MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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PUBLICATION OF THE NAME OF THE DOCTOR AND COMPLAINANT AND ANY IDENTIFYING DETAILS IS PROHIBITED	**DECISION NO:**	275/02/96C
	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 R medical practitioner of xx

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL:

TRIBUNAL: Ms P Kapua (Chair)

Mr P Budden, Dr R Gellatly, Professor W Gillett, Dr C P Malpass (Members)

Ms K L Davies (Secretary)

Mrs H Hoffman (Stenographer)

Ms P M Dunn (Scopist)

Hearing held at Christchurch on Tuesday 28, Wednesday 29, Thursday 30, Friday 31 October 2003 and Monday 8 and Tuesday 9 December 2003

APPEARANCES: Mr M F McClelland and Ms J Hughson for a Complaints Assessment Committee ("the CAC")
Mr A H Waalkens and Mr C W James for Dr R

The Charge

1. A CAC, acting pursuant to section 93 of the Medical Practitioners Act 1995 (the "Act") charges that Dr R, medical practitioner of xx, in the course of his management and treatment of his patient A:

    1. Failed to appropriately follow up on a cytology dated 10 June 1994 in relation to A's left breast which report stated that an *"in-situ ductal lesion cannot be excluded with certainty";* and

    2. In the period prior to 1 October 1998 failed to take appropriate clinical steps to diagnose and/or failed to adequately assess, pre-operatively or otherwise, an identified solid lesion in A's left breast;

    3. Failed to provide A with an acceptable standard of care.

        Particulars

        3.1 Prior to performing an excision biopsy on A on 5 October 1998 failed to carry out an appropriate breast examination in the absence of a diagnosis and/or despite not having seen her in a consultation since 23 July 1998; and/or

        3.2 On 8 October 1998 following diagnosis of invasive carcinoma offered A a wide local excision as treatment for her breast cancer when he had not taken any clinical steps to ascertain the presence or absence of further lesions in her left breast; and/or

3.3 Failed to take notes and/or adequate notes in A's medical records of his consultations with her:

3.3.1 In 1994 when he failed to document his actions after receiving the abnormal cytology reports;

3.3.2 On or about 13 February 1997 and 7 August 1997 when she presented to him with a specific palpable lesion in her left breast; and

3.3.3 Between early 1999 and mid 2000 on the occasions he met with her after hours in his practice rooms at xx.

3.4 Failed to provide sufficient information to A as was necessary for her to make informed decisions:

3.4.1 Failed to tell A about a cytology report dated 10 June 1994 that stated that an *"in-situ ductal lesion cannot be excluded with certainty"* and/or

3.4.2 Failed to provide A with accurate information about standard diagnostic tests for solid breast lumps.

4. Failed to act at all times in the best interests of his patient, A:

Particulars

4.1 Provided information to, and about, his patient, A, which was inaccurate, misleading or wrong:

4.1.1 In October 1998 stated in written communications with Dr D and Dr C, and in written reports on file, that diagnostic tests had been undertaken with respect to an identified solid lesion in A's left breast and that the results of these diagnostic tests had been reported as negative for carcinoma, when no such

tests has been undertaken and between October 1998 and July 2000, repeated these claims in verbal communication with A.

4.1.2 In July 1998 stated verbally to A, and again in October 1998, to A and her partner, B, that she had refused a procedure, being the removal of her identified solid left breast lesion, when he had not offered this procedure to her, but rather had counselled her against it;

4.1.3 Stated to A that early detection of breast cancer was ineffective in that his failure to remove A's breast lump sooner would therefore not have affected her prognosis;

4.1.4 Between April 1999 and July 2000, repeatedly denied to A any possible relevance of the cytology report dated 10 June 1994;

4.1.5 In a letter dated 30 October 2000 to ACC advised that because of the cytology report dated 10 June 1994 A had had a further ultrasound in November 1994 which is not correct.

4.2 In the period early in 1999 to mid 2000 failed to treat his patient A in a professional, honest and respectful manner:

4.2.1 Invited her to meet him outside of his practice and despite her refusal, continued to make such invitations;

4.2.2 Encouraged ongoing contact with him when she was questioning the effect of this on her mental health;

4.2.3 Continued to encourage her to development an attachment to him;

4.2.4 Suggested her memories of events were mistaken and that she was in danger of losing her mind;

4.2.5 Made disparaging comments about her expressions of distress and her desire to live;

4.2.6 Failed to recommend her to seek assistance for her disclosed symptoms of emotional distress;

4.2.7 Attempted to discourage her from taking complaint action against her by one or more of the following:

(a) failing to provide her with information about avenues for complaint action;
(b) repeatedly pointing out how a complaint would impact on his personal and professional life;
(c) stating she did not care for him sufficiently;
(d) threatening to be dishonest if she should take complaint action in order that she should fail to achieve a result;

5. On one occasion between mid 2000 and early 2001 and again in mid 2001 procured the re-reading of slides of a substance that was taken from A's left breast on 31 May 1994, without her consent.

The conduct alleged in particulars 1,2,3,4 and 5 either separately or cumulatively amount to professional misconduct.

2. Dr R denied the charge.

Factual Background

3. A was referred by her general practitioner, Dr , to xx at xx Hospital for an opinion and help in further management in respect of thickening and induration in the right breast and cystic like swelling in the left breast along with thickening and induration. She was referred as a result of her strong family history, cited as her mother having had breast cancer and dying at the age of 45 years.

4. This referral was made on 10 December 1991 and A first attended the xx clinic at xx Hospital on 17 December 1991. In the referral letter Dr C refers to her family history and the letter concludes by stating:

> *"I would therefore appreciate your opinion and help in further management."*[1]

5. In his report and response to the GP, Dr R repeats the information relating to the family history and concludes by stating:

> *"I will see her in due course for follow-up."*[2]

6. From that initial appointment A attended at intervals of at least six months. In some instances additional referrals were made outside the normal six month follow-up period. These appointments were made when A was concerned about specific lumps and sought the assistance of her GP for an additional referral.

7. From the clinical notes, it appears that on a number of occasions notes were made regarding tenderness or swelling in the breasts and references to fine needle aspiration. A's weight was taken on each occasion and on nine occasions that is the only information contained in the clinical notes.

8. The reporting letter to A's GP, although not always written by Dr R, contains more information but is still reasonably brief.

9. During the period from 17 December 1991 until A was advised that she had invasive cancer and DCIS in October 1998, she had attended 15 appointments at xx Hospital

[1] Bundle of Documents p.123
[2] Bundle of Documents p.124

and had had a number of routine mammograms and ultrasounds, although it is clear that none had been sought as part of Dr R's management after November 1996.

10. The brevity of the notes and Dr R's evidence suggest that there was not a specific management plan in place for A. During the period from 1991 to 1998, the management consisted largely of fine needle aspiration of a number of cysts that were identified over those years.

11. On 31 May 1994 A saw Dr R following a routine mammogram that had been done on 23 May 1994. In the reporting letter to Dr C, Dr R wrote:

> *"I saw A again today and re-examined her breasts. The recent ultrasound suggested a number of cysts and there is certainly two fairly large cysts in the upper outer quadrant of the left breast and I have taken an aspirate from these and sent some of the fluid to cytology. As well as this she had a firm lump underneath the right nipple which they feel is solid and probably represents a fibroadenoama. I have not aspirated from this today but have arranged for her to have a repeat ultrasound in six months and I shall see her again then. It may be necessary to consider excision of this in the longer term."*[3]

12. The cytology report following that consultation is dated 10 June 1994 and stated:

> *"Smears contain blood with histiocytes and apocrine cells. There are also tight clusters of ductal cells in each specimen with overlapping [sic] nuclei, most of which show air drying artefact.*
>
> *Although probably benign, the possibility that these clusters represent an in-situ ductal lesion cannot be excluded with certainty."*[4]

13. From the hospital records it would appear that upon receipt of the report Dr R wrote *"for biopsy"*. This was then crossed out and replaced with the words *"file see again at OPD."*

14. A had another ultrasound done in November 1994 and that was discussed with her on 30 November 1994. There was no discussion about the 10 June 1994 report ("the G Report"). At that consultation A was advised that the lump she had been concerned about had been a fibroadenoma and that is confirmed in Dr R's letter to Dr C dated 30 November 1994.

15. During 1995 A had three consultations with Dr R and a routine mammogram on 14 November. Following the consultation on 7 December 1995 Dr R reported:

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[3] Bundle of Documents p.140

> *"There was nothing specific that I felt should be aspirated today and I have reassured her about this. I will see her in 12 months after further mammogram and ultrasound."*[5]

16. A mammogram was conducted on 11 November 1996 and the reports of both these mammograms refer to the *"large amount of dense glandular breast tissue resulting in reduced detail and accuracy."*[6]

17. In December 1996 A became aware of a small palpable solid lump in the upper outer quadrant in her left breast at 2 o'clock. Her GP, Dr C referred her to xx and Dr E aspirated three cysts and in respect of the lump identified by A stated:

> *"A solid nodule located laterally at 2 o'clock was also sampled yielding cohesive groups of ductal epithelial cells, bare stromal nuclei and a few connective tissue fragments. The appearance is of a BENIGN LESION."*[7]

18. That report was to be copied to Dr R although it is unclear at what time it came into Dr R's possession. A however is clear that she referred to that report at her next consultation with Dr R on 13 February 1997.

19. Her follow-up appointment on 14 August 1997 resulted in the following report:

> *"I saw A today for a follow-up appointment. She remains well, and her breasts although still moderately lumpy are not particularly symptomatic at present. There are no discrete lumps which cause concern clinically and I have reassured her. She had a mammogram done last year so I will see her again in one year and probably arrange a follow-up mammogram then."*[8]

20. From December 1997 to early 1998 A and her partner B were in the xx but were both becoming increasingly concerned about a lump in A's left breast.

21. On 19 March 1998 A returned to Dr C and asked for a referral to Dr R because of the lump. She was seen by Dr R on 23 April 1998 and in his reporting letter he stated that she had been worried about a larger lump in the left breast which had

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[4] Bundle of Documents p.48 (p.139)
[5] Bundle of Documents p.148
[6] Bundle of Documents pp.147,149
[7] Bundle of Documents p.150
[8] Bundle of Documents p.153

been uncomfortable and had increased in size recently. He aspirated from both areas and concluded by stating:

> *"I will see her again in three months and the results should come directly to you for immediate follow-up."*[9]

22. On 23 July 1998 A saw Dr R again and three cysts were aspirated, two in the right breast and one in the left breast. There was no testing of the solid lump in the left breast and it is described by Dr R thus:

> *"The solid lump remains present in the left upper outer quadrant and does not seem to have changed but it is certainly more obvious when she is lying on her side and she is more aware of it".*

23. Dr R then states *"I think it would be better to have this removed, especially as she is keen to get pregnant and thereby we would know the exact diagnosis and could reassure her or otherwise."*[10]

24. Arrangements were made for surgery to take place on 11 August 1998 but A was found to be pregnant and the biopsy surgery was postponed. The pregnancy was ectopic and once A had recovered sufficiently the surgery was rescheduled at xx Hospital and took place on 5 October 1998.

25. The lump was excised and diagnosed by Dr E as:

> *"1. Grade 1 Infiltrating Mammary Carcinoma of No Special Type (At Least 24mm).*
> *2. Low Nuclear Grade DCIS (EIC Positive)*[11]

26. Two days after the surgery Dr R advised A that she had invasive cancer and DCIS. The following day Dr R met with A and her partner and discussed the possibility of a wide local excision and node dissection or possibly a mastectomy in terms of future management. In his reporting letter to Dr C following that meeting, Dr R stated:

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[9] Bundle of Documents p.156
[10] Bundle of Documents p.161
[11] Bundle of Documents p.218

> *"It is somewhat disappointing that this has proved to be a cancer as originally we had considered this a fibroadenoma based on the cytology from earlier in the year."*[12]

27. A was then referred to an oncologist, Dr D, and at her first consultation with him her decision to have a mastectomy was confirmed.

28. On 21 October Dr R performed a left mastectomy on A at xx Hospital. Following that surgery at a further consultation there was discussion between A, her partner and Dr R surrounding the issue as to why the "lesion" had not been more definitively diagnosed.[13]

29. In November 1998 A began chemotherapy treatment that was completed in February 1999.

30. On 14 April 1999 A underwent a second mastectomy of the right breast at xx Hospital. On the day following surgery Dr R visited A and the nurse noted in the hospital records that they had a *"long chat."* [14]

31. From November 1998 A began psychotherapy sessions with F.

32. On 20 April 1999 Dr R and A met at his rooms at xx. The meetings were scheduled for 6 o'clock in the evening but did not generally begin until around 6.30 pm. There was a second meeting in early May 1999, a third meeting at the end of June 1999, a fourth meeting in February 2000, the fifth on 14 March 2000 and a final meeting on 28 March 2000. (In total there were six of these meetings, each approximately 90 minutes long, at which A and Dr R discussed what had occurred in relation to her treatment). While the evidence as to the specifics of these meetings may have varied, it is clear to the Tribunal that these meetings were a means of explaining or understanding the sequence of events that had resulted in A being advised that she had invasive cancer in October 1998 and the resultant double mastectomy.

33. A had obtained a copy of her file just three days after the first meeting and it is clear from her evidence that what she found on the file gave her cause for concern and

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[12] Bundle of Documents p.58
[13] Bundle of Documents p.193

gave rise to a number of questions about her treatment that she wished Dr R to answer. It is also clear that having obtained her file, A undertook reasonably extensive personal research on invasive cancer and DCIS.

34. On 5 July 1999 Dr R wrote to A's GP, Dr C, and stated:

> *"I have seen A a few times since her most recent surgery when she had a right total mastectomy done prophylatically. A has been rather concerned that I missed the diagnosis of carcinoma in her left breast even though she had a lump there dating back some time. She had been investigated as far back as 1996 with fine needle aspiration and mammography showing only benign change on the investigation."*[15]

Dr R then went on in the letter to outline his view that he had aspirated a number of cysts in April 1998 but when she was seen in July as part of the surveillance and given her concern he considered it more appropriate to excise the lump. He then stated that her having become pregnant delayed the excision a few months and when the lump was finally excised it proved to be a carcinoma. He then referred to her concern about the initial diagnosis not being made at the outset and the fact that she no longer required mammography and passed over to Dr C the primary responsibility for her care and management.

35. On 13 July 1999 A wrote to Dr R referring to the "*quality of the understanding we reached on Tuesday 29 June."*[16] The letter refers to a telephone discussion and then expresses clearly A's feelings in respect of her relationship with Dr R and her desire for him to be honest about what had occurred. Dr R responded to this letter on 26 August 1999 doing no more than acknowledging receipt of the letter and referring to the biopsy report that A had forwarded to him and inviting her to make an appointment for any ongoing follow-up. By this stage A was pregnant with her first child and wrote to Dr R on 18 October 1999 and commented on the fact that his letter in response did not seem to relate to the letter that she had written. A invited Dr R to contact her by telephone and gave him some contact numbers. Over the October to November period there were a number of telephone calls between Dr R and A and in February 2000, the fourth of the six meetings took place. At the time of the last meeting in March 2000 A had resolved to bring the meetings to a

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[14] Bundle of Documents p.90
[15] Bundle of Documents p.179
[16] Bundle of Documents p.75

conclusion and while still uneasy about events accepted the position. From her own research around June 2000 she still had some concerns about the information Dr R had given her and when she confronted him about it by phone he stood his ground and A resolved to complain about his treatment of her which she did by letter dated 20 July 2000.

36. Subsequent to the lodging of the complaint re-readings of the slide that was the subject of Dr G's report of 10 June 1994 were undertaken. It is accepted by both the CAC and Dr R that those re-readings were done without A's consent.

Evidence for the CAC

37. A was the first witness for the CAC and she set out in detail her recollection of the 15 consultations she had had while under Dr R's care and her belief that the lump she felt in December 1996 was the lump that was eventually found to be malignant. She also expressed the view that it may have possibly been evident in 1994 when the cytology report by Dr G was done although she was clear that the fact that it was in the same area may have been coincidental and that the issue for her was *"that it was not pursued."*[17]

38. When asked if she could tell the difference between cysts and a lump, she replied:

> *"I couldn't always tell what the cysts were but I could always tell that this lump was different from any other lump, okay? So it was harder, it was not regular and smooth, well it began sticking out, there was no doubt, because actually I've never had a cyst that stuck out, I'm not even sure it is possible. It was irregular in shape, it didn't move about, no fluctuation at all with my periods, no painfulness. It always felt different and to touch it became creepy later on."*[18]

39. A was clear in her evidence that Dr R reassured her on a number of occasions that the lump was a fibroadenoma and it therefore could not be malignant. That evidence appears to be confirmed by Dr R's own record including his letter to Dr C following the consultation on 8 October 1998.

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[17] Transcript, p134 line 21
[18] Transcript, p.143 ll 5-15

40. There had been no mammography or ultrasound since November 1996. A found the lump in December 1996 and at that stage she was referred by her GP to the xx where the lump was identified as a benign lesion.

41. A is clear from her evidence, and it was not altered under cross-examination, that she discussed that report with Dr R on 13 February 1997.

42. Having seen A and heard her evidence the Tribunal has no doubt that A took an avid interest in her treatment, that she asked questions and was an active participant in the consultation process. The notes of the consultations are scant but it is clear that on occasion there is an amount of information recorded that would suggest relatively free flowing discussion.

43. The Tribunal also accepts A's evidence that she had confidence in Dr R, as a breast surgeon and a specialist, and that she felt reassured by his advice to her particularly in relation to the lump she found in 1996. She stated in response to questions as to why she did not consider having a further mammogram or having one done privately:

> *"Well, Mr R reassured me so confidently and he told me that they only hurt me. I thought that was kind and I thought I was in the best hands."*[19]

44. In relation to the six meetings that took place following A's double mastectomy, the Tribunal accepts that these meetings involved discussions about both Dr R's and A's concerns about her treatment and diagnosis. It is clear that the meetings were at times emotional and that each of the parties was seeking an outcome that was different from the other. For A, she wished to see Dr R confirm his alleged earlier admissions of mistake and that he would remain honest with her. For Dr R, the meetings were possibly an attempt to explain what had occurred and to deal with accusations of misdiagnosis or delayed diagnosis that were being made.

45. As Dr R and A were the only people present at these meetings, the Tribunal considers on the evidence and recollections expressed that the detail set out in A's evidence most likely reflects what occurred at those meetings. It is noted that that evidence has not been denied by Dr R but his recollection is a little more unclear.

The letters that were written at the time and the fact of the telephone calls that both parties acknowledge were made, tends to point to a more personal basis for these meetings than normal post surgery consultations.

46. The second witness for the CAC was Professor David John Gillett who is a registered medical practitioner practicing as a breast and endocrine surgeon in Sydney, Australia. Professor Gillett's evidence was that on referral A had a family history that put her at a higher risk of developing breast cancer. He asserted that given the "abnormal" Dr G report in 1994, there should have been a full investigation including further mammography and specialised views and that it was not reasonable that no mammography or ultrasound was ordered from November 1996. Professor Gillett was critical of the lack of a plan of management throughout the period from 1991 to 1998.

47. Professor Gillett acknowledged in his evidence that he had not read the evidence of Dr R or other witnesses to be called on his behalf and that his assessment had been based on the evidence to be called by the CAC. It is also to be noted that he acknowledged under cross-examination that he has not practised in New Zealand and that he does have a specialist breast surgical practice.

48. Dr C, A's GP, then gave evidence. Dr C had referred A in December 1991 for the following reason:

> *"My inclination was that she had cystic fibroplasias, however, in view of her family history I felt that she should be assessed by a specialist breast surgeon mainly for reassurance."*[20]

49. Dr C had received the reporting letters from Dr R or his registrar following A's consultations. It was Dr C's evidence that A's concern was the primary reason for her being referred and that when she expressed concern he would refer her again outside her normal appointments. It was Dr C's evidence that A had discussed her concerns about the management and treatment she had received from Dr R a short time after her double mastectomy. He expressed the view that A would have done whatever was necessary in respect of any lump and confirmed her concern that Dr R had later expressed the view that she did not wish to have surgery. That was not his

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[19] Transcript, p126 lines 29-31
[20] Brief of Evidence, para 2.2 (Exhibit 8)

impression of her willingness to take whatever steps were necessary in the management and treatment of any possible breast cancer.

50. The next witness for the CAC was F, a psychotherapist, who A consulted with from 2 November 1998, following the mastectomy of her left breast and the discovery of carcinoma and prior to her chemotherapy treatment.

51. From November 1998 until April 2000 A consulted with Ms F virtually on a weekly basis with some adjustment when Ms F was travelling. From April 2000 to August 2001 there were six consultations which resumed to weekly consultations in August 2001. These consultations remained weekly or twice weekly until August 2002. In July 2003 regular office consultations began again. It was Ms F's evidence that the consultations focused on the management and treatment A had received from Dr R. There were no notes taken of any of the psychotherapy sessions and Ms F had relied on her memory in order to give evidence before the Tribunal. Ms F stated:

> *"From the very first session I had with A, she held with clarity, the knowledge that medically Dr R had made serious errors, such as his failure to follow-up on her growing breast lump and seemingly ignoring or minimising her family history of cancer. However, whilst she knew that these errors were serious enough to warrant a complaint, she was equally clear about her determination not to hurt him. She wanted to retain him as her surgeon, and indeed later, in April 1999, had him perform a second mastectomy."*[21]

52. Ms F's evidence essentially recounted the sessions held with A and set out the matters that they had discussed in those sessions, not only the concerns about the management and treatment but the bond and feelings of affection that A had developed for Dr R. Ms F also outlined her understanding of A's need to resolve the issue with Dr R and her belief that it could be resolved positively.

53. The next witness for the CAC was Mr B, A's partner, who gave evidence about the concerns and likely treatment that A would have wished and of the consultations that took place following the diagnosis of cancer in October 1998.

54. Mr B was clearly of the view that had there been any suggestion of cancer A would have wished to have the lump removed and he expressed some anger at the meeting on 8 October 1998 when it appeared to him that Dr R was suggesting that A had

resisted any suggestion of having her breast lump removed. He also expressed some concern about the conversation that took place and recounts it as Dr R discussing his beliefs and philosophies about living with untreated cancers and expressing views on how early intervention was not necessarily in the best interests of the patient.

55. At a second meeting later in October 1998 it was Mr B view that Dr R appeared to admit, to some extent at least, that he was at fault with respect to A's early diagnosis. Mr B saw this admission as positive although he was concerned again about Dr R's discussion on philosophical ideas he had expressed relating to the cancer treatment particularly the chemotherapy and possible tamoxifen treatment that Dr D had recommended. At that second meeting Dr R hugged A telling her she was special which made Mr B feel somewhat uncomfortable.

56. Mr B was also aware of the six meetings that took place following A's surgery and in his view he believed the purpose of the meetings was:

> *"…the main point of the meetings for A was the attempt to simply get an apology from Mr R about his neglect of her care. …She wanted him to provide this without untruth, inconsistency in his empathy, defensiveness, misinformation about the cancer risk or psychological mistreatment."*[22]

57. Mr B was concerned about the lump in 1997 and was questioned extensively by Mr Waalkens about why he or A had not taken further action if they were so concerned. Mr B was clearly of the view that they had relied on the reassurances from Dr R and in particular the "*professional reassurance that it was a fibroadenoma."*[23]

58. Mr B and A had returned to New Zealand some time in late January and had not sought a referral from Dr C until 19 March. It is clear from the evidence of both A and Mr B that the assertion by Dr R that the lump was a fibroadenoma and therefore not malignant was the explanation for any delay between the return from xx and seeking further investigation. It is to be recalled that following the appointment on 14 August 1997 Dr R did not intend to see A again until a year later.

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[21] Brief of Evidence para 2.6 (Exhibit 9)
[22] Transcript, p234-235 lines 46-4

59. Mr B was clear in his evidence that Dr R had apologised initially for what had occurred but changed his position later. He also expressed concern at Dr R's suggestion that A had not wished to have surgery to have the breast lump removed. His evidence was that he knew that A had wanted the breast lump removed and was concerned at Dr R's comments about non treatment of cancers and early intervention.

60. The final witness for the CAC was Professor Grant Gillett, a neurosurgeon and professor of medical ethics at Dunedin Hospital and Otago Bio-ethics Centre at the University of Otago Medical School. Professor Gillett's evidence dealt particularly with the information A had received from Dr R and the six meetings that took place after the surgery. Although Professor Gillett had based his evidence on A's brief, his conclusion was that from an ethical point of view the meetings were unwise and were crossing professional boundaries evidenced by the arranged times of the meetings, the lack of notes and the non-involvement of a third person, whether at the meetings or by way of a referral. Professor Gillett was also of the view that, in respect of patients, doctors generally have to acknowledge the areas of uncertainty that exist in the management and diagnosis of patients.[24]

Evidence for Dr R

61. Dr R was appointed as a xx surgeon at xx Hospital in xx. He set out in his evidence that he was *"not a specialist breast surgeon and was not at the time in question."*[25]

62. At the time of hearing Dr R was employed for eighty percent of his time at xx Hospital, the remainder in private practice. **Not for publication by order of the Tribunal.**

63. Dr R did acknowledge that he had been providing surgical services for breast cancer and benign breast diseases since his appointment as consultant surgeon in xx. Whether Dr R regarded himself as a specialist breast surgeon during his time of treatment for A from 1991 to 1998 does not detract from the fact that upon referral

[23] Transcript, p238 lines 47-48
[24] Transcript, p.266 lines 42-44

to xx Hospital, Dr R was identified as a specialist in the treatment of A. It is also clear that Dr R has had an ongoing involvement in breast surgery and specialist breast diagnosis since 1989 and has been identified by his peers as somebody who has the skills to undertake work in this specialist area.

64. In cross-examination Dr R responded that he had not advised A that he did not consider himself an expert in breast surgery between 1991 and 1996[26] but did acknowledge that there were no specialist breast surgeons in xx and that from 1985 breast surgery played a moderately significant part in his workload. **Sentence not for publication by order of the Tribunal**.

65. In addressing the substance of A's evidence, Dr R's common response was that he could not recall the detail. He acknowledged on a number of occasions that A's evidence could in fact have been correct but that he could not recall particular matters being discussed.

66. The Tribunal accepts that there can be some difficulty in reconstructing events that occurred some 12 years prior to the hearing but considers that some of that difficulty arises as a result of the note taking contained in A's file. Dr R acknowledged that neither the notes nor the letters to the GP recorded everything that was done at a consultation. The lack of any reference to the details of A's mother's experience with cancer, except for the age at which she died, is an example of information that was considered significant by Dr R[27] not being recorded anywhere in the notes and leading to an inference that the information was never obtained or if it were obtained that it was never recorded.

67. A was seen at least once a year and sometimes twice. The 10 June 1994 Dr G cytology report, which A first saw when she obtained her file in 1999, was a major focus of Dr R's evidence. The report done by Dr G and referred to in paragraph 13 above was clearly a matter for discussion between A and Dr R at the meetings held after her surgery for a double mastectomy. Dr R had stated that he originally wrote *"for biopsy"* on receipt and later wrote *"file see again at OPD"*.

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[25] Brief of Evidence, para 3 (Exhibit 13)
[26] Transcript, p309 line 47

68. It is clear that Dr G's report and the fact that it was not discussed at the time with A has fuelled her concerns about her management and treatment by Dr R. Prior to this matter coming before the Tribunal there had been an ACC inquiry and in response to concerns raised about this report, Dr R had formally responded that his reaction to the 1994 report was *"she had a further ultrasound in November 1994."*[28]

69. In his response to the CAC Dr R wrote in a letter dated 10 April 2001:

> *"Going back to 1994 when I first looked at the report I felt that perhaps the area should be excised but then on reviewing her notes, and the findings on mammogram and ultrasound, I realised that there was nothing to excise as the cyst had been aspirated and had disappeared. I arranged to have the area to be re-investigated later in the year which was done. At that time the findings again showed no evidence of malignancy."*[29]

70. Dr R did acknowledge that the request for the ultrasound in November 1994 was made prior to his receipt of Dr G's report. His explanation in the letter to ACC was a mistake. In the letter to the CAC it appears that that mistake is repeated although before the Tribunal Dr R considered the words in his letter to the CAC (which enclosed the ACC letter) were not meant to convey that meaning.

71. Before the Tribunal Dr R stated that he had changed his mind about biopsy as a result of an "acrimonious" discussion with Dr G about the report. It was put to Dr R that this explanation had not been raised in any earlier enquiries and the fact that no other reference to this meeting occurs in the notes casts doubt upon its veracity. This line of questioning resulted in an affidavit being filed by Dr G just prior to the reconvened hearing in December 2003. This was accompanied by an application by counsel for Dr R to dismiss the charge, although that application was withdrawn on 4 December 2003. Counsel had agreed that the letter from Dr G would be received by consent by the Tribunal. In essence Dr G has accepted Dr R's account contained in his written evidence before the Tribunal that a meeting had taken place although Dr G was unable to recall the substance of the discussion.

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[27] Transcript, p317, line 1
[28] Bundle of Documents, p60
[29] Bundle of Documents, p184

72. What is clear from the evidence is that A was never aware of the 1994 cytology report and the difficulties in determining how that report was considered by Dr R is exacerbated by the lack of any note or reference.

73. Dr R was unclear as to why he did not discuss the G report with A and raised the possibility that it was not on the file or that he was satisfied following the ultrasound and therefore did not mention it.[30]

74. In relation to the lump identified by A in December 1996 that resulted in a referral by her GP to xx it would seem that in the report[31] the lump is identified in an area that Dr R agrees was *"where the cancer was finally excised from."*[32] This report was to be copied to Dr R and it was his evidence that he did not receive it until some time later. Dr R was unsure as to when he did see the report and he hypothesised that it could have been sent to a different Dr R. The December 1996 report stated that the lesion was benign.

75. A attended the outpatient clinic on 13 February 1997 and Dr R accepted A's evidence that he saw her accompanied by his registrar Dr H. Dr R also accepted that he may have told A that the lump was a fibroadenoma and that she therefore need not worry about it.[33] While there were no specific clinical notes Dr R stated in his letter to Dr C on 9 October 1998 following the cancer diagnosis:

> *"It is somewhat disappointing that this has proved to be a cancer as originally we had considered this a fibroadenoma based on the cytology from earlier in the year."*[34]

In his letter to Dr D, Dr R wrote:

> *"She has had numerous cysts in her breasts over the years and recently developed the solid lump in the left breast which had been suggested as a fibroadenoma on original cytology but had not been looked at by mammography."*[35]

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[30] Transcript, p346-349
[31] Bundle of Documents, p83
[32] Transcript, p354, lines 5-6
[33] Transcript, p356, lines 21-23
[34] Bundle of Documents, p58
[35] Bundle of Documents, p189

76. These letters confirm the evidence of A that she had been told that the lump was a fibroadenoma and therefore there was nothing to worry about.

77. That diagnosis does not appear to be supported by any particular testing. While Dr R asserted that he had some reservations about the accessibility to mammography at xx Hospital he does not recall advising A of this or making any suggestion that she should consider having the mammography and ultrasound undertaken privately. Dr R was somewhat reluctant to acknowledge the existence of a lump but the Tribunal is clear that A, Mr B, Dr C and Dr E had all been aware of a lump at the end of 1996 and there are references from that point on to at least one lump that appears to have been diagnosed as a fibroadenoma. Dr R did accept however that a woman is well placed to identify lumps in her own breast.[36]

78. In relation to the apparent confirmation of Dr R's thinking that the lump was a fibroadenoma, Dr R stated in cross-examination that the statement contained in the letter in paragraph 74 above was a mistake. He stated that he had made a statement to Dr C based on information A had given him and that the statement was in fact a mistake.[37]

79. Reference is also made to a cytology report earlier in the year which implies that the lump had been tested which Dr R also acknowledged was a *"clear mistake"*.[38]

80. In relation to the letter to Dr D, Dr R referred to the fact that the word *"suggested"* was included which in his view appeared to qualify the more direct statement to Dr C. That letter also referred to earlier cytology which Dr R considered was the 1996 report and it would therefore appear that he had received a copy of that report by this stage, although he was still unclear.

81. In response to questions in cross-examination Dr R considered that the 1996 report indicated the lump was most likely to be a fibroadenoma. If that were the case, then it would seem likely that the lump detected in 1996 remained there until its removal in 1998.

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[36] Transcript, p366, lines 30-35
[37] Transcript, p375, lines 37-42
[38] Transcript, p376, lines 9-10

82. Dr R was also questioned about the sudden change in management in April 1998 when he decided that he would see A in three months time instead of the normal six month or annual check-up. When asked if he were suspicious of the lump he was adamant that he still considered it to be benign and probably a fibroadenoma. Dr R considered that the urgency came from A's desire to get pregnant. His application for priority for the biopsy dated 27 July 1998 lists *"suspicious of malignancy but unproven"* and *"likely to progress to major complication"* as reasons justifying priority.[39] Dr R stated that this was normal practice to ensure a patient did not experience delays. He did however acknowledge that he had not suggested to A that she might have any of her treatment done privately to avoid delays in the public system.

83. The matter of the discussions that took place between Dr R and A and Mr B subsequent to her diagnosis were put to Dr R and he accepted that he had taken responsibility for the late diagnosis but did not accept that he had expressed a view that earlier diagnoses or earlier intervention would not have changed the diagnosis.

84. Following the second mastectomy on 14 April 1999 the hospital notes record on the following day:

> *"Long chat c surgeon staff not present"*[40]

This entry is consistent with the evidence of A. Dr R's recall was not so clear but he did acknowledge the possibility that he had made some of the statements concerning the late diagnosis and does seem to recall some knowledge of A's unhappy abusive childhood.

85. It was following this operation that the series of six meetings from 20 April 1999 to March 2000 took place. Dr R accepted that there were no records of these meetings and no charge was made for them.[41]

86. Dr R's written evidence emphasised that the discussions concerned the misdiagnosis and Dr G's 1994 report although he did not deny that the matters A had set out in

[39] Bundle of Documents p.72
[40] Bundle of Documents, p90

her evidence had been discussed. Essentially his response was that he could not recall the specific details. Dr R also acknowledged that the telephone calls between he and A took place over this time although he did not entirely accept that a number of those calls were lengthy.

87. During cross examination Dr R did acknowledge that he was trying to avoid A making a complaint but qualified that by stating that he did not consider she was going to make a complaint because she had said that she would not.[42]

88. On 5 July 1999 Dr R wrote to Dr C setting out that he had had a number of meetings with A and essentially he advised that Dr C should be the primary person responsible for A following the second mastectomy. In that letter Dr R states:

> *"Because of her concern about the initial diagnosis having not been made at the outset, she has some natural inhibitions about me necessarily following things for her in the longer term…"*[43]

Dr R did however state that he would be happy to review things if necessary.

89. On 13 July 1999 A wrote to Dr R setting out her assessment of where matters had reached. The letter sets out A's personal feelings about the discussions and towards Dr R. In that letter A also notes that she has left a copy of the 24 December 1996 report as it was not on her file when she had obtained it in April 1999. At that stage Dr R recalled that he had in fact seen the report although he could not recall the exact time and it had been when he had walked into the office and seen it on the desk of his colleague, Mr R.[44] That response appeared to conflict with earlier statements that Dr R's reference to the lump as a fibroadenoma was based on the 1996 cytology report, which does not appear to have found its way to the file until 1999. It is unclear how Dr R viewed his meetings with A and it is noted that in his response in relation to the ACC complaint he advised that he had not seen A as a patient since July 1999.[45] However, in his evidence before the Tribunal he did not consider the three meetings prior to July 1999 to be in the nature of a doctor patient

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[41] Transcript, p404, lines 2-14
[42] Transcript, p407, lines 20-24
[43] Bundle of Documents p.74
[44] Transcript, p417, lines 37-42
[45] Bundle of Documents, p 61

relationship and did not regard the meetings following his letter to Dr C of 5 July 1999 as doctor patient meetings.

90. It is clear from A's letter that she wished to pay for the consultations in order to maintain an appropriate relationship.

91. In relation to the re-reading of the slides Dr R stated that he had had legal advice to the effect that he was entitled to have those slides checked without obtaining A's consent.[46]

92. In response to questions about the note taking Dr R acknowledged that it was not his normal practice to use diagrams to identify the areas where cysts or lumps have been found or aspirated. In response to questions relating to the management of outpatients without notes, Dr R stated:

> *"Most of the patients are not seen on multiple occasions, most of them are seen once or twice. Our written record in the letter to the doctor serves as a reminder and normally has key things there which would serve to remind us."*[47]

93. The next witness called on behalf of Dr R was Dr John Edgar Harman, a registered medical practitioner specialising in breast surgery in Auckland. Dr Harman's evidence did not address the issues of factual dispute between Dr R and A but expressed his view as to her management and treatment. In questions from Mr McClelland Dr Harman initially took the view that lumps that feel solid are *"classically cystic"*[48] to agreeing that the classic breast cancer lump is *"firm, solid, solitary, irregular and fixed"*[49]. Dr Harman also offered evidence concerning risk factors, more particularly in the general population, and considered that A would have been *"a moderate risk"*[50]. There was some disagreement as to whether her family history put her into a higher risk category, which Professor Gillett had done in his assessment, but Dr Harman considered there would need to be more

[46] Transcript, p425, lines 47-48
[47] Transcript, p459, lines 8-12
[48] Transcript, p481 line 41
[49] Transcript, p482, lines 17-19
[50] Transcript, p.482 lines 35-36

information about the family history before making such an assertion. Dr Harman did however acknowledge that you would have to have the full history.[51]

94. Dr Harman also gave evidence as to the possible grading that might be applied to the 1994 G Report. Using today's guidelines Dr Harman considered it would be regarded as a C3 which Dr Harman had stated on previous occasions might require triple assessment. In this instance he considered that it could be dealt with by way of further discussion with a multi-disciplinary team and looking at the mammogram, ultrasound and clinical picture. In any event, Dr Harman regards the 1994 report as *"an abnormal cell report"*[52] and *"abnormal cytology report"*[53].

95. Dr Harman was also asked for his opinion as to how long the 24mm lump in A's breast had been present, given its size upon removal. While accepting that there was a possibility of some accelerated growth while pregnant it was his view that it had been there for between two and five years. He was then questioned further by Mr McClelland in relation to a lecture given by Dr Harman where he had stated *"by the time the cancer is palpable it has been present seven years"*[54]. Dr Harman's response was that that was an average, that it may have been seven to five years but he could not be sure.

96. Dr Harman acknowledged that this was a complex case but that as a breast clinician, you tend to be very careful and cautious about what you're doing.[55]

97. The next witness for Dr R was Dr E who is a registered medical practitioner practising as a cytopathologist and histopathologist as xx in xx. Dr E had re-read the slides reported on by Dr G on 10 June 1994 and it is noted that Dr E's evidence was that he had been told that consent had been received in respect of the re-reading of A's slides. Dr E had also read the slides taken from the cyst fluids in the solid left breast lump aspirated by him on 24 December 1996. Dr E also read the histology slides of the left breast lump excised by Dr R 5 October and the slides of the subsequent left mastectomy specimen performed by Dr R on 21 October 1998.

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[51] Transcript, p502, line 11
[52] Transcript, p485, line 15
[53] Brief of Evidence, paragraph 56, exhibit 17
[54] Transcript, p508, lines 20-21

98. Dr E could not recall specifically the details relating to the lump in 1996. In response to the question as to whether the lumps in 1996 and 1998 were the same, Dr E responded *"there's no knowing that"*[56].

At page 538 of the transcript, Dr E states:

> *"So we've got this lump at approximately 2 o'clock at 3x2 centimetres, though A says its smaller. Dr C sends a referral with a lump that's close to the nipple, is it the same lump? I do note that there was an ultrasound performed, I think within the previous six months or one year where nothing was seen in the left breast of a focal nature other than cysts. I'm not a radiologist so I don't know how sensitive or how big a lump has to be, cancerous lump, before they will pick it up. Then quite clearly I sampled a lump at 2 o'clock peripherally.*
>
> *There is an indication from the admitting notes, from what must be a House Surgeon at xx Hospital in 1998, sort of mid-year, where they have drawn a diagram of both breasts, which is probably somewhere in here…Area thickening and palpable lump. Well, is that at 1 o'clock, is it 2 o'clock? What position was the patient in? So, I come back to those variables and false negatives. It becomes very difficult to pin them down unless its an interpretive false negative, and I repeat, if you wish to pursue that avenue then the slides should be reviewed by another party.*
>
> *So, do I think that, in quotation "solid lump', which may or may not have been solid, and the subsequent tumour were one in the same? I don't know, and I don't know any way of knowing that."*[57]

99. The reference to an ultrasound being done within the previous six months was raised with Dr E and he accepted that in fact the last ultrasound was done in November 1994.[58]

100. The final witness called by Dr R was Dr I who is a registered medical practitioner practising in xx as a general surgeon. Dr I has a 30 year relationship with Dr R and they have been sharing medical premises since xx. From Easter xx, Dr R, Dr I, Dr xx I and Dr J set up xx which is a private medical company of which Dr R is a shareholder. Dr I was the Clinical Director of the Department of Surgery at xx Hospital from xx.

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[55] Transcript, p507, lines 17-20
[56] Transcript, p534, line 41 and p537, lines 33-35
[57] lines 16-49
[58] Transcript p543, lines 7-20

101. Dr I's evidence is essentially in the nature of a reference, although he did wish to give independent expert evidence as to Dr R's manner of operating and the situation that existed at xx Hospital during the time of his management and treatment of A.

102. Dr I had discussed with Dr R his recollection of a discussion with Dr G following the June 1994 report. That discussion did not form part of Dr I's brief of evidence. Dr I did not regard that as a significant event and in his opinion it was not a factor that brought about Dr R's change to his proposed action following the 1994 report.[59]

103. Dr I was also of the view that systemic issues in xx Hospital influenced the management of A during this time although he did acknowledge that his views were speculative only. He did also note that his view that A would have had an earlier appointment following the 1994 Dr G Report was not supported by any notes on the file that might have indicated to administrative staff that an earlier appointment might have been desirable. Dr I did however, consider that Dr R was, in 1991, an experienced breast surgeon based on the amount of work he was doing in that area at the time.[60]

104. A brief of evidence was filed by K who is a pathologist from xx and the Clinical Director of xx. Dr K has been involved in testing familial breast cancer since the mid-1990's and was asked to give evidence about genetic testing for breast cancer. The Tribunal had no questions of Dr K and therefore his evidence was taken as read.

Standard of Proof

105. The onus of proof is on the CAC to establish the charge in this case and that requires the charge to be proved on the balance of probabilities.

106. The requisite standard of proof in medical disciplinary cases was considered by Jeffries J in *Ongley v Medical Council of New Zealand*[61] where the High Court

[59] Transcript, p566, lines 32-34
[60] Transcript, p568, line 33
[61] (1984) 4 NZAR 369

adopted the following passage from the judgment in *re Evatt: ex parte New South Wales Bar Association*[62]:

> *"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*[63]*. 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 in 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."*

107. That position has been followed in *Gurusinghe v Medical Council of New Zealand*[64]*; M v Medical Council of New Zealand (No. 2)*[65]*; and Cullen v Medical Council of New Zealand*[66].

Professional Misconduct

108. Jeffries J in *Ongley v Medical Council of New Zealand*[67] formulated a test for defining professional misconduct as:

> *"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 examines the conduct."*

109. In *B v The Medical Council*[68] (in the context of a charge of conduct unbecoming), Elias J (as she then was) stated:

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

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[62] (1967) 1 NSWLR 609
[63] [1966] ALR 270
[64] [1989] 1 NZLR 139 at 163
[65] Unreported HC Wellington M239/87 11 October 1990
[66] Unreported HC Auckland 68/95 20 March 1996
[67] supra 41
[68] Unreported HC Auckland HC11/96 8 July 1996

on the balance of probabilities that the conduct of the practitioner is deserving of discipline."

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

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

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

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

111. The issue is essentially whether the conduct of Dr R is culpable, that is, whether it is conduct deserving of discipline.

Decision

112. The Tribunal has considered at length the evidence brought on behalf of the CAC and Dr R. Both counsel have indicated that the primary evidence having been given by A on the one hand and Dr R on the other raises the issue of credibility. The Tribunal has had the benefit of seeing and hearing the evidence from both parties and acknowledges Dr R's inability to recall the detail that is set out in A's evidence. Mr McClelland, in his submission, referred to Dr R's defence as a *"blanket denial of A's evidence"*[69] but it is noted that in his oral evidence Dr R did acknowledge the possibility that A's recollection was correct in a number of significant areas.

113. The Tribunal considered that A's recollection, which was supported on a number of points by her partner Mr B, was credible and in the event of conflict was to be preferred over Dr R's sometimes incomplete recollection.

[69] Closing Submissions para 3 (Exhibit 25)

114. Much of the evidence for Dr R centred on whether the rider to the 1994 G Report was justified and that had resulted in the re-reading of the slides. The Tribunal however considered that the significance of the 1994 G Report was rather in the fact that there had been no mention of it and that A was in fact not aware of it until she obtained her medical records in 1999.

115. The issue of whether the lump was detectable in 1994 or in 1996 cannot be answered definitively. What the Tribunal is concerned with is the action taken or not taken by Dr R in light of the information he has been presented with in his management and treatment of A. To that end it is significant that the last ultrasound was done in November 1994 and the last mammogram was done in November 1996.

116. The Tribunal, after hearing the evidence of A, Mr B, and Ms F, is clearly of the view that A was an active participant in this process. She is an articulate woman who had gone to Dr R in 1991 as a responsible move to protect herself against the possibility of breast cancer when faced with her family history. She has been reassured by Dr R on a number of occasions and even when she had doubts, resulting in referrals by her GP outside her normal surveillance, she has relied on the reassurances received from Dr R and has had confidence in his management and treatment.

117. The Tribunal accepts Dr R's evidence that his management was ad hoc and is of the view that there does not appear to have been any management plan in place. It is also difficult for the Tribunal to understand how there can be any effective management with the paucity of notes. The Tribunal considered that a lack of diagrams showing where cysts were located and aspirated and where lumps had been identified would have made any ongoing management very difficult. One clear example is the fact that it is not until 1995 that any notes as to family history were taken. Dr Harman certainly acknowledged that a family history would need to be taken before determining whether A was a moderate or high risk patient.

118. The Tribunal also accepts that from the end of 1996 through to 1998 concern was being expressed by A about a lump and the Tribunal accepts on the evidence that at the consultation on 13 February 1997 A referred to the cytology report undertaken in December 1996. The explanations as to why that report was not on the file were confusing but given the information that Dr R had received from A it is of concern

that some follow-up or attempt to locate that report or to undertake any further tests in respect of the lump was not undertaken.

119. The Tribunal also has already identified concerns about the fact that the last ultrasound took place in 1994 and that a mammogram was last done on 11 November 1996.

120. The Tribunal considers, particularly during the period of time from 1996 to 1998, that A's anxiety intensifies and yet this is the period of least activity in terms of treatment and management by Dr R.

121. The matter of the six meetings held between A and Dr R also raises concerns for the Tribunal. It is unclear on what basis Dr R entered these meetings as he was of the view that they were not in the nature of doctor patient meetings and yet he was clear that he had been treating A up until July 1999. These meetings and the length of them confirms for the Tribunal the fact that A was articulating her concerns and her issues and that Dr R was attempting to appease those concerns and to avoid the possibility of a complaint being laid. The personal and emotional nature of those meetings is also illustrated by A's letter to Dr R and the fact of the number of telephone conversations that occurred at this time.

122. Mr Waalkens in his opening and closing submissions referred the Tribunal to the matter of threshold and submitted that even if the allegations set out in the particulars of the charge were proven, that that does not of itself mean an adverse disciplinary finding is to be made against Dr R. He referred to the case of *Pillai v Messiter*[70] where it was stated:

> "*Departures from elementary and generally acceptable standards could amount to… such professional misconduct… but 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 privileges which accompany registration as a medical practitioner.*"

[70] (1989) 16 NSWLR 197

123. The Tribunal considers that the management and treatment of A by Dr R does depart from accepted standards to a point of indifference on a number of counts. The Tribunal does not accept that this can be explained by the pressures of a public hospital system but has after reading the notes and hearing the evidence, considered that, as the doctor primarily responsible for the management and treatment of A, Dr R has not discharged that responsibility in a manner that would be expected of a surgeon of his experience and expertise.

124. The Tribunal acknowledges that Dr R is a general surgeon and was so in 1991 but accepts the evidence of Dr I and Dr Harman that he was regarded as an experienced and competent breast surgeon. It is also to be noted that since xx he has been an integral part of the establishment of xx and during that time has been involved in xx. It is clear that on referral to xx Hospital Dr R was identified as an appropriate person to manage A and it is clear that A regarded him as an expert and that he offered reassurance and advice on the basis that he was such an expert.

125. The Tribunal is therefore satisfied that Dr R is guilty of professional misconduct in the course of his management and treatment of his patient A and that particulars 2 to 5 inclusive of the charge, set out in paragraph 1 of this decision have been established.

126. In relation to particular 1 the Tribunal, by a majority, considers that Dr R did appropriately follow-up on the cytology dated 10 June 1994. This is based on the evidence of Professor David Gillett who considered that reviewing A in outpatients in six months was perhaps appropriate. It is noted though that Professor Gillett's preference was for a follow up in three months time and that he did refer to a review with *"specialised views"*.[71]

127. The Tribunal considers that those matters set out in particulars 2 to 5 inclusive of the charge separately and cumulatively amount to professional misconduct.

128. In relation to penalty counsel for the CAC is to lodge submissions as to penalty no later than 14 days after receipt of this decision. Submissions on behalf of Dr R are to be lodged no later than 14 days thereafter.

DATED at Auckland this 22nd day of March 2004.

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Prue Kapua

Deputy Chair

Medical Practitioners Disciplinary Tribunal

[71] Transcript p.164 lines 28-33