



**PROFESSIONAL STANDARDS COMMITTEE INQUIRY**  
**CONSTITUTED PURSUANT TO PART 12 DIVISION 1 of THE**  
**MEDICAL PRACTICE ACT 1992 to HOLD AN INQUIRY IN TO A**  
**COMPLAINT IN RELATION TO DR WILLIAM JOHN LYNCH**

**Dates of Inquiry:** 11 and 12 June 2009

**Committee members:**

Ms Helen Kiel, Chairperson (Legally qualified, not a registered medical practitioner)

Dr Donald Moss (Registered medical practitioner)

Dr John Sammut (Registered medical practitioner)

Ms Jennifer Houen (Lay person)

**Legal Officer assisting Committee:**

Ms Bridget Andersons, Legal Officer

Appearance for Health Care Complaints Commission: Ms Katharina Buck, Hearing Officer

Appearances for Dr Lynch: Mr Bill Hawson, Solicitor

Ms Julie Brooke-Cowden, MDA National

**Date of decision:** 21 July 2009 (amended 27 August 2009)

**Publication of decision:** Refer to page 15 of this decision for details of non-publication directions

**SUMMARY**

The Professional Standards Committee finds the Complaint against Dr Lynch proved and that he is guilty of unsatisfactory professional conduct within the meaning of section 36 of the Medical Practice Act 1992. Dr Lynch is reprimanded and the subject of an order that his practice be audited, with particular reference to the systems in place for follow-up of patient test results.

## **INTRODUCTION**

1. On 22 November 2005, a complaint was received by the HCCC from the wife of a patient of Dr Lynch. The complaint alleged that Dr Lynch failed to monitor the patient's elevated PSA levels and to perform a biopsy of the prostate when he knew the patient's brother had suffered from prostate cancer. By the time the patient's prostate cancer was discovered it had metastasized beyond the prostate. As many of Dr Lynch's clinical notes of his treatment of the patient had been lost in a move between surgeries, much of the evidence of Dr Lynch's treatment of the patient came from his letters to the patient's general practitioner, hospital notes and pathology reports, and the evidence of the patient's wife.
2. On 28 May 2008 a complaint against Dr William John Lynch was referred by the NSW Health Care Complaints Commissioner to be dealt with by a Professional Standards Committee. It was prosecuted before this Committee by the Director of Proceedings acting as nominal complainant.

## **COMPLAINT**

3. The complaint against Dr Lynch dated 28 May 2008 is as follows:
4. That Dr Lynch has been guilty of unsatisfactory professional conduct within the meaning of section 36 of the Medical Practice Act in that:
  - 4.1. he has demonstrated that the knowledge, skill or judgment possessed, or care exercised, by him in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience; and/or
  - 4.2. he has engaged in conduct relating to the practice of medicine that is improper or unethical.
5. An Amended Complaint was filed on 6 April 2009 in which the second allegation referred to above was abandoned.

## **PARTICULARS**

6. At all material times Dr Lynch conducted a practice as a urologist in the state of New South Wales:
  - 6.1. On 9 February 2001 patient A came under the care of the practitioner.
  - 6.2. As at 9 February 2001 patient A presented to the practitioner with a long history of poor urine function and abnormal PSA levels.
  - 6.3. On 9 February 2001 the practitioner knew from an examination that he had conducted that patient A's prostate remnant was moderately sized and slightly irregular in shape.

- 6.4. On 9 February 2001 the practitioner was aware of the need to consider carrying out a biopsy of patient A.
  - 6.5. On 20 March 2001 and 16 July 2001 the practitioner was aware of cystoscopies performed on patient A.
  - 6.6. On 17 September 2001 the practitioner performed a cystoscopy on patient A during which the practitioner noted that the prostate cavity was quite open and "quite hard on the left lobe".
  - 6.7. Being aware of the matters referred to in particulars 1 – 6 above, the practitioner failed to offer to patient A, or arrange for, a biopsy of patient A.
  - 6.8. Between 9 February 2001 and about September 2003, the practitioner failed to inform patient A about the PSA results obtained for patient A.
7. Dr Lynch admitted particulars 1 - 5 of the complaint, although he denied in relation to particular 2 being aware of all of the patient's abnormal PSA levels at the first consultation. He denied particular 6 but admitted being present when his Registrar performed a cystoscopy on the patient. Dr Lynch denied particulars 7 and 8 but admitted in relation to particular 7 that he did not arrange for a biopsy to be performed.

## **THE MEANING OF UNSATISFACTORY PROFESSIONAL CONDUCT**

8. Section 36 of the Medical Practice Act 1992 states

*"Meaning of "unsatisfactory professional conduct"*

*For the purposes of this Act, unsatisfactory professional conduct of a registered medical practitioner includes each of the following:*

*(a) Conduct significantly below reasonable standard*

*Any conduct that demonstrates that the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of medicine is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience. ....*

9. The phrase "significantly below" is not defined in the Act. However in the Second Reading speech when this legislation was introduced to Parliament it was stated that:

*"The first main purpose of the bill is to refocus the Health Care Complaints Commission (HCCC) on investigating serious complaints about health service providers. To achieve this, Commissioner Walker recommended that unsatisfactory professional conduct be redefined so that only significant instances involving lack of skill, judgment, or care will result in an investigation or disciplinary action. .... the reference to 'significant' in that context may refer to a single act or omission that demonstrates a*

*practitioner's lack of skill, judgment or care, or it may refer to a pattern of conduct. In any individual case, that will depend on the seriousness of the circumstances of the case."*

## **STANDARD OF PROOF**

10. For the Complaint to be proved, the Committee must be reasonably satisfied on the balance of probabilities that Dr Lynch's conduct satisfies the statutory definition of unsatisfactory professional conduct. As stated in *Briginshaw v Briginshaw* (1938) 60 CLR 336

*"Reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the Issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by Inexact proofs, indefinite testimony, or indirect inferences"*

## **EXHIBITS**

11. Prior to the Hearing, and with the consent of the parties, the Committee was provided with two folders of documents by the HCCC. Volume 1, indexed 1-30, consisted of the complaint, correspondence and documents relating to the complaint, and the reports of the peer reviewer. Volume 2 was a folder of the patient's available medical records (Exhibit 1) Dr Lynch provided documents numbered 1 – 5, which included his statement dated 29 May 2009, a peer report by Dr Hunter Watt, and other correspondence related to that report (Exhibit A).
12. Shortly before the hearing commenced, Dr Lynch also provided copies of Patient A's clinical records for the period 9 September 2003 to 4 October 2005 and a delivery docket from Ausdoc dated 13 December 2005 which confirmed the loss of his notes in relation to Patient A.
13. A chronology of the patient's treatment by Dr Lynch was provided by the HCCC at the beginning of the inquiry to assist the Committee.
14. Written submissions were provided by both parties at the conclusion of the hearing.

## **BACKGROUND**

15. Dr Lynch completed his Bachelor of Medicine and Surgery in 1982 and was first registered in New South Wales on 3 March 1982. He became a Fellow of the Royal Australasian College of Surgeons in 1991. Between

1982 and 1992 he worked in a number of different hospitals in New South Wales. Between 1991 and 1992 he worked overseas in England at the Royal London Hospital. In 1992 upon his return to Australia, he commenced work in private practice, and as a Consultant Urologist at St George Hospital where he is now Departmental Head of Urology. In mid-2003 he moved his practice into a group practice with four other consultant urologists at Urology Sydney.

16. Dr Lynch's Curriculum Vitae indicates that he is a member of the Urological Society of Australasia, the British Association of Urological Surgeons, the American Urological Association, the European Association of Urology, and a number of other professional bodies and committees. He has held various executive positions in the Urological Society of Australasia. He has received many special invitations to attend meetings and conferences both in Australia and overseas. Dr Lynch has an impressive list of presentations at scientific meetings, and numerous publications both in Australian and overseas journals.

## EVIDENCE

### The patient's history

17. The patient's history as documented by Dr Lynch is highly relevant in determining the complaint against him, and is therefore set out below in some detail. In the absence of his clinical notes for a significant period of time, this history can be gleaned from Dr Lynch's letters to the patient's general practitioner following his consultations with the patient, and from hospital and other records. Dr Lynch's letters are generally quite brief.
18. The patient first presented to Dr Lynch on 9 February 2001. The letter of referral by the patient's general practitioner was not in evidence. It is therefore not clear what information was available to Dr Lynch about the patient prior to the first consultation.
19. Following the first consultation Dr Lynch wrote to the general practitioner, Dr M, that the patient *"..detailed quite a history of poor stream and his symptoms are slowly getting worse. I note his elevated PSA level of 11.5.*
- On examination the prostate remnant is moderately sized and slightly regular. I have arranged for a few baseline investigations and will consider when to proceed to biopsy after that"*
20. Dr Lynch then saw the patient again and performed flexible cystoscopies on 23 March 2001 and 17 July 2001, sending brief letters to the patient's general practitioner in relation to the patient's urethral strictures.
21. On 17 September 2001 a cystoscopy was performed by Dr Lynch's Registrar in Dr Lynch's presence. Dr Lynch's letter reporting on the procedure stated that *"..He had quite an open prostate cavity, though it was quite hard on the left lobe. The bladder itself was fine and stricture was dilated. I will follow him up in a few weeks time with a PSA"*

22. On 8 October 2001 a PSA ordered by Dr Lynch was 11.4. Dr Lynch reviewed him a week later on 15 October 2001 and noted to the general practitioner that he planned to repeat the PSA in three months. However the next PSA was not done until 7 May 2002 when the reading was 15.8. A week later Dr Lynch reported to the general practitioner that he had performed another cystoscopy. He did not mention the PSA of 15.8.
23. Further cystoscopies were performed on Patient A by Dr Lynch on 14 May 2002 and 3 December 2002 with brief reports back to the general practitioner and no mention of the PSA reading of 15.8 on 7 May 2002.
24. On 9 September 2003 Dr Lynch wrote to the general practitioner about the patient's urethral strictures following another cystoscopy *"...in view of their recurrence I will check him again in two months time, and in the meantime I have also arranged for him to have a follow up PSA."* In fact the PSA was ordered by Dr Lynch and conducted on the same day. This time the level was 36.7.
25. On 11 November 2003 Dr Lynch performed a flexible cystoscopy and noted *"...another mild recurrence of his penile stricture though much better than previously noted."*

*The prostate was quite large and there was significant trabeculation of the bladder."* Dr Lynch noted that as the patient *"was still having problems with his prostate I have commenced him on Prazosin at a dose of 0.5mg bd. I would be most grateful if you could increase him to at least 1mb bd. I will review him again in two months time"*. There was no mention of the markedly elevated PSA of 36.7 two months earlier.

26. Patient A saw Dr Lynch again on 29 January 2004 and 28 May 2004 in relation to his urinary problems and on 1 July 2004 and expedited TURP was performed.
27. On 2 August 2004 Dr Lynch reported that the patient had *"...made a good recovery from his recent resection and urethrotomy. He is voiding with a good stream and his symptoms have settled competently."*
- On examination pathology from the bladder mass resection has shown prostatic adenocarcinoma Gleason grade 9. This of course is of some concern. I have arranged for him to have some staging investigations and will review him again in a few weeks time."*
28. On this date the patient's PSA level was 52.5. It is not clear who ordered this test.
29. On 22 September 2004 Dr Lynch reported back to the general practitioner for the last time. *"He is reasonably well though of course he still has his regular back pain. He has commenced Cosudex prior to the addition of Zoladex and he is under the care of a radiotherapist for radiotherapy to his metastases. I will keep you posted."*

## Witnesses

### Dr J.H Alexander

30. Dr Alexander, a highly qualified and experienced urologist and Head of Urology at Royal North Shore Hospital and North Shore Private Hospital, provided a number of expert reports to the Health Care Complaints Commission on Dr Lynch's treatment of patient A, the later reports clarifying issues upon which he had been asked to comment. In his report dated 17 August 2006 Dr Alexander noted the difficulties in commenting on Dr Lynch's treatment of the patient because of the missing clinical notes and the lack of any history of how the patient acquired his urethral strictures and what his co-morbidities were. However, he noted that *"Although there are other causes for a raised PSA, in this case it was highly likely that the patient had cancer of the prostate dating back to 2000.....I find it difficult to understand why Dr Lynch did not biopsy (the patient's) prostate at some stage in view of the progressively rising PSA over several years"*
31. In his later report dated 6 March 2007 Dr Alexander further noted that *"Dr Lynch commented on the hardness of the prostate which also raises the significant possibility of (the patient's) prostate being malignant"* Dr Alexander concluded that Dr Lynch, in failing to biopsy the patient, fell significantly below the standard expected of a senior urologist. He stated that after the patient's prostate was found to be *"...quite hard on the left lobe"* that he would have advised the patient of this in view of the possibility of cancer, and explained the need for a biopsy procedure. He noted that a percentage of men try and delay or avoid a prostate biopsy, but stated that if the patient had refused a biopsy he would have noted this to the general practitioner for two reasons, firstly to "cover himself" and secondly, because the general practitioner would probably have a better rapport with the patient and could possibly change the patient's mind.
32. Dr Alexander noted that as the patient's PSA levels rose over the next two years the case for a biopsy became even stronger, particularly in view of the irregular rectal examination by Dr Lynch's registrar and the brother of the patient having a history of prostate cancer. He agreed in evidence that even if Dr Lynch thought the raised PSA might have been attributable to other causes, after a seven month period which included a PSA of 11.4 on 8 October 2001, a hardness of the prostate on 17 September 2001 and a PSA of 15.8 on 7 May 2002, a strong possibility of malignancy should have been considered by Dr Lynch. Dr Alexander stated that he would have done a rectal examination and a PSA test at the time of each cystoscopy if he suspected prostate cancer. He noted the importance of having in place a system which meant that every test and investigation on a patient was checked, and stated that in his own practice no test result was filed until he had signed it.
33. Dr Alexander concluded that if the patient was not informed of the possibility of prostate cancer and given the opportunity for biopsy then Dr

Lynch's conduct fell significantly below the standard to be expected of a senior urologist.

Dr Hunter Watt

34. Dr Hunter Watt, also a very experienced and well-qualified urologist, was asked by Dr Lynch to provide a report. Dr Watt is currently Chief Executive of the Greater Metropolitan Clinical Taskforce (a Ministerial appointment) and holds a number of honorary and other positions. In addition to his report he also gave evidence before the Committee. In his report dated 20 May 2009 he acknowledged that he knew both Dr Lynch and Dr Alexander, describing them as both *"highly skilled, well respected and highly regarded by the urological community"*. Dr Watt agreed with the discussion and conclusions of Dr Alexander in his report dated 17 August 2006 noting however that the conclusions reached were without knowledge of the patient's co-morbidities. Dr Watt pointed out the patient's co-morbidities documented in the materials supplied to him. These included long-standing Type 11 insulin dependent diabetes, long-standing chronic back pain for which previous surgery had been undertaken, drainage of perianal abscess (possibly a misdiagnosis), chronic perianal pain possibly relating to post herpetic neuralgia, a past history of depression and post traumatic stress disorder, a past history of previous resection of the prostate and a family history of prostate cancer. In Dr Watt's view these co-morbidities would have impacted upon the decision making process that occurred at the time of Dr Lynch's initial consultation and subsequently.
35. However Dr Watt found it difficult to understand why a prostatic biopsy was not performed at some stage in the two years following the initial consultation. He said *"I am of the view that Dr Lynch did fail in his duty of care to the patient in not following up on PSA readings which he himself ordered dated 7 May 2002 and 9 September 2003. The evidence on which I base this conclusion, is the lack of mention of the PSA level in the letter to Dr M (the general practitioner) dated 14 May 2002 and also in the letter again to Dr M dated 3 December 2002. In subsequent letters to Dr M dated 29 January 2004 and 28 May 2004 which discuss arranging a transurethral resection of the prostate for the patient, neither the PSA level nor the possibility of prostate cancer is mentioned."*
36. Dr Watt stated that at the time of the initial consultation when the patient's PSA level was 11.5 he would have taken a history which included the family history, the patient's medical history, the patient's presentation and symptoms, details of any prior investigations and that he would have conducted a physical examination of the patient. Dr Watt said that it was his personal practice to write a detailed letter to a general practitioner outlining the factors mentioned above, and that if the patient rejected his advice in relation to a biopsy he would document this in his letter.
37. When the PSA reached 36.7 Dr Watt said the patient should have been contacted and told of the strong possibility of a prostatic malignancy. His own practice in September 2003 when PSA results came to his rooms was

to make a note on the hard copy of the document and then file the result or call the patient. He said that it was quite likely that the patient had cancer of the prostate when he presented initially to Dr Lynch but it was impossible to know whether the cancer was curable at that point.

#### Patient A's wife

38. As well as her initial letter of complaint received by the HCCC on 22 November 2005, the patient's wife also provided a formal statement to the Commission dated 3 September 2007, attaching pathology reports, doctor's letters and other documents.
39. The patient's wife in evidence stated that the patient originally saw Dr Lynch because he had suffered from urinary problems for a number of years. She explained that her husband's brother had been Dr Lynch's patient and Dr Lynch had successfully treated him for prostate cancer and that they had reminded Dr Lynch of this at the first consultation. Prior to consulting Dr Lynch their general practitioner had suggested getting a PSA done in view of the family history. The patient took the PSA result to Dr Lynch and it was 11.5. Dr Lynch said that he could do a biopsy but that it was better to leave it at this stage because the patient had other problems which were more urgent. She said both she and her husband were unaware of the significance of a high PSA and that Dr Lynch had said that the PSA of 11.5 did not really demand a biopsy. Her evidence was that after a conversation with Dr Lynch in October 2001 when the PSA was 11.4 they never again discussed the patient's PSA levels with Dr Lynch. She said that both she and her husband took it for granted that Dr Lynch would tell them if there were any problems with the PSA levels. She eventually tracked down his PSA results by phoning every pathology laboratory in Sydney.
40. When asked whether her husband had ever refused a biopsy the patient's wife replied that he would never refuse one because *"he liked life too much"* and that he was enjoying being a grandfather. She said that Dr Lynch had assured them that he would do a biopsy when the time came. The patient's wife stated that during 2002 and 2003 when her husband saw Dr Lynch the consultations took place in the day surgery where Dr Lynch did a cystoscopy. She said that the first consultation with Dr Lynch was about 10 to 15 minutes and the others only about ten minutes.

#### **Dr Lynch**

##### PSA results

41. Dr Lynch conceded before the Committee that it was possible that he did not see the PSA result of 15.8 on 7 May 2002 as he was not in his rooms when he had the consultation with the patient which involved a cystoscopy. He said his notes would usually be with him at the surgery but it was possible that they were not on this occasion. He said he did not know why *"alarm bells didn't ring"* when the patient's PSA reached 15.8.

42. In his statement dated 13 May 2009 Dr Lynch said that he did not see Patient A's PSA level of 36.7 until after a complaint was made to the Health Care Complaints Commission, stating that *"It is my belief that the report may not have been sent to me, or if it was, it may have been mislaid."*

#### Failure to biopsy

43. Dr Lynch said in his statement of 13 May 2009 that *"In accordance with my invariable practice, I advised Patient A, at the consultation on 9 February 2001 that a biopsy of the prostate was required to exclude a 30% chance of prostate cancer or that there was a possibility of the presence of a cancer. It is not for me to make the decision for the patient to have a biopsy. It is the decision of the patient. A biopsy would only be arranged if that was the wish and instruction of the patient. It was not."* (Para 28 (g)) In the same statement Dr Lynch says *"I do recall that [patient A] was reluctant to undergo procedures in general. And I believe this may have been a factor relevant in his decision to defer biopsy"* (Para 11(g)) Dr Lynch said in evidence that it would be his usual practice to write to a patient's general practitioner if a patient was resistant to biopsy and that he was not overly forceful or demanding with patients. However when asked in evidence why in his letters to Dr M he did not refer to the patient's refusal to have a biopsy he said *"I can't answer that."*

#### Letters to patient A's general practitioner

44. Dr Lynch stated that every consultation with Patient A started with his lower back and perineal pain and that pain was always an issue when the patient had a rectal examination. He agreed that he never mentioned this in his letters to patient A's general practitioner. Dr Lynch also said that his standard practice when he performed a flexible cystoscopy was to also do a rectal examination. When it was pointed out that there was also no mention of such rectal examinations in his letters to patient A's general practitioner, he claimed that he would have documented them in his clinical notes. Dr Lynch was also unable to explain why there was no mention in the letters to patient A's general practitioner of the patient's PSA levels.

45. Dr Lynch stated that he allocated a 10 minute time slot for each new patient but also allowed an extra slot and that 15-20 minutes would comfortably deal with all the issues that may arise with a new patient. Dr Lynch said he would not communicate a family history back to a general practitioner as he kept his letters brief and succinct. When taken to referral letters from five other specialists in relation to their initial consultation with Patient A, he agreed that the letters were very competent and comprehensive in terms of treatment and options. Dr Lynch said his own initial letter simply outlined his plan for the patient and that he was not aware of some of the patient's other problems. He agreed that he should have found them out but was reluctant to concede that the standard in his letter was significantly below that of the letters from other specialists. He said that his clinical notes were his patient record, not his letters.

### Missing records

46. In his response to the complaint dated 23 December 2005 Dr Lynch pointed out that in mid-2003 when he moved from his solo practice into a group practice at Urology Sydney a number of patient files were subsequently unable to be located, and that all the doctors' individual patient notes had been archived at Ausdoc. Ausdoc had advised him that they had been unable to locate the patient's notes. Upon request from the Committee prior to the hearing Dr Lynch provided a one-page statement from Ausdoc which simply confirmed that the missing notes could not be located. Dr Lynch said that an extensive search had also been carried out at his offices at Kogarah and Miranda and that the records may have been misplaced during the move. He said that the transfer of his practice from July 2003 extended over a six month period. Dr Lynch said that when his practice relocated in July - August 2003 the records were transferred by a combination of scanning hardcopy records and electronic data transfer. His own rooms were used as temporary storage until the transfer to electronic records was completed and he had moved to new rooms. He said the patient's original notes never made the transfer to electronic records and he used his old records until the end of 2002. He stated that his own clinical notes were usually quite full notes and he used these as patient records rather than his letters to general practitioners.

### **SUBMISSIONS**

47. The submissions of both parties are summarized below.

#### HCCC - the Nominal complainant

48. It was submitted by the Health Care Complaints Commission that the Committee should find the facts of the complaint proved and that Dr Lynch's conduct fell significantly below the standard expected of a urologist of the equivalent experience and training, as stated by both experts who gave evidence before the committee. It was submitted that from the time of the first consultation with Dr Lynch on 9 February 2001 the patient presented with abnormal and rising PSA results which must have raised concerns about malignancy. It was further submitted that according to Dr Alexander, on 17 September 2001 there was an even stronger case that the PSA level was due to cancer of the prostate, given the comments in the operation report that the left lobe of the prostate was hard. The Commission submitted that the patient should have been offered a biopsy, had the consequences of raised PSA levels discussed with him and documented in the letters to the general practitioner. It was submitted that there was no evidence that the patient would have refused a biopsy.

#### Dr Lynch - Respondent

49. Dr Lynch submitted (at para 37) that the particular *"failing to offer the patient or arrange for a biopsy"* between 9 February 2001 and 17

September 2001 was not made out, noting that both expert reviewers Dr Alexander and Dr Watt were of the opinion that it was appropriate and reasonable to defer a decision whether to proceed to biopsy (and in the case of Dr Watt to canvass the issue with the patient) until after the cystoscopies, the optical urethrotomy, and a repeat PSA test.

50. It was also submitted (para 30) that the alternative allegation that there was a failure to arrange a biopsy only arises if the patient accepted that a biopsy be performed and that no arrangement was made to undertake the biopsy. It was noted that both expert reviewers, Dr Alexander and Dr Watt, emphasised that it is a matter for the patient to decide whether to undertake the procedure. It was pointed out that there was no evidence that the patient elected to have a biopsy and in the absence of such evidence the complaint alleging a failure to arrange a biopsy was not proved.
51. It was submitted (at para 51) that the PSA from blood collected on 7 May 2002 was advised to Patient A at the consultation on 14 May 2002 and that this "accords with Dr Lynch's invariable practice".
52. It was also submitted on behalf of Dr Lynch that the evidence and recall of the patient's wife should be considered with caution (para 44) and that her oral evidence was given with "emotion", and inconsistent with written statements made to the Health Care Complaints Commission.
53. Finally it was submitted that *"There are no medical issues which arise from a complaint of which Dr Lynch was not closely and directly aware at the time of his management of the patient and now. ...If any management of the patient was considered less than an appropriate standard it arose as a result of the failure of a system – and these failures, as Dr Lynch has stated in his practice have been addressed"*

## DISCUSSION

54. The Committee has carefully considered the submissions of the parties, the documentary evidence and the evidence of the witnesses. The Committee is mindful that the complaint is not about record keeping systems or the standard of record keeping. However the Committee's assessment of Dr Lynch's treatment of the patient must be seen in the context of the absence of Dr Lynch's clinical notes for a significant period of his treatment. In the absence of these notes and any real recall of relevant consultations with the patient, Dr Lynch seeks to rely upon his "usual" or "invariable practice".
55. There was, however, no other objective evidence before the Committee of such "usual" or "invariable practice" other than statements from Dr Lynch, leading the Committee to question what Dr Lynch's "usual" practices were. There was also no objective evidence as to recent changes in Dr Lynch's practice, so that the Committee could be certain that he now has better systems in place to ensure that abnormal results are acted upon, and that

general practitioners are appropriately informed when patients refuse recommended procedures or treatments.

56. Dr Lynch's admission that he could not explain why there was no mention in his letters to Dr M of the patient's PSA levels was of concern to the Committee, as was his concession that it was possible that he did not see the PSA result of 15.8 on 7 May 2002 as he was not in his rooms when he had the consultation with the patient. The fact that Dr Lynch was also unaware of the PSA level of 36.7 until after a complaint was made to the HCCC was of even greater concern. His concession that this PSA report "may have been mislaid" in the context of an earlier missed PSA report indicates a serious lack of care in the management of this patient.

57. It was submitted by Dr Lynch that the evidence and recall of patient A's wife should be considered with caution. However, the Committee accepts her evidence that had a biopsy been suggested by Dr Lynch, the patient would have consented to it, particularly in view of the unchallenged evidence that Dr Lynch had treated the patient's brother for prostate cancer. There was no evidence before the Committee that the patient would have refused a biopsy. The Committee also accepts the evidence of Patient A's wife that both she and her husband took it for granted that Dr Lynch would tell them if there were any problems with the PSA levels.

58. As noted above in the Second Reading speech to changes in the Medical Practice Act 1992

*"...significant instances involving lack of skill, judgment, or care ....may refer to a single act or omission .... or it may refer to a pattern of conduct. In any individual case, that will depend on the seriousness of the circumstances of the case."*

59. The failure to monitor the highly significant PSA levels not once, but twice, and to biopsy the patient or report to Dr M any discussion about biopsy after the initial consultation, indicates to the Committee that Dr Lynch's practice in relation to this particular patient, was significantly below the standard to be expected of an experienced urologist.

60. Dr Lynch states in his further response to the complaint dated 16 April 2007 that he has now instituted an electronic medical record system, that he continues to offer all patients with an elevated PSA a full discussion on the significance of such a result, and that all patients under the age of 70 are encouraged to consent to a free total PSA ratio assessment. He stated in evidence that he now has a triple check system in place. As noted above, however, Dr Lynch did not provide any evidence of these changes to his practice.

61. Both Dr Alexander and Dr Watt are critical of Dr Lynch. Dr Alexander states that in failing to biopsy the patient, Dr Lynch's conduct falls significantly below the standard he would have expected of a senior urologist. Dr Watt was of the view that Dr Lynch failed in his duty of care in not following up on PSA readings which he himself ordered. In giving their

evidence before the Committee neither of these senior urologists changed their views.

## **FINDINGS**

62. The Committee has carefully considered the written and oral evidence and the submissions by the parties. The Committee finds all of the particulars of the complaint proved, with the exception of particulars 2 and 6.
63. In relation to Particular 2 *"As at 9 February 2001 patient A presented to the practitioner with a long history of poor urine function and abnormal PSA levels"* the Committee finds that Dr Lynch was aware of the elevated PSA of 11.5 at the initial consultation.
64. In relation to Particular 6 *"On 17 September 2001 the practitioner performed a cystoscopy on patient A during which the practitioner noted that the prostate cavity was quite open and "quite hard on the left lobe"* the Committee finds that Dr Lynch was present when a cystoscopy was performed on patient A by his Registrar on 17 September 2001.
65. The Committee finds that Dr Lynch being aware of the matters referred to in particulars 1 to 6, with the exceptions noted above, failed to offer to patient A, or arrange for, a biopsy of patient A, and that between 9 February 2001 and about September 2003, the practitioner failed to inform patient A about the PSA results obtained for patient A. The Committee finds that this conduct amounts to unsatisfactory conduct within the meaning of section 36 (1) (a) of the Act in that Dr Lynch has demonstrated that the knowledge, skill or judgment possessed, or care exercised, by him in the practice of medicine is significantly below the standard reasonably expected of an experienced urologist.

## **ORDERS**

66. In determining the orders it should make the Committee is mindful of the fact that the jurisdiction is protective, not punitive (*HCCC v Litchfield* (1997) 41 NSWLR 630.) It is also, however, mindful of the principle of deterrence, both in relation to Dr Lynch and to the wider community of medical practitioners.
67. The Committee orders that in accordance with section 61(1) of the Act:
- 67.1. That Dr Lynch be reprimanded.
  - 67.2. That within 3 months from the date of receipt of this Decision and subsequently at 6 monthly intervals or as required by the NSW Medical Board he is to submit to a random audit of his medical practice, by a person or persons nominated by the NSW Medical Board. The auditor(s) must examine the following aspects of his practice: history taking, investigations (including

the recall system for follow-up of patient test results), diagnostic process and decision making. Dr Lynch is to authorise the auditor(s) to provide the NSW Medical Board with a report on his/her/their or their findings. On the basis of the audit report, the NSW Medical Board will determine if any further audit or other action is required. Dr Lynch is to meet all costs associated with the audit/s and any subsequent report/s.

- 67.3. The Board is the appropriate review body for the purpose of a review under Part 6 Division 3 of the Medical Practice Act and these conditions may be varied, amended or removed at the discretion of the NSW Medical Board.

### **PUBLICATION OF DECISION**

68. Pursuant to section 180(1) of the Act the Committee provides a copy of this written statement of decision to Dr Lynch, the Health Care Complaints Commission and the Board.

### **NON-PUBLICATION DIRECTION**

69. Pursuant to Schedule 2, clause 6 (b) of the Act, the Chairperson directed at the commencement of the hearing that the name of Patient A is not to be published by any person. At the conclusion of the hearing the Chairperson made a further direction that the name and address of the widow of Patient A is not to be published by any person.

### **APPEAL**

70. An appeal against this decision is available under section 87 of the Act, or section 88 if the appeal is with respect to appoint of law. Such an appeal is to be made within 28 days of the handing down of the decision (or such longer period as the Registrar may allow in any particular case).

Helen A Kiel

Helen Kiel

Chairperson

27 August 2009

Date