Medical Practitioners Disciplinary Tribunal

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DECISION NO: 49/98/29C

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 **JOHN MCGARVIN MCILWRAITH** medical practitioner of Auckland

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Dr J W Gleisner, Dr A M C McCoy, Dr B J Trenwith,

Mrs H White (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Auckland on Thursday 20 August 1998.

APPEARANCES: Mr R Harrison QC for the Comp laints Assessment Committee ("the CAC").

Mr C W James for Dr J M McIlwraith.

1. STATEMENT OF AGREED FACTS

1.1. **THE** CAC has laid an amended charge of conduct unbecoming against Dr McIlwraith in that in his course of management and treatment of Mrs A between on or about 23 October 1992 and 20 March 1996 he failed:

(a) To adhere to the recall suggestions on her cervical smear tests; and

(b) To have appropriate systems in place to ensure appropriate treatment and follow-up of abnormal smears.

1.2 **DR** McIlwraith admits the charge, as amended, on the basis that his conduct reflects adversely on his fitness to practise medicine.

1.3 A is a 35 year old married woman who lives with her husband and two young sons at xx.

1.4 **FROM** the age of 10 years Mrs A was a patient of Dr McIlwraith until termination of the relationship in 1996.

1.5. **ON** 21 March 1996 Mrs A was diagnosed as suffering from cervical cancer following a smear report. On 16 May 1996 her condition was identified as a Stage 1B adenocarcinoma of the

cervix. On 19 June 1996 at laparotomy Mrs A's condition was diagnosed as Stage 3B. She has since received chemotherapy and radiation treatment.

1.6. **IN** February 1997 metastases were diagnosed in Mrs A's chest. Her cervical cancer is now at Stage 4. She is receiving palliative treatment only.

1.7. **DR** McIlwraith arranged various smear tests for Mrs A between 1981 and 1991. The dates and results of those tests are as follows:

(1)	16 March 1981	Normal smear. Graded A1;
(2)	5 December 1984	Abnormal smear. Graded A2;
(3)	23 July 1985	Normal smear. Graded A1;
(4)	4 March 1986	Abnormal smear. Graded A2;
(5)	19 March 1987	Normal smear. Graded A1;
(6)	22 February 1988	Normal smear. Graded A1;
(7)	4 September 1990	Normal smear. Categorised within normal limits.

1.8. **IN** response to the two test abnormalities reported on 5 December 1984 and 4 March 1986 Dr McIlwraith requested repeats of smears from Mrs A at six monthly periods which were within the recommended period of 12 months. The results of the repeat tests were normal.

1.9 **THE** following sequence of events occurred between 1992 and 1996;

(1) In June 1992 Mrs A presented with low back pain and onset of bleeding from the bowel. She referred to a recent incident of post coital bleeding. She also attended to repeat her

oral contraceptive. Dr McIlwraith advised Mrs A that she should return shortly afterwards for a cervical smear;

(2) On 23 October 1992 a smear test from Mrs A returned an abnormal result. xx's report noted that the specimen was less than optimal because blood obscured some cell detail. The report advised and recommended as follows:

"There are cell changes present consistent with inflammation or repair. Numerous atypical, probably reactive, endocervical cells are present. A repeat smear in 6 months with a cytobrush sample, is advised. Repeat in 6 months.";

(3) In November 1992 Mrs A was referred to xx Hospital following another incident of bowel bleeding;

(4) In April 1993 a tubular adenoma was removed from Mrs A's upper rectum but Dr McIlwraith did not obtain a firm diagnosis of the cause of her bleeding. A firm diagnosis was not obtained also while Mrs A was investigated at xx Hospital.

(5) In April 1993 Mrs A became pregnant with her first child. In late February/early March 1995 she became pregnant with her second child;

(6) On 4 May 1994, one year and six months after the previous smear, another smear test was taken from Mrs A. The previous report had recommended a further smear within six months. Both the spatula and cytobrush smears were undertaken. xx's report advised that

the specimen was less than optimal because inflammation obscured some cell detail. It then advised and recommended:

"There are cell changes present consistent with inflammation or repair. No dysplastic epithelial cells were identified. In view of the sub optimal nature of the specimen, a report smear tests in 12 months would be advisable. Repeat within 12 months.";

(7) On 21 March 1996, one year and 10 months after the previous smear Mrs A returned another abnormal smear test. The previous report had recommended a further test within 12 months. The material part of the report stated:

"This is an adequate PAP smear. It is highly cellular, containing numerous large and small fragments of discohesive epithelial cells. These cells are crowded and overlapping, with pleomorphic enlarged nuclei. The chromatin is quite hyperchromatic and course, and prominent nucleoli are visible in some cells. The nuclear contours are markedly irregular. Moderate amounts of cytoplasm are present. Many discohesive cells fall apart from the tighter cellular clumps. There is a tumour diathasis in the background. The features are those of an endocervical adenocarcinoma.

The patient's past PAP smear received at this site was reviewed. This was suboptimal quality slide, due to poor preservation of cells secondary to air-drying artefact. Small clusters of cells with course chromatin and increased N:C ratio, somewhat similar to those seen in the current specimen, are seen in that older specimen. However, the atypia could not be further diagnosed because of the limitations imposed by the suboptimal quality of the smear.

Specimen is technically satisfactory for evaluation. A cervical smear has a significant false negative rate for high grade lesions. This test may not be reliable in the presence of symptoms or signs."

1.10 **THE** CAC accepts the validity of the statements made in the final two sentences of xx's report to Dr McIlwraith 21 March 1996.

1.11. **MRS** A did not learn until some time after 21 March 1996 of the true nature and extent of the abnormal results from her smear tests taken since 1984. She acknowledges that Dr McIlwraith advised her of at least one of these abnormal test results. Mrs A remembers his advice of the abnormal result in 1984. However, she does not remember receiving advice from him about the abnormal results in 1992 and 1994.

1.12. **THE** CAC had obtained independent advice from Mr Peter Sykes, a gynaecologist and gynaecological oncologist. In a report to the Committee 25 November 1997 Mr Sykes advised: *"In Mrs A's case atypia was diagnosed probably as a result of glandular dysplasia or adenocarcinoma-in-situ. At no point was it suggested from the smear result that there was a pre-cancerous lesion that although if repeated smears had been taken the diagnosis would probably have been made earlier there is certainly no guarantee that that would be the case. However, atypical smears, especially in the presence of symptoms (post-coital bleeding) should have precipitated referral for gynaecological assessment.*

Unfortunately though clinically stage IB at the time of Mrs A's surgery there were bulky para-aortic nodes. This suggests that metastases occurred at an early event in Mrs A's

cancer. Although no time frame can be put on these occurrences earlier diagnosis would not necessarily have led to an improved prognosis, as primary therapy does not affect disease that has already metastasised to the para-aortic nodes. If treatment was instituted prior to metastases taking place adenocarcinoma of the cervix is a curable condition."

2. EVIDENCE OF DR MCILWRAITH:

2.1. **IN** failing to act immediately on the recall or the repeat recommendation made on the smears, he acknowledged he denied Mrs A an opportunity for earlier detection of her cancer.

2.2. **HOWEVER**, Dr McIlwraith asked the Tribunal to note that he did not merely ignore in some flagrant way the report recommendation made on the smears. He explained that the recommended time frame coincided with Mrs A's pregnancies. He said he did consider the smear reports and recall recommendations, but made judgements which he acknowledges were defective. He now appreciates that his reasons for deciding not to perform the smears in Mrs A's pregnancies, were not sensibly based.

2.3. **IN** mitigation Dr McIlwraith explained that he misunderstood the specific and separate significance of Endocervical cell atypia in the smear report of 1992. He interpreted this in the light of his knowledge of cervical screening which was largely based on the management of Squamous cell atypia and the more significant abnormalities which may progress to Squamous cell cervical cancer. At the time the guidelines for the management of abnormal cervical smears predominantly referred to the body of knowledge relating to the much more common Squamous carcinoma. References to possible precursors of the rarer Endocervical carcinoma tended to be absorbed into these guidelines.

2.4. **WERE** he ever again to receive a smear report as in 1992 describing atypical Endocervical cells of uncertain significance, Dr McIlwraith explained he would refer immediately for specialist assessment. With his present understanding of Endocervical carcinoma, there is no other option.

2.5. **DR** McIlwraith asked if the Tribunal might take into consideration his cervical screening management in relation to the abnormal smear results of 1984 and 1986, where atypical cells were reported with recommendations to repeat the smears at 12 months. Because the atypia was not further defined, Dr McIlwraith's assumption was that this would be Squamous cell atypia. His caution was to decide on and arrange two consecutive repeat smears at six month intervals and then at 12 months. It was his subsequent belief that this was an example of Squamous atypia where a significant proportion of abnormalities may not progress, in fact regress.

2.6. **DR** McIlwraith provided the Tribunal with detailed reasons as to why the recall advice from the 1992 and 1994 smears were not followed.

2.7. **FINALLY** Dr McIlwraith provided the Tribunal with a detailed assessment as to the present status of his practice's cervical recall system. Dr McIlwraith concluded:

"Even though our current medical software is a considerable improvement on the previous one, and the above recall system would seem to be of a high standard, I know better than ever the need for audit and adjustment. The more steps in the system the more that can go wrong and with the absolute necessity for delegation of responsibility the potential for problems is compounded. As in the earlier years where there was more reliance on direct communication, where patient compliance and responsibility was an issue, this still exists

and cannot be overcome with systems however computerised and sophisticated they become."

3. SUBMISSIONS:

3.1 **FOR** the CAC Mr Harrison explained the background to his seeking (and being granted) leave of the Tribunal to amend the charge from professional misconduct to conduct unbecoming.

3.2 **IT** was further explained by Mr Harrison that Mrs A does not harbour bitterness or a sense of vengeance about what has happened. Mr Harrison said he was able to confirm this was the case, having spoken to the two sisters of Mrs A, Mrs B and Mrs C, both of whom were present at the hearing.

3.3 **IN** not seeking on behalf of the CAC a penalty that is retributive in nature, Mr Harrison indicated Mrs A's primary concern is that the errors in her treatment be identified and should not be repeated.

3.4 **FOR** Dr McIlwraith a strong plea in mitigation was entered by Mr James. In arguing that Dr McIlwraith is entitled to some credit for the admission made by him, Mr James highlighted his anguished demeanour, systems breakdowns which have been seriously addressed, and complicating factors such as rarity of presentation, post-coital bleeding and pregnancy. Mr James asked the Tribunal to take all these factors into account when addressing penalty. Mr James suggested that the misjudgement on the part of Dr McIlwraith could be dealt with simply by way of censure, which he observed would be fitting and appropriate, and would satisfy all needs, including the public interest.

4. PENALTY

4.1 **IT** was explained by the Court in *B v The Medical Council* (HC 11/96 Auckland Registry, Judgement 8 July 1996) that:

"There is little authority on what comprises "conduct unbecoming". The classification requires assessment of degree. But it needs to be recognised that conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards. That departure must be significant enough to attract sanction for the purposes of protecting the public. Such protection is the basis upon which registration under the Act, with its privileges, is available. I accept the submission of Mr Waalkens that 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."

4.2 **IN** accepting the admission of responsibility which has been made, the Tribunal does so on the basis that it considers, on the particular facts of this case, that it was an appropriate acknowledgement for Dr McIlwraith to have made. The extract from *B v The Medical Council* has been included above, simply to illustrate that a finding of conduct unbecoming is not required in every case where error is shown. In this case the Tribunal considers that the errors which occurred, while regrettable, were understandable. Primarily for that reason, the Tribunal considers that leniency in the imposition of penalty is not only warranted, but is desirable.

4.3 **ALTHOUGH** censure is an option, the Tribunal resiles from expressing harsh condemnation of Dr McIlwraith's conduct. Likewise we are of the view that neither imposition of conditions on practice, nor a fine, are warranted in this case. In mitigation, the Tribunal has taken into account the rarity of adenocarcinoma of the cervix prior to the present decade. It has also noted comments from xx, in their report of 21 March 1996, when reviewing the 1992 slide, that it was of suboptimal quality due to air-drying artefact.

4.4 **TO** his great credit, Dr McIlwraith has acknowledged his misjudgement. He has suffered much distress through two appearances before the CAC, spread over a considerable time, plus one appearance before this Tribunal. A contrite and remorseful demeanour is eloquent testimony that this caring and thoughtful medical practitioner is unlikely to find himself in a similar situation ever again.

4.5 **IT** is appropriate, and the Tribunal so orders, that Dr McIlwraith be required to make a contribution of 30% towards the costs of the inquiry conducted by the CAC, and the hearing by the Tribunal.

4.6 **FINALLY** there is a question relating to publication of Dr McIlwraith's name. Mr James informed us there is no claim or wish by Mrs A or her family, that there be publication of name.

4.7 **BY** virtue of Section 138 of the Act publication of the name of Dr McIlwraith is mandatory unless suppression is already in place under Section 106 of the Act. No order was made under Section 106. Accordingly the late application for name suppression must be declined.

DATED at Auckland this 17th day of September 1998.

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P J Cartwright

Chair

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