



## **Inappropriate Care – Professional Misconduct (02/96C)**

### **Charge:**

The Complaints Assessment Committee pursuant to s93(1)(b) of the Act charged that Robert William Robertson in the course of his management and treatment of his patient:

1. Failed to appropriately follow up on a cytology report dated 10 June 1994 in relation to the patient'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 the patient's left breast; and
3. Failed to provide the patient with an acceptable standard of care:
  1. Prior to performing an excision biopsy on the patient 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
  2. On 9 October 1998 following diagnosis of invasive carcinoma offered the patient 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. Failed to take notes and/or adequate notes in the patient's medical records of his consultations with her:
    - i. In 1994 when he failed to document his actions after receiving the abnormal cytology report;
    - ii. 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
    - iii. Between early 1999 and mid 2000 on the occasions he met with her after hours in his practice rooms at Surgical Associates.
4. Failed to provide sufficient information to the patient as was necessary for her to make informed decisions:
  - i. Failed to tell the patient about a cytology report dated 10 June 1994 that stated that an "in-situ ductal lesion cannot be excluded with certainty"; and/or
  - ii. Failed to provide the patient 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:
  1. Provided information to, and about, his patient which was inaccurate, misleading or wrong:
    - i In October 1998 stated in written communications with two doctors, and in written reports on file, that diagnostic tests had been undertaken with respect to an identified solid lesion in the patient's left breast, and that the results of these diagnostic tests had been reported as negative for carcinoma, when no such tests had been undertaken and between October 1998 and July 2000, repeated these claims in verbal communication with the patient;
    - ii In July 1998 stated verbally to the patient, and again in October 1998 to the patient and her partner 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;
    - iii Stated to the patient that early detection of breast cancer was ineffective and that his failure to remove the patient's breast lump sooner would therefore not have affected her prognosis;
    - iv Between April 1999 and July 2000, repeatedly denied to the patient any possible relevance of the cytology report dated 10 June 1994;
    - v In a letter dated 30 October 2000 to ACC, advised that because of the cytology report dated 10 June 1994, the patient had a further ultrasound in November 1994 which is not correct.
  2. In the period early 1999 to mid 2000 failed to treat his patient in a professional, honest and respectful manner:
    - i Invited her to meet him outside of his practice and despite her refusal, continued to make such invitations;
    - ii Encouraged ongoing contact with him when she was questioning the effect of this on her mental health;
    - iii Continued to encourage her to develop an attachment to him;
    - iv Suggested her memories of events were mistaken, and that she was in danger of losing her mind;
    - v Made disparaging comments about her expressions of distress and her desire to live;
    - vi Failed to recommend her to seek assistance for her disclosed symptoms of emotional distress;

- vii Attempted to discourage her from taking complaint action against him 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 the patient'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.

### **Background:**

In December 1991, the patient was referred by her general practitioner to Dr Robertson 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.

From that initial appointment the patient 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 the patient was concerned about specific lumps and sought the assistance of her GP for an additional referral.

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. The patient's weight was taken on each occasion and on nine occasions that is the only information contained in the clinical notes. The reporting letters to the patient's GP contain more information but were still reasonably brief.

During the period from December 1991 until the patient was advised that she had invasive cancer and DCIS in October 1998, she had attended 15 appointments at the Hospital and had had a number of routine mammograms and ultrasounds, although none had been sought as part of Dr Robertson's management after November 1996.

On 31 May 1994 the patient saw Dr Robertson following a routine mammogram that had been done on 23 May 1994. The cytology report following that consultation is dated 10 June 1994 and stated:

*“... Although probably benign, the possibility that these clusters represent an in-situ ductal lesion cannot be excluded with certainty.”*

From the hospital records it appeared that upon receipt of the report Dr Robertson wrote “for biopsy”. This was then crossed out and replaced with the words “file see again at OPD.”

The patient 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. At that consultation the patient was advised that the lump she had been concerned about had been a fibroadenoma.

In December 1996 the patient became aware of a small palpable solid lump in the upper outer quadrant in her left breast at 2 o'clock. Her GP referred her to another specialist, Dr E who aspirated three cysts and in respect of the lump identified by the patient 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.”*

That report was to be copied to Dr Robertson although it was unclear at what time it came into his possession. The patient however was clear that she referred to that report at her next consultation with Dr Robertson on 13 February 1997.

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

On 19 March 1998 the patient returned to her GP and asked for a referral to Dr Robertson because of the lump. She was seen by Dr Robertson 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 been uncomfortable and had increased in size recently.

On 23 July 1998 the patient saw Dr Robertson again and three cysts were aspirated. There was no testing of the solid lump in the left breast and Dr Robertson described it in his letter as follows:

*“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. I think it would be better to have this removed, ...”*

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

Two days after the surgery Dr Robertson advised the patient that she had invasive cancer and DCIS. In his reporting letter to her GP following that meeting, Dr Robertson stated:

*“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.”*

On 21 October Dr Robertson performed a left mastectomy on the patient. Following that surgery at a further consultation there was discussion between the patient, her partner and Dr Robertson surrounding the issue as to why the “lesion” had not been more definitively diagnosed. On 14 April 1999 the patient underwent a second prophylactic mastectomy of the right breast. On the day following surgery Dr Robertson visited the patient and the nurse noted in the hospital records that they had a “*long chat.*”

Between 20 April 1999 and 28 March 2000 Dr Robertson and the patient met six times at his rooms. The meetings were scheduled for 6.00 pm but did not generally begin until around 6.30 pm and each meeting was approximately 90 minutes long. At the meetings the patient and Dr Robertson discussed what had occurred in relation to her treatment. While the evidence as to the specifics of these meetings varied, the Tribunal was satisfied that these meetings were a means of explaining or understanding the sequence of events that had resulted in the patient being advised that she had invasive cancer in October 1998 and the resultant double mastectomy. There were also a number of telephone calls between Dr Robertson and the patient during October/November 1999.

The patient had obtained a copy of her file just three days after the first meeting and what she found on the file gave her cause for concern. It gave rise to a number of questions about her treatment that she wished Dr Robertson to answer.

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

### **Finding:**

The Tribunal found Dr Robertson guilty of professional misconduct.

The Tribunal considered the patient’s recollection of events was credible and in the event of conflict her evidence was preferred over Dr Robertson’s sometimes incomplete recollection.

In relation to particular 1 the Tribunal, by a majority, considered that Dr Robertson did appropriately follow-up on the cytology dated 10 June 1994, and therefore particular 1 was not established.

The Tribunal was satisfied particulars 2 to 5 inclusive of the charge were established.

Much of the evidence for Dr Robertson centred on the cytology report of 10 June 1994 and whether or not the report was justified in stating “an in-situ ductal lesion cannot be excluded with certainty”. This had resulted in the re-reading of the slides. The Tribunal, however, considered that the significance of the report was that there had been no mention of it and that the patient was in fact not aware of it until she obtained her medical records in 1999.

The issue of whether the lump was detectable in 1994 or in 1996 could not be answered definitively. However, the Tribunal was of the view that there did not appear to have been any management plan in place and considered it difficult to understand how there could 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. The Tribunal also considered it significant that the last ultrasound was done in November 1994 and the last mammogram was done in November 1996.

The Tribunal accepted that from the end of 1996 through to 1998 concern was being expressed by the patient about a lump and the Tribunal accepted at the consultation on 13 February 1997 the patient referred to the cytology report undertaken in December 1996. The Tribunal was concerned some follow-up or attempt to locate that report or to undertake any further tests in respect of the lump was not undertaken.

The matter of the six meetings held between the patient and Dr Robertson also raised concern for the Tribunal. It was unclear on what basis Dr Robertson 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 the patient up until July 1999. These meetings and the length of them confirmed for the Tribunal the fact that the patient was articulating her concerns and her issues and that Dr Robertson was attempting to appease those concerns and to avoid the possibility of a complaint being laid.

The Tribunal was satisfied that the management and treatment of the patient by Dr Robertson departed from accepted standards to a point of indifference on a number of counts. It considered that, as the doctor primarily responsible for the management and treatment of the patient, Dr Robertson did not discharge that responsibility in a manner that would be expected of a surgeon of his experience and expertise.

### **Penalty:**

The Tribunal ordered Dr Robertson be censured, pay a fine of \$10,000 and pay 40% of the costs in respect of the hearing.

It further ordered a notice of the hearing be published in the New Zealand Medical Journal.

### **Appeal:**

Counsel for Dr Robertson appealed the substantive and the penalty Decisions to the District Court. The District Court upheld the Tribunal's findings of professional misconduct, but only in the following respects:

- Particular 2 which amounted to professional misconduct.
- Particulars 4.2.i (in part), 4.2.ii (in part) and 4.2.vii.b which cumulatively amounted to professional misconduct.
- Particular 2, particular 4.1.iii and particulars 4.2.i (in part), 4.2.ii (in part) and 4.2.vii.b which cumulatively amounted to professional misconduct.

The Court reduced the fine to \$5,000.00 and granted leave to Counsel for Dr Robertson to make further submissions on the subject of costs in respect of the Tribunal proceedings.

The CAC cross appealed and submitted the Tribunal should have imposed conditions on Dr Robertson's practice. The Court dismissed the appeal filed on behalf of the CAC. The Court denied Dr Robertson permanent name suppression.

(*R W Robertson v CAC*, (District Court Christchurch, CIV-2004-009-1784, 28 November 2005, Moran J)).

The full decisions relating to the case can be found on the Tribunal website at [www.mpd.org.nz](http://www.mpd.org.nz) Reference No: 02/96C.