MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 244/03/100D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings against A medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chair)

Ms S Cole, Dr G S Douglas, Dr C P Malpass, Dr J L Virtue (Members)

Ms K L Davies (Hearing Officer)

Mrs G Rogers (Stenographer)

Hearing held at Wellington on Monday 4 and Tuesday 5 August 2003

APPEARANCES: Ms T Baker and Mr J Tamm for the Director of Proceedings.

Ms J Gibson for Dr A

Introduction

1. Dr A is a registered medical practitioner. He practises as a xx with a specialist interest in xx. Dr A has xx under the Medical Practitioners Act 1995 ("the Act"). At the time of the events examined in this decision Dr A was working as a xx at xx in xx.

The Charge

2. On 31 March 2003 the Director of Proceedings[1] charged Dr A with professional misconduct[2]. The charge relates to two aspects of Dr A's post operative management of Mr Presow at xx Hospital during late March and early April 1999.

3. The particulars of the charge allege:

> *"1. Between 27 March 1999 and 10 April 1999 in relation to Mr Presow [Dr A] failed to adequately investigate the cause or causes of the discharge of large volumes of fluid from Mr Presow's perineum.*
>
> *and/or*
>
> *2. Between 27 March 1999 and 10 April 1999 in relation to Mr Presow [Dr A] failed to adequately investigate the cause or causes of swinging pyrexia".*

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1 The office of Director of Proceedings is created by section 15 Health and Disability Commissioner Act 1994

2 Section 109(1)(b) of the Act

4. The charge alleges that the particulars either separately or cumulatively amount to professional misconduct. In her closing submissions, Ms Baker, counsel for the Director of Proceedings, invited the Tribunal to find either or both of the particulars amounted to professional misconduct, or, alternatively, that when viewed cumulatively , the particulars constituted professional misconduct.

Tribunal's Decision

5. The hearing of the charge took place on 4 and 5 August 2003. After the hearing of evidence and submissions from both counsel the Tribunal adjourned to consider its decision. Later on 5 August the Tribunal advised that the charge had been proven. The Tribunal heard evidence on penalty and whether or not its interim decision granting Dr A name suppression should be lifted or made permanent. The Tribunal indicated to the parties on 5 August that, subject to receiving submissions on the amount of costs incurred by the Director of Proceedings, and Dr A's financial circumstances, the Tribunal was minded to order Dr A pay costs but impose no other penalty. The Tribunal also advised the parties that it would reflect on the issue of name suppression and provide the parties with its decision on that topic when it delivered its reasons for finding the charge proven.

6. The Tribunal has resolved not to continue the name suppression order previously made by the Tribunal in its interim decision of 28 May 2003. The Tribunal has also determined that Dr A should pay $26,992.69 costs pursuant to s.110 (1) (f) of the Act.

7. The Tribunal now explains the reasons why it found the charge proven, its reasons for the imposition of costs, and why name suppression should not continue.

The Facts

8. Counsel for the parties provided the Tribunal with an agreed summary of facts. The Tribunal is grateful for the efforts the parties have made to prepare the summary of facts which has been substantially incorporated into the following analysis of the events leading to the charge.

Dr A

9. Dr A is an experienced xx. His curriculum vitae shows he graduated from the xx in June 1966. His other principal qualifications are:

Not for publication

10. Dr A came to New Zealand in October 1994. Prior to then he held medical positions in xx. After arriving in New Zealand Dr A held positions at xx Hospital in xx, and at xx Hospital. During 1998 Dr A held positions in xx before commencing employment at xx Hospital on 21 December 1998. Because Dr A was registered as a xx medical practitioner he needed to practise subject to the oversight of a doctor who held vocational (specialist) registration. The practitioner responsible for Dr A's oversight at xx Hospital was Mr A. There was another xx at xx Hospital (Mr B) who was also able to provide support and assistance for Dr A.

Mr Presow

11. Mr Presow passed away in October 2002. He died from cancer three and half years after he was treated by Dr A. Mr Presow's death was not due to the treatment he received from Dr A.

12. Mr Presow first underwent surgery for rectal cancer on 23 December 1996. The surgeon who performed the surgery at the time was Mr B. Two years later Mr Presow displayed symptoms of recurrent rectal cancer but was not referred to xx Hospital until 3 March 1999. There he was seen by Dr A who had been at the hospital for just 2½ months. Dr A diagnosed recurrent rectal cancer which was easily palpable in the lower part of Mr Presow's rectum. The tumour involved most of the circumference of the bowel lumen. Dr A performed a sigmoidoscopy and biopsied the tumour. Dr A also arranged an urgent CT scan of Mr Presow's abdomen and pelvis. The CT scan could not be undertaken at xx Hospital because it did not have a CT scanner. Mr Presow was admitted to Wakefield Radiology in Wellington on 11 March 1999 for a CT scan. That procedure was

undertaken urgently to enable Dr A to assess local pelvic changes and to exclude the presence of metastases.

13. On 4 March 1999 Dr A spoke to Mr B about Mr Presow. They briefly discussed the surgical options for Mr Presow. There was also discussion about who should manage Mr Presow. Mr B was content to allow Dr A to treat the patient.

14. Dr A saw Mr Presow again on 18 March 1999. The CT scan report showed no evidence of metastatic disease. Dr A thoroughly discussed with Mr Presow the option of surgically removing the recurrent cancer. Dr A explained that the long term prognosis for Mr Presow was not promising and that the proposed surgical procedure involved removing the remaining portion of Mr Presow's rectum and giving him a permanent left iliac colostomy. This procedure is called an abdominoperineal resection. Mr Presow was told of the complications and risks of surgery and of the likely duration of the time he would spend in hospital. Mr Presow elected to undergo the operation.

15. Mr Presow was admitted into xx Hospital on 24 March with the intention Dr A would perform the surgery on 26 March. Prior to Mr Presow's admission Dr A discussed the CT scan findings with the radiologist at xx Hospital and also discussed the case with Mr B and Mr A at their weekly meeting.

The Operation

16. Dr A was assisted during the operation by a registrar and house surgeon. Anaesthesia started at 9.15am. The operation took longer than anticipated and did not conclude until 4pm. The operation was complex and difficult. There were adhesions from Mr Presow's earlier surgery and an abscess was found in the left side of the pelvis. There were adhesions to the sides of the pelvis and there was a possible direct extension of the tumour which complicated dissection. There was also significant bleeding. The recorded blood loss was 7325mls. There was a further estimated 1 litre blood loss. The very large blood

loss caused significant hypotension, measured at systolic BP 60mmHG. During the surgery damage occurred to the posterial wall of the bladder. This was repaired.

17. Following the operation Mr Presow was transferred to the hospital's high dependency unit (HDC). Immediately after the operation Dr A telephoned Mrs Presow and told her about the difficulties which had been encountered. Arrangements were made for Dr A to meet Mrs Presow and one of her sons the next day. At that meeting Dr A explained the complications of the surgery and the possible short and long term difficulties which could be expected. Dr A promised to keep the family informed about Mr Presow's progress.

Post Operative Events

18. Dr A regularly reviewed Mr Presow's condition during the days following surgery. Dr A saw Mr Presow at least twice a day, and on one day he saw him four times. Dr A wrote clear clinical notes and communicated fully with nursing staff, the registrar and house surgeon during the days Mr Presow remained in xx Hospital.

19. The key medical evidence concerning the events which occurred post operatively are summarised in paragraphs 54 to 64 of this decision. At this juncture the circumstances leading to the charge are explained by chronologically describing the events which occurred during the days after Mr Presow's operation.

Saturday 27 March 1999

20. Mr Presow remained in the HDU. He was stable. Mr Presow had a low urine output which responded to Frusemide. Antibiotics were charted.

Sunday 28 March 1999

21. Mr Presow was still stable but had a distended abdomen. He was also noted to have a cardiac murmur and to be having some ectopic heart beats. An anticoagulant (Fragmin)

was started. The observation chart shows Mr Presow had a temperature of 38°C on the night of 28 March.

Monday 29 March 1999

22. On 29 March Mr Presow was transferred from the HDU to a hospital ward. He was stable and breathing well. No specific changes were made to his management. The records show that Mr Presow's temperature varied from 37.1°C to 37.4°C during the 29th of March. The nursing staff noted a large amount of haemoserous ooze from the perineal wound when Mr Presow stood up and when the wound was gently pressed. During the night shift of 29 March a large amount of fluid was observed to come from the perineal wound.

Tuesday 30 March 1999

23. During the morning shift on 30 March 1999 the discharge from Mr Presow's perineal wound was described as "oozing copious amounts, pouring out when standing or pressure applied". A nurse questioned Dr A about whether the fluid discharging from the perineal wound was urine. Dr A examined the fluid which he described as being "pinkish" in colour. He did not think it smelt like urine. Dr A thought the fluid was of the kind generated in the body following operations of the kind Mr Presow had undergone. There was clearly some concern about the fluid loss. Perineal loss was recorded in the fluid balance chart from 30 March onwards. The nursing staff continued to record large amounts of haemoserous ooze from the perineal wound. The nursing notes for the night of 30 March show the nurse on duty left Mr Presow's draw sheet in the sluice room for Dr A to examine.

24. Mr Presow's temperature fluctuated during the 30th March from 37.2°C at 6am to 36.5°C at 1pm, to 37.6°C at 4.30pm to 36.2°C at 9pm.

25. During 30 March Dr A arranged for the drum catheter to be removed and sent to the laboratory to test for bacteria.

Wednesday 31 March 1999

26. Nursing staff continued to have concerns about the loss of fluid from Mr Presow's perineal wound on 31 March. Dr A assessed the situation and noted the discharge was a possible serous ooze due to ascites[3]. A drain was inserted into the wound. The nursing staff ensured a pad, stretchy pants and incontinent sheets were put in place. Dr A noted Mr Presow had clinical signs of "shifting dullness" an indication of fluid accumulation within the abdominal cavity. Mr Presow's serum albumin had fallen to 19 g/1.

27. The fluctuations in Mr Presow's temperature on 31 March 1999 were recorded as 37°C at 6am, 37.7°C at 11am and 3.30pm, and 37.2°C at 8.35pm.

Thursday 1 April 1999

28. When Dr A saw Mr Presow on 1 April he thought his patient was improving. Dietary arrangements were put in place. The fluid balance chart shows over 2 litres passed from the perineal drain. Mr Presow's temperature fluctuated from 36.5°C to 37.9°C during the 1st of April.

Friday 2 April 1999

29. On Good Friday Dr A noted Mr Presow continued to pass large volumes of clear fluid from the perineal drain. Mr Presow's temperature fluctuated from 37.1°C at 6am to 36.8°C at 11am to 37.6°C at 4pm.

Saturday 3 April 1999

30. According to the fluid balance chart 1200mls of fluid discharged from the perineal drain on 3 April. Mr Presow also passed 1,320mls of urine. During the day Dr A placed two sutures in the perineal wound. Mr Presow's temperature spiked at 38.5°C during the evening of 3 April.

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[3] Accumulation of serous fluid in the abdominal cavity.

Sunday 4 April 1999

31. At 9am nursing staff noted a sudden deterioration in Mr Presow's condition. He was short of breath, and tachycardic, but his temperature was normal. Dr A assessed Mr Presow at 12.30pm and arranged for his patient to be transferred to the HDU. When in the HDU Mr Presow's temperature climbed dramatically to 40.2°C. Mr Presow's temperature dropped to 38.2°C at 2pm, 37.7°C at 2.30pm and 36.2°C at 10pm.

32. Dr A observed that clear to cloudy yellowish fluid was coming from the perineal drain. Mr Presow was given oxygen and commenced on intravenous antibiotics and fluids. Although short of breath Mr Presow's lungs were normal apart from a few "scattered wheezes" and a decrease in the sounds at the base of the left lung.

33. Dr A arranged for removal of the perineal drain in case it had contributed to the apparent sepsis which Mr Presow was suffering. The tip of the drain and swabs were sent to the laboratory. Samples of blood were taken for culture and blood gases. Three types of antibiotics (Flagyl, Gentamycin and Amoxil) were commenced. The urinary catheter was replaced to monitor urine output.

34. The loss from the perineal wound was recorded as "300++". The nursing staff noted the perineal pad was heavily soaked with "haemoserous ooze".

Monday 5 April 1999

35. Overnight the nursing staff noted the perineal pad was heavily soaked with "haemoserous ooze" and smelt of urine. Mr Presow had an irregularly fast heartbeat. The antibiotic regime was continued. Mr Presow's respiratory rate varied between 28 and 34. Mr Presow's heart rate remained rapid. Dr A consulted with the physician on call who recommended Mr Presow be given Digoxin.

36. The fluid balance chart for 5 April 1999 records the perineal loss as "++". The nursing notes say the perineal drainage was serous, slightly blood stained and copious. The nurses brought these matters to Dr A's attention.

37. On 5 April Mr Presow's venous white blood cell count increased to 38.5 x 10 9/1.

38. Mr Presow's temperature fluctuated from 36.8°C at 6am to 37.1°C at 11am, to 37.8°C at 5pm and to 37.3°C at 9pm.

Tuesday 6 April 1999

39. On 6 April Mr Presow was transferred back to the general surgical ward. It was noted he was alert and comfortable.

40. Mr Presow's temperature recordings on 6 April were 37.8°C at 1am, 37.1°C at 5am, 37.5°C at 10am, 37.8°C in the axilla at 4pm, 37.7°C at 6pm and 36.9°C in the axilla at 9pm.

41. The profuse drainage of perineal fluid continued. Cultures for blood taken on 4 April showed Enterobacter cloacae. Mr Presow's antibiotic treatment was changed to Ciprofloxacin.

Wednesday 7 April 1999

42. The nursing notes from the night shift state: "pt oozing +++, smelt of urine, brown in colour" and "fluid squirting out of perineal wound". Dr A noted Mr Presow had tachycardia consequent upon atrial fibrillation and tachypnoea. The perineal wound was sutured again by Dr A who also noted Mr Presow was acidotic. Sodium bicarbonate was administered.

43. Throughout 7 April Mr Presow's temperature was recorded as 37.1°C at 6am, 38.4°C in the axilla at noon, 37.9°C in the axilla at 4pm, 37.2°C at 8pm, and 37.4°C at midnight.

Thursday 8 April 1999

44. Mr Presow remained unwell. The nursing notes for the night shift record "moderate serous ooze" from the perineal wound. Mr Presow's urine output was satisfactory this day.

Throughout the day no significant perineal ooze was noted but on the night of 8 April there was again copious amounts of fluid draining from the perineum.

45. Dr A ordered an albumin infusion. A chest xray showed some left basal consolidation and effusion and small effusion in the right base.

46. Mr Presow's temperature recordings for this day were 37.4°C at 6am, 38°C at noon, 38.4°C at 4pm and 38°C at 10pm. It was thought Mr Presow's temperature changes originated from a chest infection. Dr A responded to this possibility by increasing the dose of Ciprofloxacin.

Friday 9 April 1999

47. Mr Presow's condition was noted to have improved slightly on 9 April. No discharge from the perineal wound was recorded during the day, although the night shift nursing staff had noted "perineal area ++ 0600, pad and bedding changed".

48. The temperature recordings were 37.4°C at 6am, 38.2°C at 1pm, 37.1°C at 4pm and 37.4°C at 9pm.

Saturday 10 April 1999

49. On the morning of 10 April Mr Presow went for a shower. Whilst he was in the bathroom Mr Presow collapsed from a cardiac arrest. He was resuscitated and taken to the HDU. After he was stabilised Mr Presow was transferred by helicopter to Wellington Hospital Intensive Care Unit ("ICU").

Wellington Hospital

50. Mr Presow remained in Wellington Hospital from 10 April to 17 April when he was transferred to the Hutt Hospital because of demands on space in the Wellington Hospital's ICU.

51. Throughout his time in Wellington Hospital Mr Presow was in a serious condition. On his arrival he was diagnosed as suffering septicaemic shock resulting from intra-abdominal infected fluid. On 12 April Mr Presow's condition deteriorated further. A laparotomy was performed and swabs taken from purulent fluid in the abdominal wall. During this procedure the consultant surgeon observed multiple serosanguinious fluid collections in the left iliac fossa and dirty ascitic fluid around the liver. The next day Mr Presow was profoundly unwell. He was in renal failure with significant metabolic acidosis. Mr Presow had clear evidence of ongoing sepsis. By 14 April Mr Presow's condition began to stabilise. On 15 April a venal caval filter was inserted.

Hutt Hospital and Remedial Surgery

52. Mr Presow was in Hutt Hospital between 18 April and 1 May 1999. His condition slowly improved but he continued to drain between 1,000 and 2,000mls of clear fluid from the perineum each day. On 29 April urea tests showed that the fluid coming from the perineum was urine.

53. On 2 May Mr Presow was referred back to Wellington Hospital for a urology examination. An intravenous urogramme and CT of the abdomen and pelvis indicated Mr Presow had suffered a right ureteric injury. A nephrostomy was performed on 10 May into the collecting system of the right kidney. Following this the drainage of urine from the perineum was rectified. Mr Presow was finally discharged from hospital on 13 May 1999.

Summary of Medical Evidence

54. To appreciate the issues before the Tribunal it is helpful to summarise the medical evidence during the period 27 March 1999 to 10 April 1999. This task is best approached by examining the medical evidence under the following headings:

Temperature recordings
Fluid loss
White blood cell changes
Nurses observations

Other clinical evidence

Clinical observations

Temperature Recordings

55. Mr Presow's temperature during the period in question fluctuated significantly. The following table records his highest and lowest temperatures each day from 27 March to 10 April (inclusive)

March	**27**	**28**	**29**	**30**	**31**	**April 1**	**2**	**3**	**4**	**5**	**6**
High	37.5	38	37.4	37.6	37.7	37.9	37.6	38.5	40.2	37.8	37.8
Low	37	37.3	37.1	36.2	37	36.5	36.8	37.4	36.2	36.8	36.9

April	**7**	**8**	**9**	**10**
High	38.4	38.4	38.1	38
Low	37.1	37.1	37.2	37.2

56. On many days there were also significant fluctuations in between the temperatures recorded in this table.

Fluid Loss

57. Mr Presow's fluid loss during the days in question was an important factor in the case. Of particular significance was Mr Presow's loss of fluid from his perineal wound from 31 March to 4 April. Precise details of Mr Presow's fluid intake and loss were not recorded on every day he was in xx Hospital. A record of fluid loss from the perineal wound did not commence until 31 March. The recorded fluid intake and loss (in mls) is summarised in the following table. The notation (NR) refers to days where no record was made:

Intake March	26	27	28	29	30	31	April 1	2	3
Oral	NR	NR	250	210	300	770	1200	NR	NR
Parenteral	19003	5077	3240	3020	2750	2250	560	NR	NR
(Total)	19003	5077+	3490	3230	3050	3029	1760	NR	NR
Output									
Urine	1173	1815	1537	1458	690	790	1630	1770	1320
Haemovac Colostomy + 02 Blood Loss	1900 8000	1020	30	NR	340 aspirate 100	650	80	(HPF)	50
Perineal	NR	NR	NR	NR	++++	700	2050	1050	1200++
(Total)	11073	2835	1567	1458	1130	2170	3760	2820	2570

Intake April	4	5	6	7	8	9
Oral	300+ ice	525	755	1150	120	690
Parenteral	2300	2380	2100	2200	2500	1020
(Total)	2600	2905	2855	3350	2650	1710
Output						
Urine	1023	514	600	817	1960	895
Haemovac Colostomy	550	1875	1310	50	400	1100
Perineal	300++	++	NR	NR	NR	NR
(Total)	1873	2389++	1910	867	2360	1995

White Blood Cell Changes

58. xx Hospital's laboratory analysed blood samples taken from Mr Presow on eight of the days he was in xx Hospital. There were significant changes to Mr Presow's white blood cell count during the days focused upon by the Tribunal. Those changes are summarised in the following table which also records the neutrophils component of the total white blood

cell count. The table also denotes high and low readings. There were two analyses done on 5 April:

	March 27	28	31	April 4	5	5	6	7	8	9
WBC	7.7	9.3	10.1	3.7(L)	36.9(H)	38.5(H)	29.8(H)	26.6(H)	14.8(H)	9.7
Neutrophils	NR	7.4(H)	NR	3.1	35.0(H)	36.4(H)	25.0(H)	25.1(H)	12.4(H)	NR

Nurses Observations

59. The nurses observations (as recorded in the nursing care progress sheets) contained a number of observations, the most pertinent of which relate to the fluid loss from Mr Presow's perineal wound. The principal observations were:

59.1 29 March (2302 hrs)

"… perineal wound clear – but large haemoserous ooze when stood up to get in chair, further large amount of ooze when perineal wound gently pressed …"

59.2 30 March (0600 hrs)

"Feeling miserable (his words) …"

"+++ perineal ooze. Pink stained."

59.3 30 March (1300 hrs)

"… perineal oozing copious amounts, pouring out when standing, or pressure applied. Dark blood stained fluid"

"…perineal wound left open due to ooze … pad and [incontinent] sheet used to absorb ooze".

59.4 30 March (2305 hrs)

"… continues to ooze large amounts of haemoserous ooze"

59.5 31 March (0700 hrs)

"Perineal ooze is very large amount. Have left blue and draw sheets in sluice for surgeon to review a/m".

59.6 31 March

"[seen by] Dr A, perineal loss assessed and discussed, possible serous ooze due to ascites. Drain inserted into wound … same draining blood stained ooze".

59.7 1 April

0600 hrs *"Drain in perineum – drained 450mls"*

1345 hrs *"Perineal drain 1000 mls blood/serous fluid"*

59.8 2 April (1400 hrs)

"Comfortable [this] duty … perineal drain 600 mls blood/serum …mod ooze blood perineal area initially this am then settled".

59.9 3 April (1330 hrs)

"Perineal drain – 300 mls blood stained".

"satisfactory. [seen by] Dr A, making good progress. Perineal drain removed as blood ooze present. …Drain 500 mls serous/blood ooze.

pm *"Perineal drain = 400 mls"*

59.10 4 April (1230 hrs)

am *"Perineal drain 700 mls of blood stained"*

"Perineal drain removed"

"[patient] condition deteriorating – transfer to HDU at 12.30 hrs".

"Perineal wound – draining bloody serous ooze".

"+++ drainage from perineal wound changed x2 this duty".

59.11 5 April (0600 hrs)

"Perineal pad changed x 1, having soaked with haemoserous ooze? Smells of urine".

59.12 5 April (1300 hrs)

"Condition remains unchanged though improving slightly…"

"Perianal wound resutured, pad and pants insitu – scant ooze since"

59.13 6 April

Condition stable overnight …. Perineal drainage – serous, slightly blood stained (copious) … mood bright"

59.14 6 April (am)

"Perianal wound resutured yesterday am 1 x small area continues to ooze copious amounts of haemoserous ooze … Pad and pants insitu".

"Perianal wound ooze moderate. Pad change and draw sheet".

59.15 7 April (0630 hrs)

"Moderate ooze from perianal area, changed x1"

"[Patient] oozing ++++ smelt of urine, brown in colour"

59.16 7 April

"Fluid 'squirting' out of perianal wound"

"Extra suture inserted in rectum wound. Rectum continues to ooze ++. pad insitu"

59.17 7 April (2230 hrs)

"Perineal wound moderate serous ooze"

59.18 8 April (0700 hrs)

"Looks shocking (since last Tuesday) …"

59.19 8 April (1400 hrs)

"Perineal wound – scant ooze …pad insitu""

59.20 8 April (2215 hrs)

"Perianal ooze <u>copious</u> amounts linen change x4 soaked through".

59.21 9 April (0600 hrs)

"Peritoneal area +++ … pad and bedding changed".

59.22 9 April (am)

Slight improvement … Nil ooze from perineal wound"

59.23 9 April (2230 hrs)

"Remains poorly …. Nil perineal ooze. Suture line dry".

Other Clinical Evidence

60. On 4 April Dr A arranged for swabs to be taken from Mr Presow's anal cavity. A drain tip in the anal area was also sent to the laboratory for analysis. All the lab reports showed heavy growth of Enterobacter cloacae a potentially lethal bacteria that in all likelihood originated from Mr Presow's bowel.

61. On 4 April arterial blood gases were analysed which showed a high PH concentration (7.52) and low bicarbonate (20.0).

62. The clinical notes indicate chest xrays were commented upon or planned for on 27, 29, and 31 March as well as on 4, 7 and 8 April. Only two post operative radiology reports were on the medical file made available to the Tribunal. The report for 7 April indicated *"left lower lobe pneumonic consolidation and moderately small left pleural fluid collection… the left lung remains clear except for linear atelectatic streaks right lateral costophrenic angle".*

63. On 7 April Mr Presow developed thrush in his mouth. The following day Mr Presow was found to have a herpes infection.

Clinical Observations

64. The Tribunal carefully examined Dr A's written observations, and the notes of his registrar, house surgeon and other doctors who saw Mr Presow post operatively. The following comments are extracted from the clinical notes.

64.1 28 March

Among the observations for 28 March is a reference to Mr Presow's elevated temperature and *" early pneumonia".*

64.2 29 March

Dr A noted*: "satisfactory general condition and vital signs. May be transferred to Ward 2".*

64.3 30 March

Dr A noted*: "better today … serous ooze perineal wound … vitals stable"*

64.4 31 March

Dr A noted: "*some nausea and vomiting. Perineum continues to ooze*".

64.5 1 April

The clinical notes record Mr Presow was "*doing well*"

64.6 2 April

Dr A noted "*continues to progress well*"

64.7 3 April

Dr A's notes for 3 April say Mr Presow: "*continues to progress well.*

He also noted: … *there is still some ascitic fluid*".

64.8 4 April

An unsigned record (not made by Dr A) in the clinical notes records Mr Presow's rapid deterioration including his temperature change from 36.5 to 38 °C in 10 minutes.

Dr A's notes for 9:30 on 4 April refer to Mr Presow's temperature fluctuation and that Mr Presow may be suffering "*septicaemia most likely from the pelvic area*". At 1pm Dr A noted Mr Presow's temperature had spiked to 40 degrees.

Dr A's notes for 8pm say: *"subjectively he feels better"*. The notes also refer to *"more ascites"* and *"serous fluid from perineum ++"*.

64.9 5 April

Dr A's notes say Mr Presow *"looks better than yesterday … temp is normal …still tachypnoeic but better than yesterday … Perineum leaking serous fluid, otherwise the wound and area shows no signs of acute infection"*.

64.10 6 April

Dr A recorded: *"Some perineal ooze"*. He also noted that the lab report of Enterobacter cloacae and the white blood cell results.

64.11 7 April

Dr A referred to *"serous pink leakage"* from the perineal wound.

64.12 8 April

In notes by a staff member when Dr A saw Mr Presow on 8 April there is a reference to Mr Presow's elevated temperature the previous day. The note continues: *"… probably from chest. Exclude urine infection"*.

Summary of Case for Director of Proceedings

65. The Director of Proceedings called one witness, Professor Iain Martin, a consultant general surgeon at Middlemore Hospital in Auckland, and Head of the Department of Surgery at the University of Auckland. Professor Martin's principal qualifications are:

MBChB (Leeds)	1987
FRCS	1992
MD (Leeds)	1996
FRACS	2001

Professor Martin's professional focus is in upper gastrointestinal surgery. He does not perform rectal surgery on recurrent cancer patients but is nevertheless qualified to comment on Mr Presow's post operative care and treatment. The issues raised by the charge fall squarely within Professor Martin's area of expertise.

66. Professor Martin carefully examined Dr A's care of Mr Presow and in doing so concluded the right ureter was damaged during the course of Mr Presow's operation. Professor Martin did not criticise Dr A for damaging the right ureter. Professor Martin said: *"This was a technically very difficult operation and even [during] far more straight forward pelvic surgery, the ureters can be injured"*.

67. Professor Martin analysed the complications which occurred in Mr Presow's case as a result of the damaged ureter and/or the sepsis which occurred as a result of that injury. Those complications were:

67.1 Excessive draining from the perineal wound

67.2 A septic episode including severe respiratory disease on 4 April 1999

67.3 A thrush infection

67.4 The development of herpes

67.5 A pulmonary embolism on 10 April 1999

67.6 The insertion of a nephrostomy tube into Mr Presow's kidney

67.7 The failing of [Mr Presows] kidneys

67.8 A coronary.

68. Professor Martin was in no doubt that Dr A should have been alerted to the likelihood of ureteric damage when persistent and large volumes of fluid were seen coming from the perineum. Professor Martin also said a test for urea content of the fluid coming from the

perineum would have indicated that it was urine (seeping from the damaged ureter) and that this should have been done within the first four to five days after surgery.

69. Professor Martin was firmly of the view Mr Presow had swinging pyrexia from 30 March onwards. He told the Tribunal Dr A should have been alerted to the possibility of Mr Presow suffering an abscess or an infected fluid collection by the "peaks and troughs" in Mr Presow's temperature chart. Professor Martin told the Tribunal that in 1999 the possibility of an infected fluid collection should have been assessed by CT scan. He also said: *"If appropriate facilities to investigate and manage such a patient were not available at xx Hospital, then transfer to a larger hospital should have been arranged."*

70. In his evidence in chief Professor Martin summarised his assessment of the matters at issue in this case in the following way:

> *"In my opinion Dr A should have considered the possibility of a urinary leak at an earlier stage. The fluid discharge was by all accounts copious and was on at least one occasion thought to be urine …*
>
> *It is straight forward for a laboratory to assess the urea level in such fluid and this would have easily and rapidly confirmed the diagnosis. It was clear that the urinary tract had been injured at the time of the operation and this in itself should, I believe, have resulted in appropriate investigations …*
>
> *I think the large volumes leaking from 1 April, the 4th post operative day should have resulted in such investigations … the failure to recognise a possibility that this was a urinary leak contributed very significantly to Mr Presow's septic complications.*
>
> *There is in my opinion no doubt that Mr Presow had obvious evidence of ongoing significant infection. This was manifested initially by a pattern of raised temperature that I would regard as swinging pyrexia, and a raised white cell count in the blood. This coupled with the documented deterioration in Mr Presow's condition should have resulted in a concerted effort to determine the cause of the problem. On 3 and 4 April 1999 Mr Presow was obviously very unwell. The clinical features are those of septicaemia.*

> *Whilst there are many causes of such a clinical picture after major surgery, a significant abdominal pelvic collection would be at the forefront of most colorectal surgeons minds at this stage. This, I believe should have been investigated, and the most appropriate technique would have been CT scanning. As this was not available in xx Hospital, I believe Mr Presow should have been transferred to a major centre at that stage. There was no clinical reason why the transfer should not have taken place on 4 April, some six days earlier than it eventuated".*

71. The Tribunal will refer again to Professor Martin's evidence when explaining the reasons for finding the charge proven.

Summary of Dr A's Case

72. Dr A gave evidence and also called as an expert Mr Stephen Vallance a general surgeon at Wairau Hospital in Blenheim. It is convenient to summarise Mr Vallance's evidence before summarising the evidence given by Dr A.

73. Mr Vallance is also an English trained surgeon. His qualifications are:

MBChB (Birmingham)	1970
FRCS (England)	1977
FRCS (Edinburgh)	1977
MD (Birmingham) 1985	
FRACS	1986

74. Like Professor Martin, Mr Vallance is in no doubt the ureter was damaged during Mr Presow's surgery. In Mr Vallance's view this *"almost certainly"* occurred at the time the injury to the bladder was being repaired. Mr Vallance also thought it would have been difficult to recognise the ureteric injury at the time.

75. Mr Vallance thought Dr A's post operative care of Mr Presow was "exemplary". Mr Vallance referred to the fact Dr A visited Mr Presow twice daily and that he was immediately available at all times if there were any concerns. Mr Vallance noted that although Mr Presow's recovery was slow he appeared to be making gradual improvement until 4 April when Mr Presow *"became very definitely septic"*. In his evidence in chief

Mr Vallance said that while the continuous perineal loss was certainly more than would have been expected, the fluid coming from the perineum did not appear to be grossly infected. Mr Vallance referred to Mr Presow's urinary output as being satisfactory until 4 April when it dropped significantly. Mr Vallance said this could be explained by the onset of sepsis.

76. Mr Vallance thought Mr Presow had post operative pyrexia but he also said it was not uncommon for spikes in temperature to occur post operatively and that there can be a number of reasons for this (including atelectasis – areas of lung collapse).

77. Mr Vallance said:

> *"It is noticeable that despite [Mr Presow's] temperatures, his white cell count which is a helpful marker for significant infection, remained within the normal range from the time of surgery until the 5th April … the lack of elevation of the white cell count in the first 7 post operative days along with the general improvement of the patient during this period would not have indicated a specific need for investigation. But his subsequent investigations were appropriate to the resources of xx Hospital at the time. Without the benefit of a CT scan and the significant changes on his chest xrays a respiratory cause of his sepsis was not unreasonable. He was certainly given a full range of antibiotics and appropriate intravenous fluids and other support".*

Mr Vallance also advised the Tribunal that in his opinion, Mr Presow's sepsis was most likely to be a secondary consequence of infected haematoma following the extensive intraoperative bleeding.

78. The Tribunal will refer again to Mr Vallance's expert evidence later in this decision.

79. Dr A provided the Tribunal with a comprehensive description of the events that occurred after Mr Presow's operation and the reasons for the steps and actions he took.

80. Dr A acknowledged that *"while Mr Presow improved initially, his latter post operative days proved stormy. He suddenly deteriorated developing an infection and septicaemia which appeared to have commenced, in retrospect on 3 April …".*

81. Dr A told the Tribunal that on a number of occasions he wondered if the fluid that was draining from the perineum was due to ascites or if it contained urine. However, Dr A said that the fluid he saw was not clear fluid and that it contained blood and serum. He said: *"On several occasions I smelt the fluid but it did not smell as urine"*.

82. Dr A recalled nurses raised with him the possibility that the fluid oozing from Mr Presow's perineum may have contained urine. Dr A said he asked his registrar to inquire with the laboratory to see if the perineal fluid could be tested for urine. Apparently the laboratory reported via the registrar that it would be difficult to determine whether or not the fluid from the perineum was urine. Dr A also told the Tribunal:

> *"If I had seen persistent drainage of large volumes of clear fluid, then this would have alerted me to the possibility of a urinary fistula, however that was not the presentation Mr Presow had"*.

83. In relation to Mr Presow's fluctuating temperature Dr A told the Tribunal that he treated Mr Presow with prophylactic antibiotics, and that further infection was treated with antibiotics when necessary. Dr A explained that because xx Hospital did not have a CT scanner he:

> *"… had to consider whether or not the limited information that could have been obtained from a scan would have [justified] transferring Mr Presow to Wellington Hospital or Wakefield Radiology …. Because, at the time, Mr Presow's condition was relatively stable, he would have had to travel by road as opposed to helicopter, to Wellington over the xx. One has to balance the need for such a scan against the possibility of a diagnosis being provided, and against … any deterioration in the patient's condition caused by travelling what is a reasonably arduous journey."*

84. Dr A also explained that Mr Presow's case was discussed at xx Hospital grand round on Tuesday mornings. The grand round was attended by all three surgeons and medical staff. When Mr Presow's case was discussed Dr A said: *"… no issues out of the ordinary were raised"*. Dr A also told the Tribunal he discussed Mr Presow's case with Mr A by telephone on Sunday 4 April.

85. Other aspects of Dr A's evidence will be referred to later in this decision.

Evaluation of Evidence

86. The Tribunal has very carefully evaluated the evidence presented to it and taken into account the submissions made by counsel for the respective parties.

87. In assessing the evidence the Tribunal has generally accepted that the contemporaneous records accurately reflect the events and observations recorded in those documents. In particular the Tribunal has been helped by Dr A's clinical notes and the records kept by the nursing staff.

88. In this case the Tribunal has had the benefit of two independent experts who have provided the Tribunal with carefully considered opinions. Although the Tribunal is very mindful that Mr Vallance practises in a setting similar to that which Dr A experienced at xx Hospital, the Tribunal has preferred Professor Martin's analysis of the steps Dr A should have taken to determine the causes of Mr Presow's swinging pyrexia and the cause of the discharge of the large volumes of fluid from Mr Presow's perineal cavity. The Tribunal's reasons for preferring Professor Martin's evidence on these two topics is explained later in this decision. Notwithstanding the Tribunal's preference for Professor Martin's evidence on these topics the Tribunal is extremely grateful to Mr Vallance for his having taken the time to give the evidence which he provided to the Tribunal.

Standard of Proof

89. The allegations levelled against Dr A are not as serious as many of the charges the Tribunal is required to determine. The onus placed upon the Director of Proceedings to establish the charge in this case requires the Director of Proceedings to prove the charge on the balance of probabilities.

90. The requisite standard of proof in medical disciplinary cases was considered by Jeffries J in *Ongley v Medical Council of New Zealand*[4] where the High Court adopted the

[4] (1984) 4 NZAR 369

following passage from the judgment in *Re Evatt: ex parte New South Wales Bar Association*[5]

> *"The onus of proof is upon the Association but is according to the civil onus. Hence proof in these proceedings of misconduct has only to be made upon a balance of probabilities; Rejfek v McElroy.*[6] *Reference in the authorities to the clarity of the proof required where so serious a matter as the misconduct (as here alleged) of a member of the Bar is to be found, is an acknowledgement that the degree of satisfaction for which the civil standard of proof calls may vary according to the gravity of the fact to be proved".*

91. The same observations were made by a full bench of the High Court in *Gurusinghe v Medical Council of New Zealand*[7] where it was emphasized that the civil standard of proof must be tempered "having regard to the gravity of the allegations". This point was also made by Greig J in *M v Medical Council of New Zealand (No.2)*[8]:

> *"The onus and standard of proof is upon the[respondent] but on the basis of a balance of probabilities, not the criminal standard, but measured by and reflecting the seriousness of the charge".*

In *Cullen v The Medical Council of New Zealand*[9] Blanchard J adopted the directions given by the Legal Assessor of the Medical Practitioners Disciplinary Committee on the standard required in medical disciplinary fora.

> *"The MPDC's legal assessor, Mr Gendall correctly described it in the directions which he gave the Committee:*
>
> > *"[The] standard of proof is the balance of probabilities. As I have told you on many occasions, … where there is a serious charge of professional misconduct you have got to be sure. The degree of certainty or sureness in your mind is higher according to the seriousness of the charge, and I would venture to suggest it is not simply a case of finding a fact to be more probable than not, you have got to be sure in your own mind, satisfied that the evidence establishes the facts".*

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5 (1967) 1 NSWLR 609
6 [1966] ALR 270
7 [1989] 1 NZLR 139 at 163
8 Unreported HC Wellington M 239/87 11 October 1990
9 Unreported HC Auckland 68/95, 20 March 1996

92. Although in this case the onus on the Director of Proceedings is to prove the charge on the balance of probabilities the Tribunal records that in finding the charge of professional misconduct established it believes the evidence against Dr A is compelling. The Director of Proceedings has surmounted the burden of proof hurdle by a considerable margin.

Professional Misconduct

93. In recent years, those attempting to define professional misconduct have invariably commenced their analysis by reference to the judgment of Jefferies J in *Ongley v Medical Council of New Zealand*[10]. In that case his Honour formulated the test as a question:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? … 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 position of the Tribunal which examined the conduct."*

93. In *Pillai v Messiter* [No.2][11] the New South Wales Court of Appeal signalled a slightly different approach to judging professional misconduct from the test articulated in *Ongley*. In that case the President of the New South Wales Court of Appeal considered the use of the word "misconduct" in the context of the phrase "misconduct in a professional respect". In his view, the test required more than mere negligence. At page 200 of the judgment Kirby P. stated:

> *"The statutory test is not met by mere professional incompetence or by deficiencies in the practice of the profession. Something more is required. It includes a deliberate departure from accepted standards or such serious negligence as, although not deliberate, to portray indifference and an abuse of the privileges which accompany registration as a medical practitioner."*

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[10] supra.

[11] (1989) 16 NSWLR 197.

94. In *B v The Medical Council*[12] Elias J said in relation to a charge of "conduct unbecoming" that:

> *"… it needs to be recognised conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards".*

Her honour then proceeded to state:

> *"That departure must be significant enough to attract a sanction for the purposes of protecting the public. Such protection is a basis upon which registration under the Act, with its privileges, is available. I accept the submission of Mr Waalkens that a finding of unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which is unfair to impose. The question is not whether the error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligation."*

Her Honour also stressed the role of the Tribunal and made the following invaluable observations:

> *"The inclusion of lay representatives in the disciplinary process and the right of appeal to this Court indicates the usual professional practice while significant, may not always be determinative: the reasonableness of the standards applied must ultimately be for the Court to determine, taking into account all the circumstances including not only usual practice, but patient interest and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards."*

95. In *Staite v Psychologists Board*[13] Young J traversed recent decisions on the meaning of professional misconduct and concluded that the test articulated by Kirby P in *Pillai* was the appropriate test for New Zealand.

96. In referring to the legal assessor's directions to the Psychologists Board in the *Staite* case, Young J said at page 31:

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12 Unreported HC Auckland , HC11/96, 8 July 1996

13 (1998) 18 FRNZ 18.

> *"I do not think it was appropriate to suggest to the Board that it was open, in this case, to treat conduct falling below the standard of care that would reasonably be expected of the practitioner in the circumstances – that is in relation to the preparation of Family Court Reports as professional misconduct. In the first place I am inclined to the view that "professional negligence" for the purposes of Section 2 of the Psychologists Act should be construed in the Pillai v Messiter sense. But in any event, I do not believe that "professional negligence" in the sense of simple carelessness can be invoked by a disciplinary [body] in [these] circumstances …".*

97. In *Tan v Accident Rehabilitation Insurance Commission*[14] Gendall and Durie JJ considered the legal test for "professional misconduct" in a medical setting. That case related to a doctor's inappropriate claims for ACC payments. Their Honours referred to *Ongley* and *B v Medical Council of New Zealand.* Reference was also made in that judgment to *Pillai v Messiter* and the judgment of Young J in *Staite v Psychologists Registration Board.*

98. In relation to the charge against Dr Tan the Court stated at page 378:

> *"If it should happen that claims are made inadvertently or by mistake or in error then, provided that such inadvertence is not reckless or in serious disregard of a practitioner's wider obligations, they will not comprise "professional misconduct". If however, claims for services are made in respect of services which have not been rendered, it may be a reasonable conclusion that such actions fell seriously short of the standard required of a competent and reasonable practitioner. This may be especially the case if such claims are regularly made so as to disclose a pattern of behaviour".*

99. The Tribunal has now stated on a number of occasions[15], the test as to what constitutes professional misconduct has changed since Jefferies J. delivered his judgment in *Ongley*. In the Tribunal's view the following are the crucial considerations when determining whether or not conduct constitutes professional misconduct:

- The first portion of the test involves an objective evaluation and answer to the following question:

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14 (1999) NZAR 369

15 *Van Rhyn* 214/01/74C, 26 November 2002*; Frizelle*, 219/02/94D 3 December 2002, D221/02/97C 14 May 2003

Has the doctor so behaved in a professional capacity that the established acts and/or omissions under scrutiny would be reasonably regarded by the doctor's colleagues and representatives of the community as constituting professional misconduct?

- If the established conduct falls below the standard expected of a doctor, is the departure significant enough to attract a disciplinary sanction for the purposes of protecting the public and/or protecting the standards of the medical profession and/or punishing the practitioner?

100. The words "representatives of the community" in the first limb of the test are essential because today those who sit in judgment on doctors comprise three members of the medical profession, a lay representative and chairperson who must be a lawyer. The composition of the medical disciplinary body has altered since Jeffries J delivered his seminal decision in *Ongley*. The new statutory body must assess a doctor's conduct against the expectations of the profession and society. Sight must never be lost of the fact that in part, the Tribunal's role is one of setting standards and that in some cases the communities' expectations may require the Tribunal to be critical of the usual standards of the profession.[16]

101. Recently, in *McKenzie v MPDT*[17] the High Court endorsed the two question approach taken by the Tribunal in determining whether or not a practitioner is guilty of professional misconduct. In the same judgment the High Court cautioned against reliance in this country upon the recent judgment of the Privy Council in *Silver v General Medical Council*[18]

102. The Tribunal has assessed Dr A's conduct by answering the questions posed in paragraph 99 in relation to each particular allegation in the notice of charge.

Tribunal's Findings in Relation to Each Particularised Allegation in the Charge

103. The summary of the medical evidence set out in paragraphs 54 to 64 inclusive of this decision demonstrates Dr A was confronted with a matrix of information which he needed

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[16] *B v Medical Practitioners Disciplinary Tribunal* (supra); *Lake v The Medical Council of New Zealand* (unreported High Court Auckland 123/96, 23 January 1998, Smellie J) In which it was said: "If a practitioner's colleagues consider his conduct was reasonable the charge is unlikely to be made out. But a Disciplinary Tribunal and this Court retain in the public interest the responsibility of setting and maintaining reasonable standards. What is reasonable as Elias J said in *B* goes beyond usual practice to take into account patient interests and community expectations".

[17] Unreported, High Court Auckland, CIV 2002 – 404 – 153 –02 Venning J, 12 June 2003

[18] 2003 [UK]PC 33

to carefully evaluate. Notwithstanding that Dr A was faced with a wide range of clinical data and observations, the Tribunal is in no doubt that by at least 4 April Dr A should have been very concerned about the discharge of large volumes of fluid from Mr Presow's perineum and the swinging pyrexia. The Tribunal is also very satisfied Dr A failed to adequately investigate the cause or causes of these conditions. Whilst Dr A was undoubtedly concerned about Mr Presow and very attentive, he nevertheless adopted a limited view of the patient's circumstances. He did not recognise that a ureteric injury may have occurred, nor did he properly investigate fluid leaking from the perineum or that fluid accumulating in the abdomen was contributing to sepsis.

First Particular - **Between 27 March and 10 April Dr A failed to adequately investigate the cause of causes of discharge of large volumes of fluid from Mr Presow's perineum.**

104. The medical evidence summarised in paragraphs 57 and 59 of this decision clearly demonstrate that by 31 March Mr Presow was discharging large volumes of fluid from the perineal wound. On 31 March 700mls were recorded as having been discharged from the perineal wound. The next day the discharge was dramatic – namely 2.05 litres. The following day a little over 1 litre was recorded as having been discharged from the perineal site. From 29 March onwards nurses documented their concerns about the discharge of large volumes of fluid from the perineal wound. They described the volume of discharge in no uncertain terms. They used the adjectives "large" and "copious" to describe the volume of fluid they observed coming from Mr Presow's perineal wound.

105. In his evidence in chief Dr A said that:

> *"If [he] had seen persistent drainage of large volumes of clear fluid, then this would have alerted [him] to the possibility of a urinary fistula, however that was not the presentation Mr Presow had".*

When cross examined on this point Dr A accepted there was a persistent drainage of fluid from Mr Presow's perineal wound. He also explained the colour of the fluid was not

consistent – he said that on some days the fluid was clear and that on other occasions it was pink or brown.[19]

106. Although Dr A acknowledged that the volume of fluid coming from the perineal wound on 1 April was significant,[20] he also said that the fact that this discharge occurred on the 5th post operative day reduced the importance of the discharge. The Tribunal understood Dr A to be suggesting that at the time he thought the large volumes of fluid recorded as coming from the perineal wound on 1 and 2 April was due to ascites. He acknowledged however that in retrospect this was not correct.[21] Dr A also questioned the nurses' descriptions of the volumes of fluid they observed.[22] Dr A did not think the recorded discharge from the perineal wound on 2 April (1050 mls) was a large amount.[23]

107. During cross examination it became apparent Dr A did not regard the discharge of fluid from the perineal wound on 31 March and 2 April as significant. Furthermore it appeared to the Tribunal Dr A thought the discharge on 1 April was due to ascites. Dr A's assessment of the significance he placed on the fluid coming from the perineal wound helps explain why Dr A did not take reasonable steps to ascertain the cause or causes of the large discharge that was in fact coming from Mr Presow's perineal wound.

108. The Tribunal observed Dr A did acknowledge that if there was a leak in Mr Presow's ureter then the fluid which drained into the abdominal cavity could be mixed with blood and present as a pink or brown coloured fluid.[24] Dr A also agreed that on at least two occasions he was told by nurses that the fluid coming from Mr Presow's perineal wound smelt of urine, and on at least one occasion Dr A smelt the fluid himself (but did not detect urine).

109. The Tribunal was concerned that the first reference in the clinical notes to Dr A thinking Mr Presow's sepsis might be attributable to a urine infection did not occur until 8 April. Even

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19 Transcript p60 lines 1-9
20 Transcript p.61 line 18
21 Transcript p.62 line 1
22 Transcript p.63 lines 11 to 16
23 Transcript p.64 lines 3-7
24 Transcript p.69 lines 10-15

then the reference to "excluding urine infection" related only to a suspected infection within Mr Presow's chest.

110. The Tribunal has taken full account of Mr Vallance's acknowledgement that "*…the continued perineal fluid loss was certainly more than would be expected …"* but finds itself disagreeing with Mr Vallance's explanations as to why Dr A did not investigate the cause or causes of the discharge. Mr Vallance suggested two reasons for this, namely that the fluid was clear and, that there was no evidence that Dr A had been told the fluid smelt of urine.

111. Mr Vallance's understanding in relation to both these matters is not accurate. Dr A acknowledged being told on at least two occasions that the fluid smelt like urine, and he also told the Tribunal that the fluid was not always clear – on occasions it was pink or brown. Even if Mr Vallance's opinion had been based upon a full appreciation of the facts the Tribunal would have disagreed with his assessment of Dr A's conduct. If Mr Vallance was suggesting Dr A's conduct complied with usual professional standards then the Tribunal respectfully disagrees. If other surgeons could justify Dr A's actions then the Tribunal would be obliged to say the purported standards do not comply with the Tribunal's expectations. In making these observations the Tribunal is mindful that part of its role involves the setting of reasonable standards (refer paragraph 94 of this decision).

112. The Tribunal observed there is no record in the notes of Dr A considering transferring Mr Presow to Wellington for a CT scan to determine the cause or causes of the discharge of the large volumes of fluid draining from the perineal wound. Dr A said that referring a patient for a CT scan in Mr Presow's circumstances needed to be balanced against the practicalities of transferring the patient by road to Wellington and whether a CT scan would provide a diagnosis. What is important is that there is no contemporaneous evidence that Dr A actually considered transferring Mr Presow to Wellington. Dr A acknowledged he did not consider transferring Mr Presow to Wellington on 4 April.[25]

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[25] Transcript p.91 l.24

113. The Tribunal is in no doubt Dr A did not take any steps to refer Mr Presow to Wellington for specialist care and treatment. The fact that Mr Presow could only undergo a CT scan in Wellington should have focussed Dr A's mind on the need for his patient to be transferred out of xx to a centre with the facilities Mr Presow required. At the very latest, this should have occurred on 4 April 1999.

114. The Tribunal fully agrees with Professor Martin's assessment that by 4 April most colorectal surgeons would have thought Mr Presow had a significant abdominal or pelvic collection of fluids which should have been investigated by CT scan. Because a CT scan is not available at xx Hospital Dr A should have taken steps to arrange for Mr Presow's transfer to Wellington on 4 April 1999.

115. Dr A's failure to take any steps to arrange for Mr Presow's transfer to Wellington on 4 April was a significant breach of the duty he owed his patient and was not the conduct which the Tribunal would expect of a surgeon of Dr A's position.

116. In relation to the first particular of the charge, all five members of the Tribunal found the first limb of the test of professional misconduct is established.

117. The Tribunal is not unanimous in its assessment of the second limb of the test of professional misconduct.

Three members of the Tribunal (Drs Douglas and Virtue and Ms Cole) believe that the second limb of the test for professional misconduct is satisfied in relation to the first particular of the charge. They believe Dr A's omissions were so serious that a disciplinary finding is warranted in relation to the first particular of the charge in order to maintain professional standards and to emphasise that the public's safety should not be compromised.

As will be seen later in this decision, the Chairperson and Dr Malpass are of the view Dr A's failings as described in the first particular of the charge do not by themselves justify a disciplinary finding. However, the Chairperson and Dr Malpass believe that when the

Tribunal's findings in relation to both particulars of the charge are viewed cumulatively a finding of professional misconduct is required.

Second Particular - Between 27 March 1999 and 10 April 1999 Dr A failed to adequately investigate the cause or causes of swinging pyrexia.

118. The summary of Mr Presow's temperature recordings in paragraphs 57 and 58 of this decision clearly shows that Mr Presow experienced swinging pyrexia from 27 March to 10 April. On occasions there were very profound fluctuations in Mr Presow's temperature.

119. Dr A accepted Mr Presow's temperature fluctuated above and below the normal range from 26 March to 10 April. Dr A did not however agree that Mr Presow's temperature fluctuations could be described as "swinging pyrexia". Dr A indicated that Mr Presow's temperature readings might be described as "swinging temperature",[26] at least in relation to the days when there were significant fluctuations in Mr Presow's temperature.

120. Dr A told the Tribunal that he believed Mr Presow's temperature variations were due to an infection in his left lung and/or possibly the pelvic region. Dr A's concerns about the possibility of an infection in Mr Presow's left lung was confirmed clinically and by x-ray[27] Dr A said that after the very high temperature spike of 40°C on 4 April he prescribed a regime of antibiotics that reduced Mr Presow's temperature. Dr A disagreed with Professor Martin's evidence that chest infections are usually associated with gradual temperature rises (as opposed to temperature swings).

121. It is apparent that Dr A did consider Mr Presow's temperature variations might be due to a pelvic infection. On 4 April Dr A wrote in the patient's clinical notes: *"septicaemia most likely from the pelvic area"*.

Dr A responded to this possibility by sending swabs and the tip of a catheter to the hospital laboratory for analysis. Two days later the laboratory confirmed the presence of Enterobacter cloacae.

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[26] Transcript p.69 l.19-28

[27] Transcript p.72 l. 1-5

122. Dr A's explanation for not further investigating the cause or causes of Mr Presow's swinging pyrexia was his belief that in general, Mr Presow's condition improved after 5 April. Dr A's general approach is summarised in the following portion of his evidence in chief:

> *"Following [Mr Presow's] return to Ward 2 [on 6 April] he started to have spikes of temperature to a maximum of 38°C but he was gradually looking better and we thought we needed to give a chance for the antibiotics to work. This usually needs about 3 days unless the general condition is not improving (which was not the case)".*

123. Mr Vallance had little hesitation in agreeing Mr Presow had swinging pyrexia as early as 30 March, and that this condition could be evidence of infected fluid in the abdomen.[28] However Mr Vallance supported Dr A's management of Mr Presow and suggested that the investigations carried out by Dr A were appropriate in light of the resources at xx Hospital at the time. Mr Vallance thought that in light of the radiology evidence " … *a respiratory cause of [Mr Presow's] sepsis was not unreasonable"*.

124. The Tribunal agrees Dr A did what he could reasonably do with the resources then available at xx Hospital. But that approach does not address the fundamental criticism levelled against Dr A namely, that he should have realised that Mr Presow required services that were not available at xx Hospital and that it was reasonable to have taken steps to arrange for his transfer to Wellington no later than 4 April. Mr Vallance was obliged to implicitly agree with the force of this proposition when he acknowledged that without obtaining a CT scan of the abdomen it would not have been possible to exclude the likelihood of septicaemia resulting from an infection in Mr Presow's abdomen.[29]

125. The Tribunal fully agrees with Professor Martin's observations that Dr A did not take appropriate steps to investigate Mr Presow's swinging pyrexia. Dr A recognised the likelihood of Mr Presow suffering septicaemia "from the pelvic area" on 4 April. However he did not take reasonable steps to ascertain the likely cause or causes of that condition. When Mr Presow's swinging pyrexia is viewed against the background of the substantial

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[28] Transcript p.109 l. 24-27

discharge of fluid from the perineal wound, then it was reasonable to expect Dr A to take positive steps to investigate the cause or causes of Mr Presow's swinging pyrexia. This should have involved Dr A taking steps to arrange for Mr Presow to be transferred to Wellington Hospital to enable a CT scan to be undertaken on 4 April.

126. In relation to the second particular in the notice of charge the Tribunal concludes Dr A's failure to arrange for Mr Presow's transfer to Wellington Hospital on 4 April was a significant breach of the duty he owed his patient and was not the conduct which the Tribunal would expect of a xx in Dr A's position.

127. In relation to the second particular of the charge, the Tribunal is satisfied the first limb of the test of professional misconduct is established.

128. As with the first particular, the Tribunal is not unanimous in its conclusion in relation to the second limb of the test of professional misconduct. Three members of the Tribunal (Dr Douglas, Dr Virtue and Ms Cole) believe that the second limb of the test of professional misconduct is satisfied in relation to the second particular of the charge. They believe that Dr A's omissions were so serious in relation to the second particular of the charge that a disciplinary finding is justified in order to maintain professional standards and uphold public safety.

129. The Chairperson and Dr Malpass are of the opinion that the breaches described in the second particular of the charge do not by themselves justify a finding of professional misconduct. However the Chairperson and Dr Malpass believe that when the established breaches identified in the first and second particulars of the charge are viewed cumulatively, a finding of professional misconduct is required in order to maintain professional standards and to protect public safety.

130. Although not all members of the Tribunal have followed the same route, they have reached the same destination. The Tribunal is unanimous that the charge of professional misconduct has been established.

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[29] Transcript p. 113 l. 15-21

Penalty

131. A medical practitioner found guilty of professional misconduct could normally anticipate the Tribunal imposing any one or more of the penalties set out in s.110(1)(b)-(f) of the Act.

132. In this case the Tribunal believes there are extenuating circumstances which justify the Tribunal imposing only an order for costs. The factors which have influenced the Tribunal in reaching this conclusion can be succinctly recorded:

132.1 Dr A has not previously appeared before any disciplinary body in this country. He deserves credit for his long and unblemished career.

132.2 Aside from the two matters focused upon during the hearing Dr A appears to have managed Mr Presow in a caring and professional manner. Aspects of Dr A's management of his patient were described as exemplary by the expert witnesses.

132.3 There was a very unsatisfactory delay in investigating the complaint and laying of the charge. A chronology provided to the Tribunal showed that the Health and Disability Commissioner received the complaint on 20 August 1999. The Commissioner's office wrote to Dr A seeking his response on 9 August 2000. Other delays occurred in investigating the complaint. The delays do not appear to be attributable in any material way to Dr A. It is very evident that delay in itself has caused considerable distress to Dr A. The Tribunal believes that delay can be fairly regarded as a punishment in this instance.

132.4 At the time he was working at xx Hospital Dr A was practising under oversight. The Tribunal believes that in the circumstances of this case proactive steps could have been taken by others at xx Hospital which may have resulted in a more timely transfer of Mr Presow to Wellington Hospital.

Costs

133. Section 110(1)(f) of the Act confers on the Tribunal jurisdiction to order a medical practitioner to pay part or all of the costs and expenses of and incidental to:

133.1 The investigation made by the Health and Disability Commissioner in relation to the subject matter of the charge.

133.2 The prosecution of the charge by the Director of Proceedings.

133.3 The hearing by the Tribunal.

134. In this case:

134.1	The costs of the investigation and prosecution of the charge by the Director of Proceedings were:	$26,608.21
134.2	The costs of the hearing by the Tribunal were:	$32,698.81

135. At the request of the Tribunal, counsel for both parties filed helpful submissions on the principles the Tribunal should follow when considering what, if any, costs should be ordered in this case.

136. The Tribunal believes a distinction can be drawn when assessing the costs Dr A should pay in relation to the costs incurred by the Health and Disability Commissioner/Director of Proceedings and the costs incurred by the Tribunal.

137. The High Court has said that in relation to the costs incurred by the Tribunal "*… the choice is between the [doctor] who was …found guilty … and the medical profession as a whole*".[30] These observations arise from the fact that the costs of running the Tribunal are met in the first instance by the entire medical profession.

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[30] *Vasan v The Medical Council of New Zealand*, unreported, High Court Wellington, AP No.43/91, 18 December 1991, Jeffries J.

138. In balancing the circumstances of a doctor found guilty of a disciplinary offence against the interests of the "medical profession as a whole" the High Court has said that it is not unreasonable to require a professional to pay 50% of the costs incurred by the professional disciplinary body.[31] Of course, before making any award of costs the Tribunal must take account of the total amounts involved and the doctor's ability to pay costs.

139. The offices of the Health and Disability Commissioner and Director of Proceedings are funded by the State. In assessing the costs incurred by these offices it is not necessary to take account of the interests of "the medical profession as a whole". When assessing the amount of costs Dr A should pay the Health and Disability Commissioner and the Director of Proceedings in relation to the subject matter of the charge, the Tribunal derives some guidance from the key principles which apply to awards in High Court civil proceedings, namely:

139.1 A doctor found guilty of a disciplinary hearing should expect to pay costs to the Health and Disability Commissioner and Director of Proceedings. The extent to which a prosecution succeeds is a relevant factor for the Tribunal to take into account under this heading.

139.2 Costs awards should reflect the complexity and significance of the proceeding.

139.3 Costs should reflect a fair and reasonable rate being applied to the time taken to investigate the complaint as well as preparing for and conducting the prosecution. The emphasis is on reasonable as opposed to actual costs.

140. The Tribunal also records that it must have regard to the ability of the practitioner to pay costs and to ensure that any orders for costs the Tribunal makes are not viewed as a punishment against a doctor for electing to defend a disciplinary charge.

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[31] See for example *Neuberger v Veterinary Surgeons Board*, unreported, High Court Wellington, AP No. 103/94, 7 April 1995, Doogue J.

141. In this case the Tribunal believes it appropriate to give Dr A credit for the cooperative way in which he conducted his defence and for his willingness to agree to a summary of facts which reduced the time taken to hear the charge against him.

142. Having regard to these factors the Tribunal orders:

142.1 Dr A pay $16,349.41 being 50% of the costs and expenses of the hearing by the Tribunal.

142.2 Dr A pay $10,643.28 being 40% of the costs and expenses of and incidental to the investigation and prosecution of the charge by the Director of Proceedings.

Name Suppression

143. In its interim decision dated 28 May 2003 the Tribunal granted Dr A interim suppression of his name pending determination of the charge. The Tribunal also ordered that nothing be published which identified Dr A as being a xx in xx – the city he was working in at the time he applied for interim name suppression.

144. The Tribunal will not reiterate what it said in its earlier decision which should be read in conjunction with this decision. Suffice to say the Tribunal granted Dr A interim name suppression because of the combined effect of the unique circumstances relating to Dr A's case. Those circumstances were:

144.1 Many of Dr A's family live in xx. At the time he applied for interim name suppression the (**not for publication**). Dr A had suffered considerable stress due to the xx because he was unable to contact his family living in xx and xx.

144.2 Mrs A had suffered serious health issues. It is not necessary to explain those matters in this decision. The Tribunal was satisfied this factor, combined with the effects of the unusual events in xx upon Dr A justified an interim order for name suppression.

145. Since the Tribunal made its interim name suppression order two significant events have occurred which impact upon the Tribunal's earlier decision. Those events are:

145.1 Dr A has now been found guilty of the charge.

145.2 The events in xx whilst still far from satisfactory have stabilised and Dr A is able to communicate with his family in that country.

146. The Tribunal concludes the following public interest considerations greatly outweigh Dr A's personal circumstances and the circumstances of his wife:

146.1 The public interest in knowing the name of a doctor found guilty of a disciplinary charge.

146.2 The accountability and transparency of the disciplinary process.

146.3 The importance of freedom of speech and s.14 New Zealand Bill of Rights Act 1990.

147. These three factors will now be briefly explored.

Public Interest in Knowing the Name of a Doctor Found Guilty of a Disciplinary Charge

148. In its interim decision the Tribunal recognised that when Parliament passed s.106 of the Act it wanted to ensure hearings of the Tribunal would be held in public. Closely interwoven with this objective was Parliament's desire that the public should usually know the identity of a doctor found guilty of a disciplinary offence by the Tribunal.

149. The Tribunal is often told when doctors make application for interim name suppression pending the determination of a charge that applications of that kind should be viewed more favourably than cases where the Tribunal has found the doctor guilty of a disciplinary offence. If there is a logical force to that submission then it must follow that where a doctor's conduct has been found wanting by the Tribunal the public interest in knowing the

identity of that doctor becomes a very powerful factor in favour of allowing publication of the doctor's name.

Accountability and Transparency of the Disciplinary Process

150. A major criticism of the disciplinary regime under the Medical Practitioners Act 1968 was that disciplinary hearings were not heard in public. This in turn led to claims that the disciplinary process was neither transparent nor accountable. It is not necessary to debate that view in this decision. Suffice to say the profession's and public's confidence in the disciplinary process should not be put at risk by suppressing the name of a doctor found guilty of a disciplinary offence unless there are compelling reasons for doing so. Both the profession and public should derive assurance about the transparency and accountability of the disciplinary process. Assurance of this kind is enhanced through knowing those who are found wanting by the Tribunal are likely to have their names published. Part of the rationale for this proposition can be found in the judgments of the House of Lords in *Scott v Scott*[32] and *Home Office v Harman*[33] where Lords Shaw and Diplock explained the reasons why civil proceedings are invariably heard in open Court, and why the identity of parties in civil action is rarely suppressed. Their Lordships referred to Bentham's statement that *"publicity is the very soul of justice"*. Bentham's comments have been interpreted to mean that transparency and openness are essential in judicial and quasi judicial proceedings in order to ensure Judges and Tribunals are kept "up to the mark" (to quote Lord Diplock in *Home Office v Harman*).

Importance of Freedom of Speech in s.14 New Zealand Bill of Rights Act 1990

151. The Court of Appeal in *R v Liddell*[34] and *Lewis v Wilson & Horton Limited*[35] stressed:

> *"The importance in a democracy of freedom of speech, open judicial proceedings and the right of the media to report [proceedings] fairly and accurately as "surrogates of the public"*

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32 [1913] AC 47
33 [1982] 1 All ER 532
34 [1995] 1 NZLR 538
35 [2000] 3 NZLR 546

as an important factor which weighs against suppression of the name of an accused in criminal proceedings. This same consideration applies to a doctor found guilty of a disciplinary offence before the Tribunal. The Tribunal believes that if the media wish to publish the Tribunal's decisions then in most cases it would be unreasonable to constrain the media from identifying any doctor found wanting by the Tribunal.

Dr A's Circumstances

152. Whilst the situation in xx is still a source of concern for Dr A, he is no longer subject to the intense stress and apprehension he suffered when he was unable to maintain contact with his immediate family in xx. The unique events which unfolded in xx earlier this year and which influenced the decision to grant Dr A interim name suppression are no longer a significant consideration.

Mrs A's Circumstances

153. Mrs A's health remains a source of concern. The Tribunal is conscious that any publicity concerning the Tribunal's findings which identifies Dr A will aggravate Mrs A's stress. Nevertheless the Tribunal is very satisfied the public interest factors traversed in this decision greatly outweigh Mrs A's personal circumstances.

154. The Tribunal does not believe it is necessary for the public to know anything about Mrs A's health and the factors relating to that topic which are recorded in the Tribunal's interim name suppression decision. Accordingly, on 5 August the Tribunal directed nothing be published which referred to Mrs A's health. That order was made pursuant to s.106(4) of the Act.

Summary

155. The Tribunal finds the charge of professional misconduct proven and orders Dr A to pay $26,992.69 by way of costs pursuant to s.110(1)(f) of the Act. The Tribunal also directs

the secretary of the Tribunal publish a summary of the Tribunal's findings in the New Zealand Medical Journal. That order is made pursuant to s.138(2) of the Act.

156. The Tribunal is aware Dr A may wish to appeal its decision concerning Dr A's application for name suppression (amongst other matters). In order to accommodate Dr A the Tribunal will direct that the Tribunal's order declining Dr A's name suppression application will not take effect until the expiration of five working days from the date of this decision.

DATED at Wellington this 29th day of August 2003

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D B Collins QC
Chair
Medical Practitioners Disciplinary Tribunal