Medical Practitioners Disciplinary Tribunal

PO Box 5249 Wellington Telephone (04) 499-2044 Facsimile (04) 499-2045
All Correspondence should be addressed to The Secretary

DECISION NO: 12/97/7C

NOTE: NAMES OF PARTIES NOT FOR PUBLICATION (Refer NOTE at conclusion of DECISION)

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 **STUART WHITAKER BROWN** registered medical practitioner of Hamilton

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chairperson)
Dr F E Bennett, Dr I D S Civil, Dr L F Wilson,
Mr P Budden (Members)
Ms G J Fraser (Secretary)
Mrs K G Davenport (Legal Assessor)
Mrs M Walker (Stenographer)

Hearing held at xx on Thursday 14 August 1997

APPEARANCES: Mr M McClelland for the Complaints Assessment Committee ("the CAC").

Mr H Waalkens for Dr Brown ("the respondent").

WITNESSES: Ms G J Fraser, Mr A, Dr G L Stone, Dr D,

Dr C, Dr F, Dr B, Ms I, Dr J, Dr M C Thorburn

UPON ENQUIRING into the complaint brought by the Complaints Assessment Committee and after hearing evidence from the witnesses referred to, and after considering the submissions made by counsel for the Complaints Assessment Committee and Dr B,

THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL FINDS:

1. THE CHARGE:

'**THE** Complaints Assessment Committee pursuant to Section 93 (1) (b) of the Medical Practitioners Act 1995 charges Mr Brown registered medical practitioner of xx with disgraceful conduct in the professional respect OR professional misconduct OR conduct unbecoming a medical practitioner which reflects adversely on the practitioner's fitness to practise medicine in that his management and communication concerning Mrs A undertaken between 14 December 1992 and 29 October 1993 was inadequate in one or more of the following respects:

(a) Failed to ensure that the specimen taken following removal of a left breast lump of A on 14 December 1992 was properly examined by a pathologist, especially as he was removing

the lump on the basis it might be malignant, as suggested by a mammogram dated 20 November 1992.

(b) In a letter dated 18 December 1992, misled Mrs A's GP, and thus Mrs A, by advising that the said lump was a lipoma.

(c) In a consultation held on or about 29 October 1993, lied to Mr A, and Mrs A, by stating that the said specimen had been examined and was benign."

2. THE BACKGROUND FACTS:

2.1 **AROUND** November 1992, Mrs A detected an abnormality in her left breast during a routine self examination. Although Mrs A's family doctor was Dr C, of xx, at that time Mrs A was working as a locum physiotherapist in xx and it was more convenient for her to attend the practice adjacent to where she was working. She went to see Dr D who examined her and confirmed that there appeared to be an abnormality in the left breast. Dr D immediately referred Mrs A for a mammogram, and to Dr B, a general surgeon based in xx.

2.2 **THE** mammogram was taken by Dr E and he reported:

> *"There is asymmetrical density superolaterally in the left breast which contains a little micro-calcification. This is solid rather than cystic on ultrasound and I believe excision is warranted to categorically exclude malignancy".*

2.3 **MRS** A went to see Dr Brown on 4 December 1992, and by letter of the same date he reported his findings to Dr D. In his letter Dr Brown concluded:

> *"On examination she has a benign lesion in the one o'clock position of the left breast. She has had mammography however and the recommendation of Dr E is that we remove this. In light of this, I would be dumb to ignore it and we have therefore made arrangements to attend to this at xx Hospital on the afternoon of the 14th".*

2.4 **ON** 14 December 1992 the biopsy operation duly proceeded. The hospital's operation record records that the operation commenced at 1635 hours and was completed at 1700 hours. The operation performed was "excision of left breast lump". Mrs A returned home the same day.

2.5 **BY** letter dated 18 December 1992, Dr Brown reported to Dr D:

> *"This was a lipoma and the remainder of the breast was normal.*
> *I followed her up in the xx Clinic today.*
> *The wound is soundly united with an excellent clinical and cosmetic result. I have reassured her but stressed the need for continuing vigilance as far as breast lumps are concerned".*

2.6 **DR** Brown included a copy of Mrs A's operation note for Dr D's interest. That operation note recorded:

> *"On deeper dissection the lump appeared to be a lump of fat which was removed. No further lump could be palpated throughout the quadrant or within the breast tissue. It was therefore elected not to proceed any further ..... Mrs A can be discharged home as soon as she is recovered and will be followed up in my rooms in a weeks time".*

2.7 **DR** D gave evidence that she assumed from the terms of that letter that the lump was benign and that no additional follow up was required. Dr D also assumed that Dr Brown would not have advised that the lump was benign unless he had received a pathological report confirming this to be the case.

2.8 **MR** and Mrs A celebrated the receipt of Dr Brown's report on the basis of their understanding that it constituted an "all clear" report.

2.9 **IN** August 1993 Mrs A returned to Dr Brown, on this occasion she presented with a much more prominent lump in much the same place in her left breast. By letter dated 13 August 1993 Dr

Brown advised Dr D that he had seen Mrs A that day with a further lump in the left breast above and medial to the previous scar. Dr Brown reported:

> *"This is a large firm well circumscribed mass measuring 5 cm x 3 cm in the 12 o'clock position of the left breast. It is prominent and she is keen to have it removed, and I have made arrangements to attend to it on 20 September 1993 to fit in with her other arrangements".*

2.10 **THE** operation was duly carried out on 20 September 1993 and the lump excised. The histology report subsequently described the tissue sample as:

> *"an infiltrating ductal carcinoma approximately 50 mm main diameter, Elston Grade II (intermediate grade) with extensive neoplastic permeation of lymphatic channels. There was an intraduct component exhibiting cribriform and comedo growth patterns. No tubule formation was seen and mitotic figures were readily seen".*

2.11 **MRS** A underwent an extended simple mastectomy at xx Hospital on 13 October 1993. On mastectomy extensive lymphatic permeation beyond the confines of the tumour was found. Mrs A was considered to be a very high risk of systemic disease and was referred to the Oncology Department at xx Hospital where she was treated with chemotherapy and radiotherapy. However her disease progressed very rapidly and Mrs A died on 26 January 1995.

3.0 ISSUES:

3.1 **THE** charge brought against Dr Brown involved his management and communication with Mrs A undertaken between 14 December 1992 and 29 October 1993. The significant events are:

1) The excision of the lump in Mrs A's left breast carried out by Dr Brown on 14 December 1992.

2) Dr Brown's advice to Mrs A's GP, and thus to Mrs A, that the lump was a lipoma. That advice being given in a letter dated 18 December 1992.

3) Mr and Mrs A's consultation with Dr Brown on 29 October 1993.

In coming to its decision, the Tribunal considered each of those events in turn, before determining the charge. The Tribunal took this approach mindful that Dr Brown faced a single charge albeit encompassing three quite separate events. For completeness, as well as its determination on the charge laid against Dr Brown, the Tribunal sets out its reasons for its findings on each of the Particulars alleged:

4.0 PARTICULAR (a) EVIDENCE:

4.1 **THE** first respect in which Dr Brown's management of Mrs A is alleged to have been deficient is that he failed to ensure that the specimen taken following the removal of the lump in Mrs A's left breast, on 14 December 1992, was properly examined by a pathologist, "especially as he was removing the lump on the basis it might be malignant, as suggested by a mammogram dated 20 November 1992", (Ref: Dr Stone's evidence for the CAC).

4.2 **DR** D gave evidence of her referral of Mrs A to Dr Brown. The relevant contents of the reporting letter from Dr Brown to Dr D dated 4 December 1992 have already been set out, at paragraph 2.3 herein.

4.3 **IT** seems from that letter that Dr Brown had made a presumptive diagnosis that the lump was "a benign lesion". Perhaps significantly in the light of subsequent events, there is no reference to, or recommendation of, any pathological examination, contained in that letter.

4.4 **DR** Brown gave evidence that it was his usual practice to take tissue or cells for pathological or histological diagnosis. In his experience, a significant number of women do not wish to have a lump in their breast, even if it is shown to be benign. Patients who present with a breast lump

invariably want the lump removed. Dr Brown also described a "triple test" involving examination, imaging, histology/cytology which he adopted, and stated that he regarded the removal of lumps as the "gold standard" in order to conduct a follow-up histological report on the tissue removed.

He said:

> *"Thus, even if the female patient has, in my opinion, a discreet (sic) lump, it is my usual practice to recommend its removal after the above "triple test". ..... indeed it has been my usual practice to submit all specimens removed from a patient for histology."*

4.5 **DR** Brown's operation note records Mrs A's operation as an "excision biopsy left breast lump".

The note goes on to record:

> *"HISTORY:* *This lady has had a lump in her left breast for approximately eighteen months.*
>
> ***Clinically this was benign but she was admitted electively for excision."*** (Emphasis added)

4.6 **AGAIN**, and possibly significantly in light of later events, there is no reference in the operation note to the taking of a tissue sample for histology, or indeed of any intention to do that, stating only that "..... she was admitted electively for excision". The note continues:

> *PROCEDURE:* *Under a general anaesthetic the lump (previously marked) in the one o'clock position of the left breast was approached through a skin crease incision. On deeper dissection the lump appeared to be a lump of fat which was removed. No further lump could be palpated throughout the quadrant or within the breast tissue. It was therefore elected not to proceed any further and the wound was infiltrated with ½% Marcaine and closed in layers using 3/0 Dexon to fascia and subcuticular 4/0 Dexon to skin. The wound was dressed with Tinc Benz and Steristrips.*
>
> *MANAGEMENT:* *Mrs A can be discharged home as soon as she is recovered and will be followed up in my rooms in a week's time.*

4.7 **THE** xx Hospital operation record sheet is also relevant. That sheet contains a space for the description of the "OPERATION PERFORMED". In that space the words "left breast biopsy" have been ruled out and the "operation performed" is described as "excision of left breast lump", i.e. this record is consistent with the operation note prepared by Dr Brown.

4.8 **EVIDENCE** was given as to the method of collecting specimens in theatre at xx Hospital. In 1992, no formal register of specimens collected and sent to a laboratory for examination was kept. Dr Brown gave evidence of the usual practice, which was that when a piece of tissue is removed surgically from a patient in theatre it is given to the scrub nurse who passes it off the table to one of the theatre nurses who prepares it for transportation to the laboratory. It is usually placed into a container to which is affixed the patient's identification label. A label is placed onto a laboratory request form which carries all the details of the case. This label accompanies the specimen to the laboratory. Dr Brown gave evidence that he usually filled in all the clinical details between cases and signed the form at that time, although from time to time other staff assisting at the surgery might do so.

4.9 **THE** specimens and forms are usually collected up at the end of the theatre operating session and assembled ready for collection by the laboratory staff.

4.10 **DR** Brown also gave evidence that, as far as he could ascertain, he was not aware of any other specimens going missing or otherwise not actioned "as unfortunately happened in this case".

4.11 **DR** Brown also gave evidence that, at surgery, he found the lump to be subcutaneous rather than within the breast tissue, and that it had the clinical appearance of a fatty lump or a lipoma. Its

appearance and his examination of it following removal were consistent with his earlier examination and palpation of it during his pre-operative consultation with Mrs A. Dr Stone, who gave expert evidence on behalf of the CAC, confirmed that a lipoma is readily recognisable by an experienced surgeon, especially if removed from subcutaneous tissue as was the case at the operation on 14 December 1992.

4.12 **REFERENCE** has already been made to Dr Brown's reporting letter to Dr D, dated 18 December 1992. Dr Brown also gave evidence that the results of any laboratory examination of tissue removed during surgery arrive at his rooms several days after the surgery in the form of a typed report. It was, said Dr Brown, his practice to read these reports on a daily basis and to sign them before providing them to his staff to record the relevant details onto the computer record of the patient notes before they are filed in the patient record itself. Any unusual, unexpected or abnormal results are set aside and the patient's records are located and held separately for appropriate follow up action.

4.13 **THIS** system relies upon the receipt of reports to initiate follow up action. If no report arrives, then the system may break down, although it is still likely that the patient will be seen for follow up at a later date. In this case, Mrs A was seen by Dr Brown on the fourth post-operative day. Dr Brown also gave evidence that he has since instituted a new system whereby the notes of any patient who has any type of specimen or tissue sent for laboratory examination are set aside and not returned to the file until the report has been seen, signed and inserted into the notes. He has also now implemented systems to ensure patients follow up with inquiries about the results of tissue examinations and for a check box in the consultation notes for ticking off an entry "patient asked to telephone for histology results". Dr Brown has also reviewed his systems for the

collection of specimens in theatre and for ensuring that specimens are sent to the laboratory for examination.

4.14 **FOR** the CAC, Dr Stone gave evidence that, in his opinion, "it would be inconceivable" that a qualified general surgeon in New Zealand would remove tissue from a female breast and not submit the specimen for analysis. It is relevant in this context that, on mammography, the radiologist, Dr E reported:

> *"There is asymmetrical density superolaterally in the left breast which contains a little micro-calcification. This is solid rather than cystic on ultrasound and I believe excision is warranted to categorically exclude malignancy"*.

That report is dated 20 November 1992.

4.15 **EVIDENCE** was given to the Tribunal regarding the difference between the description of the lump contained in Dr E's report (solid rather than cystic with some micro-calcification) and the consistency of a lipoma such as was removed from Mrs A's breast on 14 December 1992.

4.16 **DR** Stone's evidence was that there is a discrepancy between Dr Brown's pre-operative and inter-operative findings on the one hand and the mammogram report on the other. It was possible therefore that the clinical palpable lump and the radiological abnormality were not one and the same thing. Dr Stone's evidence was that:

> *"One has to be sure that the palpable lump corresponds to the radiological abnormality which may not be palpable at all. In Mrs A's case this would mean that the radiological finding was quite fortuitous. To deal with the situation, one either:*
>
> *a) Arranges for the radiologist to biopsy the lump under radiological control;*
>
> *b) Arranges for the radiologist to mark the lump so that the surgeon can remove it (this is most appropriate where there is strong clinical suspicion that the palpable lump is benign and the radiological abnormality possibly*

malignant a suspicion further strengthened by a negative, benign, pre-operative cytological or histological sampling of the palpable lump);

c) Arranges a "mammogram" of the lump to check that the radiological abnormality is found within it;

d) Arranges a near immediate post-operative mammogram of the breast to check the abnormality is no longer present;

e) Arranges a follow up mammogram with or without radiological-guided biopsy where the first four regimens above are not followed (for example if the lesion seen on x-ray is doubtfully malignant)".

4.17 DR Stone concluded:

"There remains a possibility therefore that the lump removed from Mrs A's left breast on 14 December 1992 was a lipoma but the deeper lesion in the breast tissue proper was not biopsied. This may have been the lesion seen on x-ray and the subsequently diagnosed cancer".

4.18 VIEWED objectively, it could reasonably be inferred from the evidence that notwithstanding Dr E's report and recommendation, and Dr Brown's comment about the radiology report contained in his letter dated 4 December 1992 to Dr D that "he would be dumb to ignore it", Dr Brown satisfied himself pre-operatively that the lump was a discrete, benign lesion and this diagnosis was clinically confirmed for Dr Brown when the lump was surgically removed and examined by him. The pre-operative diagnosis, and the clinical findings, were confirmed by Dr Brown in his letter to Dr D dated 18 December 1992 in which he stated "this was a lipoma .....". It did not appear from the evidence presented to the Tribunal that Dr Brown referred to Dr E's report, or that he otherwise revisited the report at any time, to ascertain if there was any discrepancy or inconsistency between Dr E's findings and his own clinical findings.

5.0 PARTICULAR (b) EVIDENCE:

5.1 IN respect of this particular, Dr Brown accepted that his letter to Dr D of 18 December 1992 was inadvertently misleading although, he said, this was quite unintended by him at the time. The evidence given by Dr D was that she "assumed" that Dr Brown would not have advised that the lump in Mrs A's left breast was benign unless he had received a report confirming this to be the case. The Tribunal accepts that assumption was reasonably made in the circumstances and that, in the face of such clear advice given without caveat or reservation, neither Dr D nor Mrs A could have come to any other conclusion. They were entitled to rely on the advice given by Dr Brown as being correct and conclusive.

6.0 PARTICULAR (c) EVIDENCE:

6.1 PARTICULAR (c) alleges that in a consultation on 29 October 1993, Dr Brown lied to Mr and Mrs A by stating that the specimen taken at the operation on 14 December 1992 had been examined by a pathologist and was benign.

6.2 BY way of background to the consultation on 29 October 1993, Dr C, for the CAC, gave evidence that, on 4 October 1993, Mrs A had consulted her to discuss her by then diagnosed carcinoma of the left breast, and the mastectomy scheduled for 13 October 1993. Mrs A apparently spoke to Dr C about the 1992 diagnosis that the lump was benign. She told Dr C that she had requested further documented evidence about the 1992 biopsy from Dr Brown, but felt that Dr Brown was defensive when asked about the 1992 biopsy results.

6.3 IT was Dr C's evidence that on 26 October 1993 Mrs A telephoned her and was upset about her interview with Dr Brown. Dr C told Mrs A to confront Dr Brown directly to clear up the

matter of whether a biopsy was available from the 1992 operation. Mrs A asked Dr C to obtain the histology reports from the 1992 biopsy and the 1993 biopsy. Mrs A was apparently worried about her next interview that was to take place with Dr Brown and Dr C advised her to take her husband, Mr A to all future interviews with Dr Brown.

6.4 **MR** A gave evidence that by September 1993 Mrs A "suspected" that the December 1992 test results were missing and she told Mr A that she intended to ask Dr Brown about them again. Mrs A also told her husband that the xx Hospital Oncology doctors treating her were perplexed that such an aggressive malignant tumour had appeared in virtually the same place as a so-called benign tumour and they had asked her for a copy of the December 1992 histology report, but she did not have one.

6.5 **MR** A also gave evidence that he was aware that on or about 12 October 1993 Dr F from the xx Hospital's Oncology Department, who was by then treating Mrs A, made inquiries as to the whereabouts of the December 1992 histology report with xx in xx, without success.

6.6 **DR** F, who gave evidence on behalf of the CAC, confirmed that she was aware of Dr E's mammogram report of 20 November 1992 which stated that malignancy needed to be excluded. It was Dr F's evidence that:

> *"In light of the prior mammogram and ultrasound reports by Dr E dated 20 November 1992, I believe a definitive diagnosis could not have been possible without the necessary pathological tests having been performed".*

Dr F confirmed that the pathology from the previous lesion excised from the upper quadrant of the left breast was requested for comparison. Dr F considered it interesting and somewhat

unusual that a purely benign lesion had been excised from the same area nine months previously and she wished to have confirmation that the lesion was indeed benign. The pathology could not be located either by her, or other members of the department, or by Dr G at xx, or by xx. In a clinical note dated 26 October 1993, prepared by Dr F, she confirms that "we have been unable to find pathology from the lump excised last year". Copies of that note were sent to Dr Brown and to Dr C.

6.7 **IT** is clear from the evidence therefore that, by mid October 1993 at the latest, attempts to ascertain the whereabouts of a histology report from the 1992 investigations were being made by Mrs A, Dr F and possibly other members of the Oncology Department.

6.8 **ON** 29 October 1993, Mr and Mrs A visited Dr Brown at his rooms at xx Clinic in xx. Both Dr Brown and Mr A gave lengthy and detailed evidence as to what passed between Mr and Mrs A and Dr Brown at that meeting. It was perhaps an unusual turn of events for cases of this sort that it was Mr A who submitted written notes in support of his evidence as to what was said at the meeting. Dr Brown's written record of the meeting is, in contrast, brief in the extreme.

6.9 **MR** A is a banker by profession and he gave evidence that it was because of his experience working in law firms for 12 years and banking for 14 years that he considers it important to record important conversations, by way of file notes, particularly those involving facts, verbal agreements or contentious issues, or issues which may, at some later stage, become contentious. It was Mr A's evidence that he made his file note of the discussion between himself and his wife and Dr Brown shortly after the meeting. When pressed as to both the content of the file note, and the time at which it was prepared by Mr Waalkens, Mr A confirmed his oral evidence on

both counts and the Tribunal is satisfied that, notwithstanding that he was undoubtedly surprised, if not shocked, by what transpired at the meeting, nevertheless his account of the meeting, particularly as recorded in his file note, was truthful.

6.10 **MR** A described meeting Mrs A and her mother at the clinic and accompanying Mrs A into Dr Brown's consulting room. Dr Brown initially examined Mrs A's mastectomy site. He summarised the result of the operation and the healing process. Mr A gave evidence of Dr Brown saying to them that the cancer which Mrs A had was "quite treatable". In evidence, Mr A said:

> *"Next thing A ask (sic) him outright "Was the original lump ever tested?" Dr Brown was stunned and quite speechless but assured us both it was tested. He stated:*
>
> *"I assure you, accordingly to my file the tissue was definitely tested and it was a lipoma." At the same time he tapped his file.*
>
> *.....*
>
> *I was surprised by my wife in effect accusing Dr Brown of not testing the tissue. I could see the tears welling up in her eyes and decided it was best to get her out. It was apparent from Dr Brown's behaviour and from the response he gave that something was amiss ....."*

6.11 **IN** his file note Mr A recorded:

> *"During the course of the consultation my wife asked Mr B about the histology on the original breast lump which he removed in December '92.*
>
> *She specifically asked him if in fact he did have the tissue removed on that occasion analysed or did he just assume that it was benign and recorded it as such.*
>
> *My wife explained to Mr B that the Consulting Oncologist Dr F had specifically asked for the histology of the December '92 operation as she was surprised that a malignant tumour should occur so quickly after a benign tumour and she was interested not only from the point of view of treating my wife, but also from a professional interest point of view.*
>
> *My wife explained to Mr B that neither of the two doctors Dr C or Dr D had any written report and that Dr F had been in contact with both the private*

Medical Laboratories in xx namely xx and xx but neither had any record at all of having processed any tissue from my wife. Mr B appeared to be caught short for an explanation and said he would investigate the matter and advise. He went on to say that his notes, to which he referred, stated that the December '92 lump was definitely a lyhtoma (sp) (sic).

I could see that my wife was in quite a distressed state by this time but she was being very brave, and because of this I didn't get involved in the discussion, but Mr B's response both in his words and his manner left me with the distinct impression that he felt uncomfortable with the inquiry .....

Mr B quickly passed over the guts of the question i.e. did he in fact have the tissue examined and spent considerable time advising of various studies in Sweden and USA whereby it had been discovered that there was in fact no evidence to support the assumption that the earlier a cancer was detected and treated the better the chance of cure. His explanations went to such depth in fact that my parting impression was one of Mr B saying that even if he hadn't had the (Dec '92) sample tested it and it was malignant it would make no difference to my wife's prognosis. This was of cold comfort to my wife and myself.

Our request to Mr B for a copy of the Histology was made because:

(i) My wife really wanted to know for her own peace of mind that the original lump was not malignant.
(ii) That Dr F had asked us to follow the matter up with Mr B because her efforts to obtain the report thru the Labs and GP's had been fruitless.
(iii) Because my wife's own GP Dr C said that she should press for a copy of the report if she really wanted to see the document for her own peace of mind.

I also spoke to pathologist Dr H of xx xx. He advised me that a lab should be able to produce reports up to 20 yrs. In all cases its reports would be in written form. He advised me that in his experience B was a top professional and that it was highly unlikely that he would not have had the tissue examined. He did however say it was a very serious matter and to avoid confrontation with Mr B he suggested I ask C to write to Mr B asking for full report for her records."

6.12 **IN** cross examination, Mr Waalkens questioned Mr A closely about what had transpired at the meeting. Mr A confirmed that Mrs A's question about whether or not the original lump was ever tested was made very early on in the meeting. He confirmed that Dr Brown gave an explanation about research studies in Sweden and the United States which seemed out of context. Mr

Waalkens suggested to Mr A that his file note was possibly an interpretation rather than a record of what was said. Mr A said that his wife asked if the original lump had been tested and Dr Brown said that it had definitely been tested "I assure you". Mr A said that he took that to mean that the lump had been sent to the xx or xx and tested.

6.13 **WHEN** challenged to show where the question "was the original lump ever tested", or Dr Brown's response "yes I had it tested", is recorded in the file note Mr A conceded that neither that question or that response was written down. Mr A explained that he was not familiar with medical terminology and that his file note reflected that lack of familiarity on his part. He also said that it was an uncomfortable and unusual situation and his first concern was for his wife.

6.14 **MR** A also gave evidence of a visit he made to Dr Brown in September 1994. Mr A also made a file note of that meeting.

6.15 **AT** that meeting Mr A asked Dr Brown three questions:

> *(1) "Was the sample ever tested" - he said no it wasn't.*
>
> *(2) "Why was the sample not sent to the lab - was it his arrogance, negligence or mistake". He said he couldn't explain why not but that he had changed his systems to ensure that it would never happen again i.e. before he reacted proactively to Lab Reports coming back but now be has a system to follow up each operation if reports are not back.*
>
> *(3) "As he was aware that the tissue was never tested, did he report that it was benign when he new it hadn't been tested and why didn't he admit that it hadn't right at the beginning". He confessed that in retrospect he had erred in not telling A and her GP's that for some reason the tissue didn't go to the lab.*
>
> *He expressed genuine sorrow and apologised and when I left appeared to be in a distressed state."*

Having had the opportunity to observe the straightforward way in which Mr A gave his evidence, and his demeanour when cross-examined at some length by Mr Waalkens, the Tribunal found him to be an honest and credible witness.

6.16 **DR** Brown's written record of the October '93 meeting records only:

> *"A OK. See 3/12"*

6.17 **DR** Brown gave evidence of Mrs A's return to him in August 1993 following her discovery of a further lump in her left breast. He described the subsequent histology which revealed a "poorly differentiated infiltrating duct carcinoma".

6.18 **DR** Brown confirmed that he met with Mrs A and her husband on 29 October 1993. He also confirmed that he explained the histology of the mastectomy specimen and that it revealed an inflammatory carcinoma with 18 axillary lymph nodes involved. After discussions, it was agreed that Dr F should take over Mrs A's ongoing care and management of adjuvant chemotherapy.

6.19 **AS** to the question why he did not tell Mrs A that the original specimen removed at the surgery in December 1992 had been lost and had not been reported on, Dr Brown said:

> *"This was because I did not consider it would contribute to her situation in any way. I now recognise that this was an error of judgement on my part and that I ought to have told her. .....*
>
> *I now wish that I had told her about it and very much regret not doing so. I recognise this was an error of judgement on my part."*

6.20 **DR** Brown said that he had no record of Dr C's letter of 1 November 1993 asking for a copy of the histology, nor did he recall talking to Dr C about Mrs A. At that time he was still apparently under the impression that Dr D was Mrs A's regular GP.

6.21 **DR** Brown gave evidence of receiving a telephone call from Dr F in which Dr F asked for a copy of the histology of the original specimen. Dr Brown said that he informed Dr F at that time (which he could not recall) that the specimen had been mislaid and no histological diagnosis was made. Dr Brown said that he also informed Dr G and Dr H in response to their inquiries, that the specimen appeared to have been mislaid and not examined and that he discussed it with other theatre and administration staff at xx Hospital. Dr F, in evidence, said that she did not recall any such telephone discussion with Dr Brown.

6.22 **AS** to the meeting on 29 October 1993, Dr Brown's account of what was said, in general terms, was consistent with Mr A's file note. However, Dr Brown denied that he had been asked directly if the original specimen had been sent to the laboratory or what or where the histological result was. He said, "I certainly did not say to the A's that it had been examined and was benign ....." He therefore denied Particular (c).

6.23 **DR** Brown maintained that denial in cross examination by Mr McClelland. Dr Brown gave evidence that, as an experienced surgeon, by the time he removed the lump on 14 December 1992 he was 100% sure that it was a lipoma. He denied the possibility that, because of his by then very firm belief, he simply decided not to have the lump tested after examining it in theatre. He agreed there was no evidence to show that a specimen was ever prepared or sent off for examination. Dr Brown denied saying to Mrs A "this is a lipoma, you have nothing to worry

about". Dr Brown said that he would not have done that but accepts that, in the absence of any reference to a histology report, what he did say could be seen that way. Dr Brown maintained his evidence that, if he had been asked directly by Mrs A whether or not the 1992 lump had been tested, he would have answered truthfully, but he denied that he had ever been asked the question directly.

7. THE SUBMISSIONS - CAC:

7.1 **FOR** the CAC, Mr McClelland submitted that, if the facts alleged in the charge were found to be proven by the Tribunal, then Dr Brown was guilty of disgraceful conduct. In relation to Particulars (a) and (b) Mr McClelland submitted that it was the purpose of the December 1992 operation to obtain a histological diagnosis of the lump in Mrs A's breast. No such diagnosis was obtained. It was the case for the CAC that Dr Brown formed the clear view that the lump was benign when he first saw Mrs A.

7.2 **HIS** first report to Dr D, given pre-operatively, was that the lump was a "benign lesion". Notwithstanding the radiology report, Dr Brown appeared almost reluctant to remove the lump saying that, after discussion with Mrs A it was eventually agreed that the lump should be removed. In reference to Dr E's report, Dr Brown said that "I would be dumb to ignore it". At surgery Dr Brown confirmed his pre-operative diagnosis and, being confident as to the correctness of his diagnosis, he did not consider it necessary to obtain a histological report. Similarly, that same confidence was the basis upon which he reported to Dr D in "the clearest of terms", and there could be no doubt that Dr D, and Mr and Mrs A were misled by the terms of the letter.

7.3 **AS** a result, neither Mrs A, nor her GP, took the matter any further. Perhaps most significantly, no follow-up mammogram or ultrasound was obtained which might have revealed that there was another, more sinister area (the area detected on the original mammogram) in Mrs A's left breast.

7.4 **AS** to Particular (c), Mr McClelland submitted that Dr Brown would have known that no laboratory report had been obtained in 1992 when she returned to see him in August 1993, yet he did not advise either Mrs A, or any of her medical advisers, of that fact, until confronted by Mr A in September 1994. Further, said Mr McClelland, Dr Brown would have known that Dr F, and Mrs A, were making inquiries about the report in October 1993. Yet the evidence that Dr Brown was asked if the lump had been tested histologically, and that he assured Mr and Mrs A that it had, was overwhelming. There were, said Mr McClelland, different accounts of these events which could not be explained away by one of the parties being mistaken as to what was said.

7.5 **DR** Brown, it was submitted, lied to and misled Mr and Mrs A. He put his own personal interests before those of his patient and such conduct would undoubtedly be regarded as disgraceful or dishonourable by Dr Brown's professional brethren of good repute and competency; it is conduct deserving of the strongest reprobation.

SUBMISSIONS - Dr Brown:

7.6 **FOR** Dr Brown, Mr Waalkens conceded on his behalf that it was a matter of fact that no histological or other laboratory report had been obtained in December 1992. However, while Dr Brown accepted responsibility for that fact, he was not culpable, and a distinction must be made between "responsibility" and "culpability". The omission could not be explained. Dr Brown

intended that a specimen be sent off to a laboratory for the necessary examination; he agreed that such examination was the object of the operation, but he could not explain why this seemed not to have occurred. Dr Brown could offer no explanation for the fact that no report was received, and described efforts to ascertain what had happened. He was unaware of any other occasion on which a specimen was lost. He accepted that his internal systems management failed to alert him to the fact that no report had been received back by him. He also accepted that his report to Dr D was misleading, but that was unintentional.

7.7 **MISS** I, a registered comprehensive nurse who has worked in theatre with Dr Brown since 1993, gave evidence of his care and diligence in ensuring that laboratory specimens are properly collected and sent for testing.

7.8 **DR** J, an Oncologist of xx, gave his opinion as to the nature of the breast lump and cancer which Mrs A had. It was his conclusion that Mrs A had an inflammatory carcinoma of the breast which meant that she had a very poor prognosis from the outset irrespective of the treatment she received, or could have received.

7.9 **THE** crux of the case for Dr Brown in relation to Particular (c) was that Dr F telephoned him seeking a report from the 1992 operation, and that he told her none was available. He was not asked by Mr or Mrs A if tissue taken in December 1992 has been tested until Mr A went to see him in September 1994.

7.10 **IT** was Mr Waalkens' submission that, applying the criteria set out in *Farris v MPDC* [1993] 1 NZLR 60 (and in *Pillai v Messiter (No 2)*, (1989) 16 NSWLR 197, referred to therein), and

B v The Medical Council HC 11/96, to the facts of this case, Dr Brown's conduct is to be viewed in the context of Section 109(1)(c) only. Mr Waalkens also referred to MPDC decision 30/8/94 in support of his submission. This case involved a similar factual situation although limited to allegations of professional deficiencies on the part of the practitioner, and absent the more serious allegations of deliberate misfeasance which are a feature of this present case.

8. THE FINDINGS:

8.1 **THE** burden of proof falls upon the CAC, and its witnesses. Clearly, in their respective accounts of what was said at the meeting of 29 October 1993, there is a direct conflict between Mr A and Dr Brown and the credibility of both witnesses is an important issue for the Tribunal. The onus is upon the CAC to present a credible case. In circumstances where the allegations are so serious, the CAC's case supporting the allegations must be sufficient to convince the Tribunal that its account of the events at issue is more likely, on the balance of probabilities, to be true. The Tribunal must be satisfied that Mr A's account is an accurate description of the events giving rise to the charge. Most especially, Mr A bears the onus of proving the allegations made by the CAC, especially in relation to Particular (c). The seriousness of the allegation contained in that Particular demands that a correspondingly high standard of proof be satisfied. The standard of proof required in medical disciplinary hearings is the civil standard, i.e. the Tribunal must be satisfied on the balance of probabilities that the charge is made out, having regard to the seriousness of the allegations. In coming to its decision, the Tribunal has borne in mind the principle that, in disciplinary cases, the standard of proof is not fixed; it will vary in accordance with the gravity of the charge faced by the practitioner; *Ongley v Medical Council of New Zealand* (1984) 4 NZAR 369 and *Gurusinghe v Medical Council of NZ* [1989] 1 NZLR 139. Previous cases have often referred to a 'sliding scale', moving between the ordinary civil

standard, and the criminal standard of beyond reasonable doubt. In *M v Medical Council of NZ (No 2)* 11/10/90 HC Wellington M239/87, Greig J said (at p 24):

> *"The onus and standard of proof is upon the accusers but on the basis of a balance of probabilities, not on the criminal standard but measured by and reflecting the serious nature of the charge."*

In this present case, Dr Brown faces a single charge, albeit particularised in three respects, which raises very serious issues. The standard of proof required to be satisfied is, therefore, correspondingly higher, albeit it remains the balance of probabilities.

8.2 **THE** charge effectively combines three complaints by alleging a course of conduct on the part of Dr Brown as Mrs A's specialist practitioner. The Tribunal has considered each particular independently from the others, then cumulatively in the context of the overall charge that Dr Brown's "management and communication concerning Mrs A undertaken between 14 December 1992 and 29 October 1993 was inadequate".

8.3 **BECAUSE** Dr Brown has been charged in the alternative in terms of the findings available to the Tribunal under Section 109 of the Act, and for completeness, the Tribunal decided that it is appropriate to indicate the level at which it would have found the charge upheld if it had been supported by any one of each of the particulars.

8.4 **IN** *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513, the Court of Appeal approved this approach saying:

"Whether a broad allegation, or any narrower separate ones, is or are established will depend on the findings of fact reached by the Council and the Council's assessment of gravity, which if adverse will be open to appeal ... by the practitioner. But we see nothing in the Act or in natural justice to prevent the Committee, after investigating a range of complaints, from regarding a comprehensive charge as appropriate as well as separate ones. Indeed it might be against the public interest to deny the Committee any right to present an all-embracing charge. It may be important that the appropriate professional tribunal should be able to look at the practitioner's whole attitude to practice."

8.5 **THEREFORE** the Tribunal has considered the evidence relating to each particular separately before coming to its determination on the single, comprehensive, charge.

PARTICULAR (a):

8.6 **WITH** respect to Particular (a) the Tribunal finds that, on the basis of the evidence presented to it, and on the balance of probabilities, no specimen from the tissue taken from Mrs A's left breast at the operation on 14 December 1992 was sent to any laboratory for testing; and therefore Dr Brown failed to ensure that any specimen taken from Mrs A's left breast was properly examined by a pathologist.

8.7 **IN** coming to this view, the Tribunal was influenced by the following factors:

8.7.1 **DR** Brown's very positive statement, in his letter to Dr D dated 4 December 1992, that "on examination she has a benign lesion in the one o'clock position of the left breast". That statement, and indeed the tenor of that letter generally, strongly suggests that Dr Brown satisfied himself, pre-operatively, that the lump was benign.

8.7.2 **THIS** inference is supported by the fact that Dr Brown appears not to have referred to Dr E's report at any time subsequently, and particularly notwithstanding any discrepancy between the lump described by Dr E, and the lipoma removed at the operation.

8.7.3 **THE** deletion of the words "left breast biopsy" and the substitution of "excision of left breast lump" in the xx Hospital operation record sheet.

8.7.4 **THE** language of Dr Brown's own operation note in which he recorded that Mrs A "was admitted electively for excision".

8.7.5 **THE** absence of any reference to the taking of a specimen for histology, or that any histology report was to follow, in Dr Brown's operation note, dated 14 December 1992, or his letter to Dr D dated 18 December 1992.

8.7.6 **THE** evidence given by Mr A that, at her post-operative visit to Dr Brown on 18 December 1992, Mrs A received an "all clear" report, apparently given without reservation and regarded by Mrs A as a cause for celebration.

8.8 **DR** Stone's evidence for the CAC was premised on the assumption that the objective of the procedure carried out on Mrs A on 14 December 1992 was to disprove the presence of malignancy. The Tribunal is not satisfied that the evidence given by Dr Brown, or otherwise ascertainable from the correspondence and other materials placed before the Tribunal, supports that assumption. It appears to the Tribunal to be at least arguable that the operation was initiated, to a significant degree, by Mrs A's desire to have the lump removed and that Dr Brown was satisfied at an early stage that the lump was "benign".

8.9 **THIS** is notwithstanding Dr E's report and recommendation that "excision is warranted to categorically exclude malignancy".

8.10 **ACCORDINGLY**, the Tribunal is satisfied that Dr Brown failed to ensure that any specimen of the tissue taken from Mrs A's left breast on 14 December 1992 was properly examined and this particular is upheld.

8.11 **GIVEN** the circumstances of the case, and particularly Dr Stone's evidence that it is "inconceivable" that a qualified general surgeon in New Zealand would remove tissue from a female breast and not submit the specimen for analysis, especially where the objective of the procedure should be to disprove the presence of a malignancy, together with Dr Brown's own evidence that he agrees that it is standard and prudent practice to submit tissue from all biopsies for histological examination, the Tribunal is satisfied that this failure constitutes conduct unbecoming a medical practitioner that reflects adversely on Dr Brown's fitness to practise medicine.

PARTICULAR (b):

8.12 **THIS** particular was, in effect, admitted by Dr Brown, albeit that it was also his evidence that the misleading character of the statements in his letter to Dr D was unintentional. Nevertheless it seems inevitable that the certainty with which the diagnosis expressed his opinion that "this was a lipoma ...." unreservedly reassured Dr D, and thus Mr and Mrs A. The importance of ensuring that diagnostic information, especially in circumstances where the alternatives are so dire, cannot be overstated. The fact that the diagnosis might, in fact, have been correct, does not in all the circumstances absolve Dr Brown. The misleading aspect of the advice was that Dr D, and thus Mr and Mrs A also, presumed that the advice was soundly based being supported by appropriate pathological examination and that, in giving this advice, Dr Brown had properly and appropriately taken into account what was reported [on the mammogram] by Dr E.

8.13 **ACCORDINGLY**, Particular (b) is also upheld and, if this particular had been the only particular supporting the charge, the Tribunal's finding would have been that the misleading nature of Dr Brown's advice of 18 December 1992 constitutes conduct unbecoming a medical practitioner that reflects adversely on Dr Brown's fitness to practise medicine.

PARTICULAR (c):

8.14 **THIS** particular contains a most serious allegation against Dr Brown. Both Mr A and Dr Brown gave evidence at the hearing and both were closely, and comprehensively, cross examined. The Tribunal has already referred to the onus and standard of proof. There are several ways a witness might persuade the Tribunal to prefer his evidence over that of another witness. Two are relevant for this Tribunal. Mr A displayed a good recollection of events. First, his version of the relevant events was made credible by his linking of other, unrelated but contemporaneous events to the events being recalled. Secondly, the written records of the events made by Mr A were persuasive. It is perhaps ironic that the complainant supported his evidence with written notes, rather than the practitioner as is more usually the case. Mr A's account of events, whilst no doubt affected by what happened to his wife, nevertheless demonstrated a clear recall of what was said. He gave evidence of his professional background and training which lead him to record in writing contentious or momentous matters. He is evidently trained to objectively record events and his record was consistent with his memory and, in significant respects, with Dr Brown's own account.

8.15 **MR** A therefore impressed the Tribunal as a truthful and articulate witness. He demonstrated a clear recollection of the events of 29 October 1993, and the Tribunal is satisfied that he did write his file note later that same day. The Tribunal is therefore satisfied that Dr Brown was "specifically asked" if he did have the tissue removed in the operation in December 1992 tested.

8.16 **WITH** the exception of the issue as to whether or not Dr Brown was asked if the tissue removed in December 1992 had been tested, the degree of consistency between Mr A's file note and evidence, and Dr Brown's evidence as to what was talked about at the meeting, was a further factor which persuaded the Tribunal to prefer the account of what transpired at the 29 October meeting given by Mr A.

8.17 **MR** A gave evidence that, at least by September 1993 at the latest, Mrs A suspected that the December 1992 results were missing, and she told Mr A that she intended to ask Dr Brown about them again. Dr Brown gave evidence (at paragraph 55 of his written statement) that when Mrs A returned to him in August 1993, he checked his file and looked for the histology of the specimen taken in December 1992. It was at this time that he noted that no such report was in his notes. He made various inquiries to ascertain its whereabouts "immediately after the consultation with Mrs A on 10 August". He was aware then, almost immediately, that no report existed.

8.18 **YET** he saw Mrs A subsequently in September when he performed a biopsy on the second lump; at a consultation on 28 September; on 13 October when he performed a simple mastectomy; at consultations on 19 and 22 October 1993. On none of these occasions did he tell Mrs A that there was no histology report available from the 1992 surgery.

8.19 **DR** Brown's evidence as to when he became aware that there was no report available from the 1992 surgery, and when he relayed this to others was vague and, in some significant respects, contradictory when viewed in its totality. He said that he made inquiries and ascertained the non-existence of the report in August 1993; he relayed that information to Dr F (but could not recall

the date that might have occurred); he also informed Drs H and G, when asked, that the specimen appeared to have been mislaid and not examined and he discussed it with staff and administrators at xx Hospital. His evidence, while vague as to specific chronological detail, appeared to be that all of these events occurred between August and October 1993.

8.20 **BUT**, when cross-examined by Mr McClelland, Dr Brown was adamant that, during the period August to October 1993, he was not aware that anyone was looking for a 1992 report. He did not recall seeing Dr F's note of 26 October 1993 copied to him. He said he did not tell anyone that there was no report because he was not asked, nor did he recall receiving Dr C's request for a copy of the report, and that is why he did not respond to that request.

8.21 **IN** his evidence Dr Brown confirmed that the 29 October 1993 consultation was the final time he saw Mrs A. He said (at paragraph 59 of his evidence):

> *"The question arises as to why I did not tell Mrs A that the original specimen removed at surgery in December 1992 had been lost and had not been reported on. This was because I did not consider it would contribute to her situation in any way. I now recognise that this was an error of judgement on my part and that I ought to have told her. However, at the time, I was very conscious of the fact that Mrs A was a very young woman who had just been given a diagnosis of an inflammatory carcinoma of the breast with a very poor prognosis. It is and was regarded by me at the time, as the most rapidly growing and lethal form of breast disease and the question of what had happened to the small subcutaneous fatty lump some ten months previously was regarded by me as being less significant and something that would only add to Mrs A's distress.*
>
> *I now wish that I had told her about it and very much regret not doing so. I recognise this was an error of judgement on my part."*

8.22 **ON** the basis of that evidence, the last opportunity Dr Brown had to tell Mrs A that the original specimen removed at surgery in December 1992 had not been reported on, was at the meeting on 29 October 1993. Thus, the Tribunal finds that, as a matter of fact, Dr Brown's decision not

to tell Mrs A the truth was made prior to 29 October 1993. If the Tribunal therefore accepts Mr A's evidence that the question was "specifically asked", and it does, then, on the basis of Dr Brown's evidence, the Tribunal must accept that, in response to that question, Dr Brown decided to tell Mrs A that the lump had been tested. It does not matter whether Dr Brown made a deliberate decision not to have the tissue sent for pathological examination (because he was confident in his own diagnosis of the lump, or simply omitted to do so) or a specimen was sent for examination but was lost. The Tribunal finds as a matter of fact that Dr Brown knew there was no histological report but decided, for whatever reason, to tell Mr and Mrs A that the lump had been tested and was a lipoma.

8.23 **THE** Tribunal also accepts Mr McClelland's submission that there are a number of other factors which support Mr A's evidence and which cast doubt over the evidence given by Dr Brown. For example:

8.23.1 **DR** F, the oncologist who was primarily responsible for Mrs A's care post-October 1993, impressed the Tribunal as a conscientious and well organised practitioner. Her reports submitted in evidence were very thorough and it seems to the Tribunal more likely than not that if she had contacted Dr Brown, as alleged by him, asking for the 1992 histology report and been told by him that it was missing, she would have recorded that fact in Mrs A's clinical notes, and relayed that advice to Mrs A.

8.23.2 **DR** F copied her report in which she recorded that "we have been unable to find pathology from the lump excised last year" to Dr Brown and there was no evidence presented to the Tribunal which indicated any response to that note on the part of Dr Brown.

8.23.3 **THREE** days after the 29 October 1993 meeting, Mr A requested Dr C to write to Dr Brown asking for a copy of the report, which is consistent both with his account of the consultation on 29 October 1993 and his belief at that time that there was a report. Such a belief would be entirely consistent with Dr Brown's having told him that such a report existed when asked at the 29 October meeting.

8.23.4 **AS** late as September 1994, Mr A was still pursuing his inquiries seeking copies of the report.

8.23.5 **BY** September 1994 it seems inevitable that Dr Brown would have been aware from others, at least Dr F and possibly Dr G of xx, or Dr H of xx, that they were looking for the December 1992 report.

8.23.6 **IN** September 1994, some twelve months after the matter was first raised, and in response to questioning by Mr A, Dr Brown told Mr A that no such report had, in fact, been obtained.

8.24 **AS** has been said many times before, the doctor/patient relationship is a relationship of trust and confidence. A patient must be able to rely on her practitioner being truthful, especially in answering specific questions directed to him.

8.25 **BEING** less than truthful, or unwilling to admit to the truth of facts or circumstances evidencing a mistake, or misconduct, on the part of the practitioner is effectively a preference for his or her own interests over the interests of the patient. Such preference cannot be anything but a serious

breach of the doctor/patient relationship, founded as it is upon trust. Perhaps the most distinctive characteristic of the doctor/patient relationship is the vulnerability of the patient, whether due to infirmity, the uncertainty inherent in the clinical situation or for any other reason. That vulnerability imposes special responsibilities of fidelity and trustworthiness on the practitioner which responsibilities necessitate the suppression of self interest.

8.26 **THE** emphasis upon the causative effect of the events of December 1992 raised in Dr Brown's defence of the charge (as in the evidence given by Dr J) is, in the Tribunal's view, misplaced. This disciplinary Tribunal is not concerned so much to apportion blame as it is to judge the conduct of the medical practitioner against the criteria of professional standards, and according to the rules of professional conduct.

8.27 **THE** question for the Tribunal is not whether what was done by Dr Brown would be wrong for anyone, it is whether it was wrong for a doctor, particularly a doctor of Dr Brown's experience, and in his position.

8.28 **IN** coming to its decision, the Tribunal has been mindful of the comments made by Justice Elias in *B v The Medical Council* (Unreported) HC 11/96, 8/7/96:

> *"The structure of the disciplinary process is set up by the Act, which rely in large part upon a practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standard supplied by competent, ethical, and responsible practitioners. But the inclusion of lay representatives in the disciplinary process and the right of appeal to this Court indicates that usual professional practice while significant, may not always be determinative; the reasonableness of the standards apply must ultimately be to determine, taking into account all the circumstances including not only usual practice but also 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."*

8.29 **THE** conduct on the part of the practitioner may well constitute conduct which would be considered reprehensible for any person, but the question for this Tribunal will also be to consider how much more reprehensible is that conduct if engaged in by a doctor in the context of his or her professional duties and obligations -

> *"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 judgement of the professional brethren of acknowledged good repute and competency."*
>
> *Ongley v Medical Council of New Zealand* [1984] 4NZAR369.

8.30 **IN** submissions, and in the context of the definition of "professional misconduct", counsel referred to *Farris v MPDC* [1993] 1 NZLR60, per Gallen J, and the reference therein *Pillai v Messiter* (No 2) (1989) 16 NSWLR197 in which the Court of Appeal of New South Wales concluded that misconduct in a professional respect meant more than mere negligence. The Tribunal whilst agreeing that the test might be more elegantly stated in *Pillai,* nevertheless does not consider that it is, for all practical purposes, a different test to the one expressed in *Ongley*. In *Pillai* the Court said:

> *"..... but the statutory test is not met by mere professional incompetence or by deficiencies in the practise 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 ...."*

8.31 **IN** the Tribunal's view, a practitioner's decision to give an untruthful response to a question directly asked, in circumstances where at least an inference can be made that the lie was motivated by self interest, clearly falls into the "something more" category.

8.32 **AT** least at the theoretical level, the distinction between "professional misconduct" and "conduct unbecoming" with the rider now attached to it in Section 109(c) of the Act, is a matter of degree. The Tribunal has already indicated that, in respect of Particulars (a) and (b), if either of those Particulars had, on their own, been cited in support of the charge, the Tribunal would have found the charge upheld at a level of conduct unbecoming. However, in the Tribunal's view, an allegation that a practitioner lied, if found to be proven, clearly falls into a more serious category than misconduct which, while constituting a serious departure from professional standards, can nevertheless be explained on the basis of inadvertent omission or otherwise unfortunate or unintentional lapses or deficiencies.

8.33 **ACCORDINGLY**, the Tribunal does not accept Dr Brown's evidence that he was never "directly asked" about the 1992 report prior to September 1994. The Tribunal is satisfied that Dr Brown was asked, by Mrs A on 29 October 1993 if the specimen removed from her left breast in December 1992 had been tested. The Tribunal also finds that Dr Brown told Mr and Mrs A at that meeting that the lump had been tested.

8.34 **ACCORDINGLY**, the Tribunal is satisfied that the allegation contained in Particular (c) is proven. Having considered each of the particulars alleged, the Tribunal then considered the charge in its totality. It finds that the charge laid against Dr Brown by the CAC is upheld and constitutes professional misconduct on the part of Dr Brown. The Tribunal's decision is unanimous.

9. PENALTY

9.1 **THE** charge having been upheld, the Tribunal invites submissions from counsel as to penalty. The timetable for making submissions will be as follows:

9.1.1 **COUNSEL** for the CAC should file submissions with the Secretary of the Tribunal and serve a copy on counsel for the respondent not later than 14 working days from the date of receipt of this decision.

9.1.2 **IN** turn counsel for the respondent should file submissions in reply with the Secretary and serve a copy on counsel for the CAC not later than 14 working days from receipt of the CAC counsel's submissions.

9.2 **THE** Tribunal reminds counsel, and all parties to this proceeding, that the Tribunal has made orders that:

(a) The publication of any report or account or any part of the hearing by the Tribunal in any manner in which the applicant is named or identified is prohibited pending further order of the Tribunal;

and

(b) The publication of the name or any particulars of the affairs including the occupation, place of residence and/or practice of the applicant, is also prohibited pending further order of this Tribunal.

9.3 **ACCORDINGLY**, the Tribunal invites counsel to address the issue as to whether or not those orders ought to remain in place, or be discharged in their further submissions.

DATED at Auckland this 29th day of September 1997

.....

W N Brandon

Chairperson

Medical Practitioners Disciplinary Tribunal