultant who worked with Dr Williams and whom Dr Williams knew had special expertise in the field of disordered gastric motility.

2.13 **NO** such consultation seems to have occurred and Dr Williams had no further contact with Mr or Mrs A. On their return from Australia, Mr A went to his General Practitioner, on 28 August 1996, and reported a worsening of his condition. Dr B then referred Mr A to Dr Phillip Y N Wong for a second opinion.

2.14 **DR** Wong arranged for Mr A to have a barium swallow examination. The barium swallow reported a significant narrowing at the junction of the oesophagus and the stomach and a tumour in this area could not be excluded on the x-ray pictures.

2.15 **IN** view of the x-ray findings, Dr Wong arranged a repeat endoscopy which he performed on 25 September 1996. That endoscopy revealed an obvious tumour at the junction between the oesophagus and the stomach. Biopsies taken on endoscopy confirmed a *"Poorly differentiated adenocarcinoma"*. Mr A subsequently underwent surgery and chemotherapy and radiotherapy. Mr A succumbed to his illness in October 1997.

3. THE EXPERT EVIDENCE:

3.1 **DR** Wong a gastroenterologist, hepatologist and endoscopist was called on behalf of the CAC. Dr Wong gave evidence that he was asked to consider whether the initial diagnosis made by Dr Williams was at variance with the symptoms which were described to him by Mr A. Dr Wong's view was that the diagnosis of reflux disease did not *"fit well"* with Mr A's dysphagia. However, he said, as dysphagia can sometimes accompany reflux disease, he was of the view that it was not unreasonable for Dr Williams to try a course of Losec given that Mr A apparently complained of heartburn at the time of his first consultation with Dr Williams. This report of heartburn was consistent with the inflammatory changes in the oesophagus reported by Dr Williams on the initial endoscopy.

3.2 **DR** Wong said that if Losec did not lead to an improvement in symptoms an alternative explanation should have been sought.

3.3 **DR** Wong also gave evidence that it is his preference to limit a therapeutic trial of Losec to two weeks, rather than four weeks as preferred by Dr Williams. However, in his evidence and in cross examination, he made it clear to the Tribunal that the length of a therapeutic trial such as was prescribed for Mr A, was purely a matter of personal preference. *"There are no hard and fast rules"* said Dr Wong. Because Mr A's symptoms were not typical for reflux disease, it was Dr Wong's evidence that *"In the majority of people, I would consider a two week trial of Losec as sufficient to confirm the clinical impression of a reflux disorder. I think that if the trial of Losec fails and reflux still suspected I would have then considered additional tests including 24hr oesophageal pH monitoring. A barium swallow x-ray and/or oesophageal manometry would be appropriate in the context of dsyphagia."*

3.4 **HOWEVER**, Dr Wong also confirmed that a trial of Losec of anywhere between one and four weeks is within the bounds of acceptable clinical practice.

3.5 **IN** relation to the complaint that Dr Williams did not provide a system for adequate monitoring and follow up of Mr A's condition, Dr Wong gave evidence of his own practice of not referring a patient back to the General Practitioner until he has definitively determined in his own mind a diagnosis, or at least outlined a plan of management with referral back to himself if the problem persisted.

4. MR ALLEY'S EVIDENCE:

4.1 **ON** behalf of Dr Williams, Mr P G Alley, a Fellow of the Royal Australasian College of Surgeons; Assistant Dean (Academic) at Auckland University; and Clinical Associate Professor of Surgery, Auckland University, gave evidence regarding Dr Williams' clinical care of Mr A and

Dr Williams' general care, in particular his communication with Mr and Mrs A, and his follow up care after Mr A was commenced on the trial of Losec. Mr Alley also gave evidence as to professional standards generally in the context of Dr Williams' fitness to practise medicine in terms of Section 109(c) of the Act.

4.2 **IT** was Mr Alley's evidence that Mr A's history of heartburn and his more recent history of dysphagia, "*quite properly*" prompted Dr Williams to conduct an endoscopy. The endoscopy confirmed Dr Williams' clinical suspicion of reflux oesophagitis, but also Dr Williams would have been anxious to exclude cancer, and that was evidenced by his taking biopsies, at random, from the three sites in the oesophagus.

4.3 **THE** histology results, reporting as they did an absence of malignancy confirmed Dr Williams' initial diagnosis of reflux oesophagitis. On the basis of his visual examination and the histological information obtained, Dr Williams prescribed a course of Losec for a period of four weeks. Mr Alley confirmed Dr Wong's evidence that the length of any such trial of Losec might vary from one to four weeks and is entirely a matter of personal preference on the part of the clinician.

4.4 **BOTH** Dr Wong and Mr Alley gave evidence that oesophageal adenocarcinoma is unusual in a patient of Mr A's young age. It is apparently a particularly aggressive carcinoma which spreads rapidly and widely. There was no disagreement between Dr Wong and Mr Alley, in their descriptions of this particular cancer. Perhaps most significantly, all of the clinicians giving evidence in this hearing agreed that it is a notoriously difficult disease to diagnose as it presents and spreads beneath the lining of the oesophagus i.e., its spread is on, or within the external wall of the oesophagus, spreading outwards into surrounding tissue. Because of this pattern of

growth, the tumour is not visible on endoscopy from within the oesophagus. While it was undoubtedly present when Dr Williams performed his endoscopy in June 1996, it might well have not been visible on endoscopy examination until sometime later, in this case three months later when Dr Wong performed his repeat endoscopy.

4.5 **ALL** of the clinicians similarly agreed that the prognosis for patients diagnosed with this form of carcinoma, is poor. This is principally because these patients are usually diagnosed late in the context of the spread of the disease, and the survival rate at five years post diagnosis is around 1-3%.

5. OTHER EVIDENCE:

5.1 **EVIDENCE** as to the events giving rise to this charge was also given to the Tribunal by Mrs A and by the respondent, Dr Williams. The evidence of both of these witnesses, and the conclusions drawn from it is set out in detail in the Tribunal's findings.

5.2 Medical Assessor:

THE Tribunal was assisted at the hearing by Dr Ravindranath Rao Ullal MB BS FRCS Edin FRCS Eng FRACS of the Department of Surgery, Waikato Hospital, as Medical Assessor. A Medical Assessor was appointed on this occasion due to the unavailability of specialist expertise on the part of any members of the Tribunal in the area of practice which was the subject of the hearing.

6. SUBMISSIONS ON THE CHARGES LAID:

6.1 **BOTH** counsel made submissions to the Tribunal of the charge laid, and the particulars which supported the charge. In making her submissions, Ms Davenport for the CAC submitted that the charge was established "on the balance of probabilities". Mr James, on behalf of Dr Williams, challenged that submission asserting that the standard of proof in disciplinary cases was higher than the balance of probabilities simpliciter. Mr James conceded that the standard of proof will increase according to the level, or gravity, of the charge laid. However it is this Tribunal's view that it is working within a disciplinary regime with graduated offences in respect of which only the civil standard applies and, while it is correct that when considering the highest level of charges, the standard of proof may be very close to the criminal standard, the continuum of the applicable civil standard must by definition have a starting point and an end point. It seems to the Tribunal that, as a matter of logic and pragmatism, the starting point, at the lowest level of charges, should be the civil standard simpliciter.

6.2 **ANY** disadvantage which might be seen to accrue to a respondent doctor as a consequence of this approach is balanced by the requirement, added in the 1995 Act, that at the lowest level of charge, conduct unbecoming, the Tribunal is only entitled to find a practitioner guilty and to make orders as to penalty where it finds conduct unbecoming that "reflects adversely on the practitioner's fitness to practise medicine" (Section 109(1)(c)).

6.3 **THE** decision as to whether or not the respondent doctor's conduct comprises "conduct unbecoming" will always require an "assessment of degree", see *B v The Medical Council* (High Court, Auckland), HC 11/96, Elias J, 8/7/96:

".... 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. .... 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."

6.4 **IN** assessing the "degree" to which a practitioner's conduct may, or may not, be culpable the relevant benchmark is the degree to which the practitioner's conduct departs from acceptable professional standards - as these are made known to the Tribunal in the evidence presented to it at the hearing of the charge. In a case such as this, where the evidence as to the conduct complained of is, in significant respects, admitted by the respondent, the standard of proof may be for all practical purposes of secondary consideration. The real task for this Tribunal is twofold: It must consider first if Dr Williams' clinical management of Mr A's case was appropriate in terms of acceptable clinical practice in cases of this sort; and, secondly, if, in the context of Dr B's referral to him, Dr Williams adequately fulfilled his professional obligations as a specialist physician charged with Mr A's care. To do this, the Tribunal must be satisfied that these obligations are properly identified. It accepts that in any area of professional practice the range of 'acceptability' will vary.

6.5 **ONLY** once the Tribunal has reached its decision on these matters and if its conclusions require it, is it necessary for it then to proceed to determine whether or not the respondent practitioner is culpable in terms of the Act and the charge as it is framed.

7. THE FINDINGS:

THE charge against Dr Williams was particularised in five respects. The Tribunal dealt with each particular in turn:

7.1 PARTICULAR 1:

THAT *Dr Williams failed to recommend or implement an active plan for managing Mr A's condition following (a) a gastroscopy and (b) histology which were at variance with the symptoms presented and described by Mr A of dysphagia.*

7.1.1 **MR** A was referred to Dr Williams with a six month history of dysphagia. It was Dr Wong's evidence that the letter of referral from Dr B to Dr Williams was a referral for an opinion of the problem. It was something more than a mere request for a particular investigation and a report.

7.1.2 **DR** Wong gave evidence of his personal practice that if he was asked for such an opinion by a General Practitioner he would not be happy to refer the matter back to the General Practitioner until he had definitively determined in his own mind the diagnosis, or at the very least outlined a plan of management with referral back to himself if the problem persisted. His practice is evidenced by his letter back to Dr B dated 3 September 1996. That letter sets out a full description of Mr A's symptoms, the

investigations undertaken by Dr Wong together with advice as to the further investigations to be undertaken.

7.1.3 **IN** contrast, Dr Williams' letter to Dr B dated 21 June 1996 i.e. before he had undertaken any investigations beyond the initial consultation, simply records Mr A's symptoms as reported to him, together with the advice that he is to undertake a gastroscopy.

7.1.4 **IN** fairness to Dr Williams however it must be acknowledged that when Dr Wong's letter was written three months later, Dr Wong had the benefit of the results of Dr Williams' investigations, and the knowledge that a one month trial of Losec had resulted in no improvement. He was therefore *"primed"* to the possibility that he was dealing with a condition that was more serious than gastric oesophagitis.

7.1.5 **WITH** the benefit of hindsight, it appears that from the outset Dr Williams was led astray by Mr A's report of suffering heartburn for several years. In his letter of 21 June 1996 he reports that Mr A related *"also that he was prescribed mylanta for this in the past but no other medications were required"*.

7.1.6 **THAT** evidence is at variance with Mrs A's evidence that Mr A had no particular history of indigestion or heartburn and that he had taken proprietary antacids only once or twice in the ten years or so of their marriage.

7.1.7 **DR** Williams also recounted his initial impression of Mr A as *"anxious"*. Rightly or wrongly, he formed the impression that Mr A *"sat on the edge of his seat throughout the consultation"* and that he was anxious about his health as a result of his being diagnosed as a diabetic later in life.

7.1.8 **THE** reports of *"heartburn"* were borne out for Dr Williams by his findings of inflammatory changes in the lower oesophagus and lower stomach at the gastroscopy

of 25 June 1996. Dr Williams assessed the level of inflammation as moderate, probably Grade 2-3 gastro-oesophageal reflux disease and he commenced the one month trial of Losec.

7.1.9 **RATHER** than formally reporting the gastroscopy and histology findings, and his decision to commence Mr A on a one month trial of Losec, directly to Dr B, Dr Williams was content to leave it to Dr B to deduce his plan of treatment from the copies of the reports which were forwarded to him, together with a copy of the application and special authority for Losec, which were also forwarded to Dr B.

7.1.10 **HOWEVER** it seems to the Tribunal that rather than failing altogether to put in place a plan of management for Mr A, at least at the outset, it was more a matter of Dr Williams failing to communicate explicitly to Dr B and to Mr and Mrs A what plan, albeit preliminary and inchoate, was put in place following Mr A's gastroscopy, and the receipt of the histology reports he had initiated.

7.1.11 **FURTHER**, the Tribunal is not satisfied that it is proven, even on the balance of probabilities simpliciter, that the results obtained on gastroscopy and from the biopsy were *"at variance"* with the symptoms presented and described by Mr A of dysphagia. For the CAC, Dr Wong in his evidence acknowledged that while Dr Williams' diagnosis of reflux oesophagitis did not fit well with Mr A's reported dysphagia, nevertheless there were inflammatory changes in the oesophagus observed on gastroscopy which were consistent with reflux oesphagitis and Dr Williams took the added precaution of taking biopsies to exclude any malignant disease. The Tribunal is satisfied that when viewed in its totality, the medical evidence was not sufficient to impugn either Dr Williams' initial diagnosis, or his decision to try Mr A on a four week trial of Losec.

7.2 PARTICULAR 2:

FAILING *to reconsider the diagnosis of oesophagitis made of Mr A's condition in the knowledge that his clinical and histological assessment and response to treatment did not reconcile with the symptoms presented and described by Mr A.*

7.2.1 **THE** Tribunal finds this particular similarly not proven, principally for the reasons given in respect of Particular 1.

7.2.2 **THIS** Particular however differs from the first in that it, in effect, alleges that Dr Williams should have reviewed his initial diagnosis immediately Mr A reported to him that he was receiving no relief after taking Losec for eight days, and that possibly his symptoms were worsening.

7.2.3 **AS** was the case in respect of Particular 1, the medical evidence presented to the Tribunal did not go so far as to impugn Dr Williams' decision to stick to his original decision to trial a four week period of Losec rather than curtailing the trial at eight days and carrying out further investigations at that stage.

7.2.4 **DR** Wong for the CAC and Mr Alley on behalf of Dr Williams, did not disagree that the period of the therapeutic trial was within the parameters of accepted clinical practice.

7.3 PARTICULAR 3:

FAILING *to provide a system for adequate monitoring and follow up of Mr A's condition, that allowed all contact and treatment to lapse prior to satisfactory diagnosis and management.*

7.3.1 **THE** Tribunal had some difficulty with the wording of this Particular. For the purposes of its deliberations, and in context of the totality of the evidence received, the Tribunal came to the view that this Particular effectively dealt with two quite discrete periods of time. First, the complaint alleges that Dr Williams failed to put in place a system that enabled adequate monitoring of the therapeutic trial of Losec and, secondly, that Dr Williams failed to follow-up, i.e. to review, the outcome of the therapeutic trial after the four week period of the trial ended. The Particular effectively alleges that because of his failings at these two respects, Dr Williams allowed contact between himself and Mr A to cease, and his treatment of Mr A's symptoms to lapse.

7.3.2 **FOR** the reasons given in respect of Particular 1, the Tribunal is satisfied that Dr Williams did put in place a system for monitoring Mr A's condition at least at the outset of the period of care. Following gastroscopy Dr Williams contacted Mr A at home to advise him of the diagnosis of oesophageal gastritis, and his prescribed four week trial of Losec. He provided Mr A with his personal telephone number on the patient information sheet, *"After Your Gastroscopy"*, which information sheet was given to Mr A by Dr Williams on the day of his gastroscopy, 25 June 1996.

7.3.3 **IN** addition, Mr A also was able to contact Dr Williams by telephoning his professional rooms and leaving a message with Dr Williams' nurse receptionist. Dr Williams reported that he had on two occasions made contact with Mr A as a result of Mr A's leaving a message asking him to return his call. The first of these being eight days into the trial of Losec, and the second appears to have occurred on or about 18 August 1996 at the end of the four week trial of Losec.

7.3.4 **IT** was on this latter occasion that Dr Williams advised Mr A that he would speak to Dr C about Mr A and that he would contact him after he had done that.

7.3.5 **DR** Williams admits that he failed to pursue the matter with Dr C and that he had no further contact with Mr A. Dr Williams was candid in his admission that, overtaken by other events and his own absence from Auckland between 19 and 26 August 1996, he appears to have forgotten his undertaking to Mr A.

7.3.6 **MR** and Mrs A returned to Auckland from Australia on 27 August 1996 and immediately upon their return Mr A went to see Dr B and asked for him to obtain a second opinion. Mrs A gave evidence that by the time they returned from Australia Mr A's symptoms were significantly more serious and, given the difficulties they had had contacting Dr Williams during the period Mr A was in his care, she insisted he was not to contact Dr Williams but was to ask to see another specialist. Neither Mr or Mrs A had any further contact with Dr Williams and Dr Williams admitted that he did not contact Mr A again after the telephone conversation between them on 18 August 1996.

7.3.7 **THUS**, and again for the reasons given in respect of Particulars 1 and 2, the Tribunal is satisfied that Dr Williams did put in place a system for "*adequate*" monitoring, and that it was a system that could be no better described, but clearly there was no follow-up, or review, of Mr A's condition at the conclusion of the four week therapeutic trial.

7.3.8 **BY** Dr Williams' own admission, he did allow all contact with, and treatment of, Mr A to lapse. On that analysis, and viewed in its totality, the Tribunal treated Particular 3 as admitted.

7.4 PARTICULAR 4:

FAILING *to specifically perform an undertaking to communicate with Mr A after he had obtained a second opinion from another specialist about the presence or otherwise of disturbed oesophageal motility.*

7.4.1 **FOR** the reasons given in respect of Particular 3, the Tribunal is satisfied that this Particular also is admitted. Dr Williams does not recall speaking to Dr C, as he undertook to Mr A to do, and he admits that he did not communicate with Mr A as he had arranged.

7.5 PARTICULAR 5:

FAILING *to respond promptly or at all to telephone messages and messages left after personal visits to the surgery.*

7.5.1 **MRS** A gave evidence of the difficulty she and Mr A had in contacting Dr Williams. The Tribunal accepts that these difficulties occurred on three occasions:

7.5.2 **THE** first occurred in the period after Dr Williams prescribed the trial of Losec and prior to the approval from the Health Benefits being received. Dr Williams described his usual practice of completing Special Authority Applications for Losec before he left the Endoscopy Clinic. He also described the delay of several days which generally occurred between the time the application was made and approval was given. He could not explain why the first application form he completed was apparently not received by the Health Benefits Centre. Mrs A recalled becoming concerned about how long it was taking to get the prescription approval, and her frequent calls to Dr Williams during this time to obtain the prescription. Her concern was understandably exacerbated by her husband's worsening symptoms during this period.

7.5.3 **DR** Williams eventually signed a second Special Authority Application form on 5 July 1996, and that form was sent by facsimile to the Health Benefits Centre.

7.5.4 **HOWEVER**, notwithstanding that a copy was forwarded to the Health Benefits Centre by facsimile, thereby presumably indicating some urgency, no approval was forthcoming

until 15 July 1996 and Mrs A was unable to get the prescription filled until 18 July 1996.

7.5.5 **MRS** A also described visiting Dr Williams' rooms in an unsuccessful attempt to obtain the prescription. Given that in any event there would have been some days delay between the time the admission form was submitted and approval obtained, it is likely that Mr and Mrs A would have presented their inquiry as to the whereabouts of the approval around one week after 25 June, say 1 or 2 July. In 1996 the 1st of July fell on a Monday, and the second signed form sent by facsimile on Thursday 5 July. Thus it is likely that there was a period of 2-3 days during which Mr and Mrs A could reasonably have become alarmed about the non-appearance of the approved prescription.

7.5.6 **DR** Williams gave evidence of his workload, and his heavy reliance on his nurse/receptionist to "screen" or "filter" his telephone calls. Mrs A gave evidence of Dr Williams' nurse's advice to her that she was trying to obtain Dr Williams' signature on the form so that she could forward it to the Health Benefits Centre. Given that all that was required was for Dr Williams to affix his signature to the form, and his own evidence that he attended in his rooms on a daily basis, usually at the end of each day prior to his returning home, the Tribunal considers that Dr Williams' failure to attend more promptly to the matter is unacceptable.

7.5.7 **HOWEVER**, given that it took the Health Benefits Centre some 10 days (from 5 July 1996 to 15 July 1996) to give approval in response to the second application form, it must be inferred in Dr Williams' defence that a period of 10 days to respond to an application was not out of the ordinary for the Health Benefits Centre, even in response to an application forwarded to it by facsimile. Neither Dr Williams nor his nurse could

have been alerted to a non-receipt of a form completed by Dr Williams on 25 June 1996 until 4 or 5 July, or until the inquiry was made by Dr Williams' nurse on 5 July 1996.

7.5.8 **ON** this basis therefore whilst the Tribunal accepts that the delays and difficulties would quite reasonably have caused Mr and Mrs A to become worried, frustrated and angry, the Tribunal is not satisfied that Dr Williams' conduct in this regard constitutes conduct unbecoming which reflects adversely on Dr Williams' fitness to practise medicine. In this regard, Dr Williams also gave evidence of certain changes he has made with regard to the handling of messages received by his nurse/receptionist and to his practice generally as a result of this complaint.

7.5.9 **THE** second aspect of Particular 5 is Dr Williams' apparent failure to respond promptly to telephone messages left by Mr A around the period eight days into the trial of Losec. In this regard Dr Williams gave evidence of his contacting Mr A in response to Mr A's telephone message and of his telling Mr A that, in his opinion, that a one week trial of Losec was too short to enable him to assess whether or not Losec was effective to treat Mr A's symptoms. It appears from the evidence that Mr A only attempted to contact Dr Williams through his professional rooms, notwithstanding that Dr Williams had given Mr A his home telephone number as there is no record of Mr A having left any messages, or attempting to contact Dr Williams at his home in the evening.

7.5.10 **THIS**, in conjunction with Dr Williams' early assessment of Mr A as "anxious" perhaps influenced Dr Williams into taking Mr A's concerns less seriously than he otherwise might have. Dr Williams also gave evidence of the difficulty he had contacting patients who are themselves very busy, particularly because, due to his workload, he has only limited times during the day when he can make his calls. He also gave evidence as to

his reliance on his nurse/receptionist to assess the seriousness, or urgency, of calls received at his rooms so that she may contact him during the day if necessary to enable him to respond promptly to any such calls.

7.5.11 **IN** the context of the diagnosis he had made, and his plan for a four week trial of medication, it appears that Dr Williams simply did not accord a high level of urgency to Mr A's messages. Notwithstanding he did return Mr A's call and he did speak to Mr A regarding Mr A's concerns.

7.5.12 **THE** third aspect of Particular 5 is Dr Williams' failure to contact Mr A again after he had assured him that he would do so to report the outcome of his discussion with Dr C.

7.5.13 **MR** Alley set out in his evidence four options for follow-up mechanisms between general practitioners and specialists, and practitioners and patients. Of relevance in the context of Particular 5, Mr Alley described the practise adopted by some specialists of asking the patient to contact the specialist after a defined period of time. It was this option which Mr Alley said Dr Williams opted for. Under this option, the onus is on the patient to contact the specialist after a defined period of time, or they are otherwise invited to contact the specialist directly if necessary.

7.5.14 **DR** Williams invited Mr A to contact him at his home telephone number on the patient information sheet *"After Your Gastroscopy"*. However that invitation is restricted to the reporting of specific events set out on the sheet. As none of those events occurred, it is reasonable to assume that Mr A was not communicating with Dr Williams in response to that invitation. Mr A's attempts to contact Dr Williams directly could only have occurred as a consequence of a more general invitation, or because he had concerns arising out of the treatment prescribed by Dr Williams.

7.5.15 **THROUGHOUT** the period of time he was cared for by Dr Williams, Mr A also had access to his general practitioner. When a patient is referred by a GP to a specialist physician the general practitioner does not cease to be the patient's primary carer, and, as such the clinician to whom any concerns about their treatment, or lack thereof, can be addressed. That this relationship of patient/primary physician existed in this case is evidenced by Mr A's return to Dr B on 28 August to request a second opinion as a result of his dissatisfaction with the care provided by Dr Williams.

7.5.16 **AS** he did in respect of Particulars 3 and 4, Dr Williams admitted his failure to contact Mr A notwithstanding his undertaking to do so at the conclusion of the four week trial of medication.

8. CONCLUSIONS:

8.1 **GIVEN** these findings, the Tribunal proceeded to consider Dr Williams' conduct in this case in its totality to determine whether or not the shortcomings identified and/or admitted by Dr Williams constitute conduct unbecoming which reflects adversely on his fitness to practise.

8.2 **IN** her closing submissions Ms Davenport cited an Interim Decision of the Tribunal *The Director of Proceedings v J* (39/98/19D, 30/6/98) in which the Tribunal considered the definition of conduct unbecoming as defined under the 1995 Act.

8.3 **THE** definition of the new terminology outlined in that Decision draws heavily on the statement by Justice Elias in *B v The Medical Council* (1996) referred to earlier in this Decision. This Tribunal sees no reason in this case to depart from, or add to, that analysis. In *CAC v Edwards* (97/1) this Tribunal, in the context of its assessment of the respondent's conduct and that analysis,

referred to the requirement that there be 'something more' than mere error or omission, indicating a lack of professional care and skill which reflects adversely on the practitioner's fitness to practise, which must be proven to establish a finding adverse to the practitioner.

8.4 **THAT** analysis is particularly apt in the present circumstances. That Dr Williams made an error in forgetting his undertaking to Mr A to discuss his case with Dr C, and to report back to him, was an admitted error on his part. The central issue for this Tribunal is the issue as to whether Dr Williams' conduct was an acceptable discharge of his professional obligations owed to Mr A.

8.5 **THE** most significant shortcoming identified on the part of Dr Williams was his failure to consult with Dr C and to report back to Mr A as promised. Dr Williams' evidence as to his dependence upon his nurse/receptionist to *"screen"* or *"filter"* calls to his private rooms initially concerned the Tribunal. It almost goes without saying that a patient referred to a specialist seeks a level of expertise and advice that cannot be satisfied by a nurse/receptionist, no matter how well qualified or experienced. It is understandable that a patient whose care is entrusted to a specialist, but who finds it difficult to contact that specialist and is given advice by the 'gatekeeper' might have cause to complain.

8.6 **THE** patient is entitled to be reassured that all calls are logged and referred to the specialist so that the specialist has the opportunity to assess the relevance and importance of the call, and the request for advice which is implicit. If this is the counsel of perfection, or 'gold standard', so be it. No practitioner should assume a level of work and/or responsibility which is so onerous that basic obligations to his or her patients cannot be met.

8.7 **HOWEVER**, on further inquiry, Dr Williams' evidence satisfied the Tribunal that in fact all calls to his private rooms were recorded and a list of the calls received during the day was available to him when he returned to his rooms each evening, together with the relevant patients' records. Screening of his calls was limited to his nurse/receptionist providing assistance to simple 'administrative' type queries, and referral to him if the matter was urgent.

8.8 **IN** any event, the most serious omission occurred as a result of Dr Williams himself forgetting the undertaking he had made to Mr A on or about 18 August 1998. In the Tribunal's view, that omission, which occurred in circumstances where Dr Williams had almost no opportunity to remedy his oversight, does not constitute conduct warranting sanction.

8.9 **IN** coming to its decision that Dr Williams' errors and shortcomings in this case do not constitute conduct warranting sanction, the Tribunal is influenced by the fact that Dr Williams' clinical care of Mr A is not significantly criticised by either of the other clinicians giving evidence in this hearing.

8.10 **THERE** is no evidence that Dr Williams' gastroscopy on 25 June 1996 was deficient in any respect, or that he failed to see any sign of the carcinoma which was evident to Dr Wong three months later. Similarly, his decision to try Losec for a four week period was within the bounds of acceptable professional practice, and his decision to take biopsies on gastroscopy to obtain histological information could only have been an added precaution taken for the purposes of excluding any malignancy.

8.11 **DR** Williams' care of Mr A was found wanting only in respect of his communication with Mr A during the period of the four week therapeutic trial, and on follow-up once the period of the trial

was concluded. However, by the time of Dr Williams' most significant omission, his failure to contact Mr A at the end of the four week trial period, Mr A had already taken matters into his own hands and had returned to his GP seeking a second opinion, and was shortly thereafter being cared for by Dr Wong. Dr Williams did fail to return to Mr A as promised but neither did Mr A contact Dr Williams. It must fairly be inferred that had Mr A contacted Dr Williams on his return from Australia, Dr Williams would have been reminded of the arrangement he had made and his care of Mr A would have resumed. Because Mr A returned to his primary caregiver, Dr B, on his return from Australia and asked to see another specialist, Dr Williams did not have the opportunity to put matters right and to review Mr A's case on the basis of the investigations and care given over the past three months, and Mr A's worsening condition.

8.12 **THUS**, although not known to Dr Williams, his failure to speak with Dr C and to contact Mr A again did not cause Mr A to suffer harm, at least in the context of his illness. The Tribunal does not overlook, or wish to treat lightly, the worry and stress which was undoubtedly caused to Mr and Mrs A as a result of their difficulties communicating with Dr Williams.

8.13 **IN** his evidence, as a colleague and peer asked for a specialist opinion on how he *"rated"* Dr Williams' management of Mr A's case, Mr Alley concluded by reflecting on the aspect where Dr Williams *"could have done better - that is the monitoring and follow-up - Charge B (3)"*. Mr Alley said *"I give him only a "pass""*.

8.14 **THE** Tribunal considers that a very forthright, fair and objective assessment on Mr Alley's part, and it concurs with that assessment. In coming to its decision that Dr Williams is not guilty of the charge laid the Tribunal has also taken into account Dr Williams' prompt acknowledgement of

his error in forgetting to obtain a second opinion from Dr C, and in not contacting Mr A to discuss the outcome of the trial and any future investigations or treatment; his apology given to Mrs A as soon as he was advised of this complaint; and the steps he has taken to ensure that such an omission does not occur again.

8.15 **ACCORDINGLY**, the Tribunal finds that none of the Particulars are upheld at a level of conduct unbecoming a medical practitioner that reflects adversely on Dr Williams' fitness to practise medicine.

8.16 **NONE** of the Particulars being upheld, the charge laid against Dr Williams is dismissed. There are no issues as to costs.

8.17 **THERE** are several features of this case which are unfortunately not uncommon in complaints brought to the Tribunal for hearing. Most particularly, a breakdown in the communication between practitioner and patient.

8.18 **IT** is not unusual for the Tribunal to find that the practitioner's clinical care of the patient is satisfactory, even on occasion, exemplary, but a complaint subsequently arises as a result of the practitioner's failure to communicate appropriately with the patient, and/or the patient's family. Often this failure occurs as a result of overwork, especially where the respondent doctor is a specialist with both a private practice, and a practice within the public health sector, and possibly is also carrying academic or teaching responsibilities.

8.19 **THERE** may also be issues as to the 'ownership' of the patient if care or treatment is being provided by a team of doctors, or by specialists and a general practitioner. In such cases it is not always made clear to the patient which practitioner is primarily responsible for his or her care - and which practitioner is the appropriate point of inquiry if concerns arise or matters go awry, as happened in this present case. Whilst not wishing to add to the burden of the profession, the importance of maintaining patients' records to record all relevant events, especially any undertakings made to the patient, and of developing strong inter-professional relationships so that all practitioners involved in each patient's care (and the patient) are kept properly informed, cannot be overstated.

DATED at Auckland this 2nd day of October 1998

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W N Brandon

Deputy Chair

Medical Practitioners Disciplinary Tribunal