MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 214/01/74C

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 **LEON VAN RHYN** medical practitioner of Hamilton

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Dr D B Collins QC (Chair)

Dr L Henneveld, Dr U Manu, Dr J L Virtue, Mrs H White (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Hamilton on Tuesday 22 through to Friday 25 October 2002 inclusive

APPEARANCES: Ms K G Davenport for a Complaints Assessment Committee

Mr A J Knowsley and Ms K Bicknell for Dr L van Rhyn.

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The Charge

1. Dr van Rhyn is a registered medical practitioner in Hamilton. He was charged with disgraceful conduct. The charge was brought by a Complaints Assessment Committee established pursuant to s88 of the Medical Practitioners Act 1995. The charge was amended before it was heard by the Tribunal. The amendments were made following decisions of the High Court and Court of Appeal in this matter.

2. The amended notice of charge particularised the basis upon which the Complaints Assessment Committee alleged Dr van Rhyn was guilty of disgraceful conduct. All but particular 4 of the amended notice of charge related to the manner in which Dr van Rhyn managed a serious illness which affected his former wife, Margaret van Rhyn, when they were still married. Particular 4 of the amended notice of charge focused upon Dr van Rhyn's prescribing sleeping tablets for himself.

3. The particulars of the charge alleged Dr van Rhyn

> "1. … failed to obtain Margaret van Rhyn's informed consent to forcibly administer psychotropic medications and antidepressants to her when no committal order was in existence at the time and/or;
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> 2. … failed to inform Waikato Hospital by admission note when Margaret van Rhyn was admitted on or about 3 February 1997 that he had been prescribing benzodiazapines for a prolonged period and/or;
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> 3. … failed to keep a full and accurate record of Margaret van Rhyn's mental state, his diagnosis and his prescribed treatment plan for her;
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> 4. … self prescribed Imovane, a sleeping tablet for a few months without any supervision or monitoring by another practitioner, and/or;
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> 5. … administered to Margaret van Rhyn, psychoactive drugs, antidepressants and tranquillisers from drug company samples without the drugs being formally prescribed and documented;
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> 6. … treated Margaret van Rhyn in circumstances where his clinical judgment was or could have been impaired, and where it was in the best interests of the patient to refer on to an independent general practitioner.

4. The charge stated Dr van Rhyn's alleged disgraceful conduct occurred between 1993 and 1999. Most of the evidence before the Tribunal was confined to 1996 and 1997.

Hearing

5. The hearing of the evidence and submissions took four days. The Tribunal heard comprehensive evidence from:

Mrs van Rhyn
Ms Renee van Rhyn – a daughter of the complainant and Dr van Rhyn
Ms Paula van Rhyn – another daughter of the complainant and Dr van Rhyn
Professor Grant Gillett – a neurosurgeon and professor of medical ethics at Otago University
Dr Vasanthi Bradley – a general practitioner in Hamilton
Dr Margaret Honeyman – a psychiatrist from Whangarei
Dr van Rhyn
Dr James Walshe – a psychiatrist from Christchurch

6. At the conclusion of the evidence and after hearing submissions on 25 October the Tribunal advised the parties that it was satisfied Dr van Rhyn's acts and omissions constituted professional misconduct. The parties were advised that the reasons for the Tribunal's decision would be delivered in writing at a later date. After the Tribunal's decision was announced submissions as to penalty were received. The Tribunal reserved to both parties the opportunity to make any further submissions they might wish to make in relation to penalty. Counsel for Dr van Rhyn was invited to provide information on Dr van Rhyn's financial circumstances before the Tribunal reached a decision about what, if any, financial penalty would be imposed upon Dr van Rhyn by way of orders under s110(1)(e) and (f) of the Medical Practitioners Act 1995. Additional submissions on penalty were to be received by the Tribunal by 1 November, however this time limit was extended to 15 November.

7. The following comprises the reasons for the Tribunal's decision announced on 25 October and the Tribunal's decision as to the penalties it imposes on Dr van Rhyn.

Summary of the Complaints Assessment Committee's Case

8. It is convenient to commence with a brief summary of the case advanced against Dr van Rhyn by the Complaints Assessment Committee.

9. The gravamen of the case against Dr van Rhyn is that he breached fundamental professional ethics by treating his wife for a serious illness. In mid-1996 Mrs van Rhyn's health began to deteriorate. She became seriously depressed. Dr van Rhyn was Mrs van Rhyn's general practitioner. He treated her with a variety of medications including:

    Aropax (an antidepressant) and
    Oxazepam (a benzodiazepine)

10. Mrs van Rhyn's condition did not improve. On 3 February 1997 Mrs van Rhyn went to Dr Hester Swart, a psychiatrist in Hamilton. Dr Swart concluded Mrs van Rhyn was very depressed and needed assistance urgently. The following day Dr van Rhyn took his wife to Waikato Hospital. Dr van Rhyn told the staff at Waikato Hospital his wife had been on Aropax and Oxazepam.

11. Mrs van Rhyn remained in Waikato Hospital until 2 April 1997. For a part of that period she was admitted under the Mental Health (Compulsory Assessment and Treatment) Act 1993. She was administered ECT on 8 occasions whilst in hospital.

12. The Complaints Assessment Committee alleged Dr van Rhyn continued to act as Mrs van Rhyn's general practitioner when she was in hospital and provided input into Mrs van Rhyn's care whilst she was in hospital. After Mrs van Rhyn's discharge from hospital Dr van Rhyn continued to provide psychiatric care to his wife even though she was at that stage under the care of the Community Mental Health Service, an outpatients clinic of Waikato Hospital.

13. The Complaints Assessment Committee maintained Dr van Rhyn administered medication to his wife in a haphazard way and that he failed to keep proper records of the treatment he was providing. The essence of the Complaints Assessment Committee's case is that Dr

van Rhyn endeavoured to treat his wife's serious illness himself and in doing so seriously breached his ethical obligations.

14. The allegation Dr van Rhyn administered medication to himself was based upon a concern Dr van Rhyn had prescribed Imovane, a sleeping tablet, for himself, over a period of months without any supervision or monitoring by another general practitioner.

Summary of the Case for Dr van Rhyn

15. Dr van Rhyn acknowledged he was treating his wife for deteriorating and serious psychiatric illness in 1996 and that he continued to do so on occasions during 1997. Dr van Rhyn maintained he was not culpable because he had no alternative other than to treat his wife. Dr van Rhyn submitted that his wife failed to appreciate the seriousness of her illness and resisted all of Dr van Rhyn's efforts to have her assessed and treated by other doctors. Dr van Rhyn said he had no alternative other than to treat his wife and that he was, figuratively speaking, placed "between a rock and a hard place".

16. Dr van Rhyn also accepted he prescribed Imovane for himself without supervision or monitoring from another practitioner. He denied his conduct justified a disciplinary finding against him because the medication he took was for a short period of time and caused by external and extenuating circumstances.

Assessment of the Evidence

17. In reaching its findings of fact the Tribunal has been greatly assisted by its ability to critically evaluate the testimony of all members of the van Rhyn family who gave evidence.

18. As with many complex cases there are some aspects of the evidence of the principal protagonists which the Tribunal accepts and some which it rejects. The Tribunal wishes to stress that where it has made a finding which does not accord with the assertions of a witness it has done so by objectively evaluating the credibility of the evidence in question. The Tribunal is very mindful that the events focused upon occurred a considerable time ago.

With the passage of time witnesses memories have faded. Some witnesses have convinced themselves that events occurred which may not have happened in the way they

now recall. That is understandable in light of the traumatic events which have occurred in the van Rhyn household.

19. The Tribunal also had the benefit of evidence from four independent expert witnesses whose thorough evidence was greatly appreciated by the Tribunal. The Tribunal has reached its own views on the facts of the case and on whether or not Dr van Rhyn's acts and omissions breached relevant professional standards. As will be seen however, the Tribunal has found itself in general agreement with Professor's Gillett's analysis of Dr van Rhyn's ethical obligations.

20. In reaching its conclusions the Tribunal has evaluated the evidence on the basis that the onus of proof in relation to all allegations rests with the Complaints Assessment Committee. The burden of proof is the civil standard of proof; however, where the allegations are serious the Tribunal has satisfied itself that the evidence is compelling before reaching a finding adverse to Dr van Rhyn.[1]

Findings of Fact

21. All agree that assessing the facts of this case is a complex task. The events which gave rise to the hearing involved a matrix of events which the Tribunal will now endeavour to explain in a coherent manner.

22. To understand what occurred in the lives of Dr and Mrs van Rhyn in Hamilton during 1996 and 1997 it is necessary to briefly traverse events which led to their arriving in Hamilton.

South Africa

23. Dr van Rhyn graduated MB ChB from the University of Pretoria in 1973. He obtained further medical qualifications in South Africa during the 1980s which are recognised by the Medical Council of New Zealand.[2]

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1 *Gurusinghe v Medical Council of New Zealand* [1989] 1 NZLR 139.

2 MFGP 1984, DCH 1986.

24. After graduating Dr van Rhyn worked at the HF Verwoerd Hospital and Kalafong Hospitals, both teaching hospitals attached to the University of Pretoria. From 1976 to 1988 Dr van Rhyn was a general practitioner in a four doctor general practice in Brakpa. In that capacity he provided general medical care as well as services in obstetrics and gynaecology, paediatrics, orthopaedics, anaesthetics, urology, as well as psychiatry. In New Zealand it is unusual for one doctor to provide such a vast range of "specialist" services. The Tribunal understands however that it is not unusual for general practitioners in South Africa to provide a wide range of "specialist" services to their patients.

25. Dr van Rhyn developed a particular interest in psychiatry. In 1986 he joined the editorial board of a South African magazine called *"Psychiatric Insight"* – a magazine aimed at furthering understanding of psychiatry.

26. After 1988 Dr van Rhyn worked at the Far East Rand Hospital in the department of paediatrics for approximately a year. He then returned to general practice in a city called Benoni in the Orange Free State from June 1989 to November 1993 when the van Rhyn family immigrated to New Zealand.

27. Mrs van Rhyn was born in Verkeerdevlei, a small rural community in the Orange Free State. She met Dr van Rhyn when they were both students at the University of Pretoria (Mrs van Rhyn studied biology). Mrs van Rhyn's family were closely connected with the Dutch Reform Church in South Africa. Mrs van Rhyn's father was the local Church Minister. It is apparent Mrs van Rhyn's religion played a major role in her life and was undoubtedly a source of considerable support for her when the van Rhyns immigrated to New Zealand.

28. Although Mrs van Rhyn and Dr van Rhyn now speak fluent English they regard Afrikaans as their first language. Mrs van Rhyn was apparently reluctant to converse in English until very recently.

29. It would appear Dr van Rhyn was general practitioner for Mrs van Rhyn when they lived in South Africa. He was also general practitioner for the van Rhyn's three daughters and at one stage was also general practitioner to Mrs van Rhyn's parents. The Tribunal was told

that such arrangements are common in parts of South Africa, particularly in the Afrikaans community.

Immigration to New Zealand

30. In December 1992 the van Rhyn family followed the path taken by many South African medical families and immigrated to New Zealand. Their first port of call in this country was Christchurch where Dr van Rhyn was employed as a general practitioner at an after hours surgery. They initially lived in rental accommodation and appear to have had financial difficulties.

31. In April 1994 the van Rhyns moved to Hamilton. That move was prompted by Dr van Rhyn being offered the chance to establish a new medical practice with another general practitioner. The family initially lived in small rented accommodation in Silverdale. The house was described in oppressive terms. The family were clearly not very happy.

32. Mrs van Rhyn struggled with the dramatic changes which had occurred in her life. She had been used to living a comparatively comfortable lifestyle in South Africa which included her having assistance from servants. Mrs van Rhyn confined her social interaction in Hamilton to other Afrikaans speaking South Africans and members of the Dutch Reform Church. The Tribunal has complete sympathy for the predicament Mrs van Rhyn found herself in. She was living in a foreign country, had primary responsibility for three daughters and was undoubtedly very homesick. In April 1996 the van Rhyns returned to South Africa for a month long holiday, primarily to enable Mrs van Rhyn to visit her family and friends.

Mrs van Rhyn's Deteriorating Health

33. On the van Rhyns return to Hamilton in May 1996 Mrs van Rhyn's mental wellbeing began to decline. An impression of what was occurring to Mrs van Rhyn can be gleaned from an affidavit filed by Dr van Rhyn in Family Court proceedings in Hamilton in August 1999:

> *"When [Mrs van Rhyn returned from South Africa in May 1996] she became very depressed and anxious. I asked [Mrs van Rhyn] to obtain help from a psychiatrist, psychologist or counsellor but she refused saying that she was not sick. She also refused to see anyone who spoke English saying she could only express herself in*

Afrikaans. The situation became more and more stressful. [Mrs van Rhyn] deteriorated into depressive pseudo/dementia and would not get out of bed in the morning. She refused to shower, eat, dress or perform any acts of living that a normal person would do. All she did was read one spiritual book after the other. She acted like a small child wanting her mother and this was all she could talk about. She could not remember how to wash herself, prepare food and she did not appear to have any memory of anything that I said. The children and I had to say the same things to [Mrs van Rhyn] over and over again."

34. The Tribunal appreciates Mrs van Rhyn has a different view of the events from that recorded by her former husband. She says:

"I had been raised by my parents and school teachers to be very patriotic and I found it extremely hard to sever myself from the ties which bonded me to my beloved fatherland. Upon my return from South Africa [in May 1996] I felt overwhelmed by the task of moving into a new and unfinished home. At that time I still faced doing all the housework and even mowing the lawn, mostly on my own, very hard. I had had home help and a gardener in South Africa for the past 16 years and was not at all used to doing everything all by myself. I had very little practical support from the rest of the family. My parents, especially my mother, were unwell at that time and I was feeling anxious about them. My former husband was not supportive of my feelings and homesickness and would not permit me to say anything negative about New Zealand, not even about the weather. I was not allowed to go through the normal grieving process after having lost my country, my culture and language, my close friends and even closer relatives. Initially, I did not have close friends in New Zealand and I was not so fluent in English at that time, my native tongue being Afrikaans. I found it harder and harder to cope with daily life. One of my daughters, Renee's best friends committed suicide in November 1996 – a very traumatic experience for my children and myself! Renee was devastated and leaned heavily on me for emotional support.

I began to lose my appetite and to feel more and more unhappy. My husband had been my general practitioner of his own choosing at all times during our marriage and had treated our children and myself when necessary. The more unhappy I became the less emotional support he gave me. He labelled me as being depressed and began to give me medication, which I refused and resisted, as I knew I was not depressed, just stressed out and homesick."

35. The Tribunal is in no doubt that by August/September 1996 Mrs van Rhyn was seriously unwell. Two of New Zealand's most experienced psychiatrists gave evidence about Mrs van Rhyn's mental health in the latter part of 1996. Dr Honeyman, called by the Complaints Assessment Committee said:

"It appears very clear that Mrs van Rhyn had a major depressive disorder in 1996 and early 1997. I do not think that there can be any diagnostic doubt."

36. Dr Walshe, called by Dr van Rhyn said by December 1996 *"Mrs van Rhyn was inert, unwilling/unable to care for herself, finding it hard to put sentences together, assemble thoughts. She had lost considerable weight. Her sleep pattern was unsettled. She was distrait, dishevelled, disorganised, disheartened, and almost disorientated."* It was Dr Walshe's opinion that Mr van Rhyn gradually succumbed to a major depressive illness.

37. The Tribunal unhesitatingly accepts the independent expert opinions of Drs Honeyman and Walshe concerning Mrs van Rhyn's medical condition in the latter half of 1996 and early 1997.

Dr van Rhyn's Management of his Wife's Condition

38. It is not easy to reconstruct Dr van Rhyn's management of his wife's condition from August 1996 until her admission to Waikato Hospital on 4 February 1997. There are two reasons why it is difficult to work out exactly what treatment Dr van Rhyn provided his wife. Those reasons are:

- Dr van Rhyn's notes, such as they are, were totally inept. He appears to have made only two clinical notes relating to his wife's treatment during the period he was managing his wife's very serious illness.

- Quite understandably, Mrs van Rhyn does not have an accurate recollection of precisely what medication she received from her husband.

39. It is convenient to deal with the issue of Dr van Rhyn's clinical records at this juncture. The first entry is simply dated "December 1996". The Tribunal was told that this entry was made on Sunday 15 December 1996 when Dr van Rhyn telephoned a fellow South African doctor at his home to discuss his wife's condition. The note reads:

"Severe anxiety: Separation anxiety. Worried about parent's health in South Africa. Depression. Psychomotor retardation. No appetite. Amotivated.

Discussed with Dr Wayne de Beer Psychiatrist. Suggest: continue Aropax 20 mg ³ or ii mane & add Oxazepam tabs 10mm 1½tds prn."

40. The second note made on 17 January 1997 (although inadvertently written as 17 January 1996) reads:

"Getting Psychotherapy from Community Mental health team. Somewhat better. Now able to prepare meals occasionally. Appetite has improved.
Replace Oxazepam ----> Novapam 5mg ³ –ii tds (180)
Continue Aropax 20mg per day"

41. As will be seen, apart from when Mrs van Rhyn was in Waikato Hospital, Dr van Rhyn played a very significant role in the management of his wife's serious clinical depression from its onset in approximately September 1996 until she left for South Africa on 2 December 1997. It was unacceptable for Dr van Rhyn to have made such sparse and incomplete notes of his diagnosis and treatment of his wife. The notes give very little guidance as to the extent Dr van Rhyn was administering psychoactive drugs to his wife prior to her hospitalisation in February 1997. Dr van Rhyn's inept record keeping was a serious breach of professional standards.

42. Dr Walshe endeavoured to analyse what medications Dr van Rhyn administered to his wife prior to her admission to Waikato Hospital. The Tribunal generally accepts Dr Walshe's assessment that at some point in the latter half of 1996 Dr van Rhyn started to administer Paroxetine (Aropax) from surgery samples. The dose was 20mg each morning. Exactly when this medication regime started is not entirely clear. Equally unclear is the extent to which Mrs van Rhyn actually ingested this medication. It is also unclear if the daily dose of Aropax was actually increased following Dr van Rhyn's discussions with Dr Wayne de Beer in mid-December. At some point after the mid-December discussion with Dr de Beer the medication regime was altered to include the anxiolytic oxazepam 10mg, 1½tablets 3 times a day, as needed. Again, it is not certain when this medication was commenced because of the absence of adequate records.

43. In mid-January 1997 Dr van Rhyn appears to have changed Mrs van Rhyn's medication by switching the benzodiazepine anxiolytic from Oxazepam to chlordiazepoxide (Novapam).

44. Mrs van Rhyn said the medications she received from her husband prior to her hospitalisation were:

Oxazepam
Aropax
Aurorix
Novapam (from 17 January)

45. Mrs van Rhyn produced three sample packets of Aurorix (exhibit 7). She said she obtained these from her husband at the time in question. Mrs van Rhyn may be correct. The Tribunal cannot be certain that Aurorix was also administered prior to Mrs van Rhyn's admission to hospital. Dr van Rhyn acknowledged he provided Aurorix to Mrs van Rhyn in September 1997 long after her discharge from hospital.

46. Equally disturbing is the complete lack of clarity concerning Dr van Rhyn's attempts to include appropriately independent medical professionals in his wife's care.

47. Dr van Rhyn said that as early as August 1996 he endeavoured to persuade Mrs van Rhyn to consult two of his colleagues in his surgery, Drs Sayer and Reeder as well as a counsellor in the practice, a Mrs Marion Waters. The Tribunal did not hear from any of Dr van Rhyn's Hamilton colleagues. It would not be surprising if Mrs van Rhyn declined to seek assistance from partners and employees of her husband. Mrs van Rhyn needed treatment and assistance from persons who had no direct involvement with her husband.

48. Contrary to Dr van Rhyn's assertions it is clear Mrs van Rhyn was willing to seek assistance from appropriately qualified medical people during the course of 1996 and early 1997. Dr Armand de Beer, a South African psychiatrist in Hamilton has recorded in a letter received by the Tribunal that in 1996 Mrs van Rhyn approached him for psychiatric assistance. Poignantly Dr Armand de Beer says:

"Unfortunately I had to decline the request seeing that we knew each other socially and was of the opinion that professional contact between us would therefore be inappropriate. Alternative suggestions for seeking professional help were made."

The Tribunal received a similar letter from another member of the Hamilton South African medical community, Christine Vorster, a clinical psychologist.

49. The Tribunal accepts neither Dr Armand de Beer nor Ms Vorster were presented for cross examination. However, their letters are consistent with other evidence received by the Tribunal concerning Mrs van Rhyn's willingness to seek help from persons other than her husband/or members of his practice.

50. Included in the evidence received by the Tribunal was a report prepared on 30 October 1996 by another South African clinical psychologist in Hamilton, a Ms Sandi Shillington, a member of the Community Mental Health Service team. Ms Shillington's contemporaneous record shows Mrs van Rhyn approached her by way of telephone call on 30 October. The conversation was conducted in Afrikaans. Ms Shillington's comprehensive four page record of the discussion is written in English and shows Ms Shillington was easily able to establish a rapport with Mrs van Rhyn who "talked easily and openly" during the telephone interview. Ms Shillington's record also provides some assistance in working out when the Aropax was probably administered to Mrs van Rhyn (possibly around 24 October).

51. The Community Mental Health Service records refer to consultations which Mrs van Rhyn had with that service on 8 November 1996, 11 November 1996 and 27 November 1996.

52. The Tribunal also received records made by Dr Wayne de Beer following a consultation which Mrs van Rhyn had with him on 29 January 1997.

53. The records of Mrs van Rhyn's consultations with Sandi Shillington in late 1996 and the evidence of her approaches to Dr Armand de Beer and Ms Christine Vorster also in 1996 reinforced the Tribunal's belief that Mrs van Rhyn was willing to seek appropriate assistance from people other than her husband, his partners and/or employees of his practice.

Hospitalisation

54. In January 1997 Dr Hester Swart, a psychiatrist, arrived in Hamilton from South Africa. She was contacted about Mrs van Rhyn's circumstances. Dr van Rhyn says he contacted

Dr Swart. Dr Swart, in a report to the Complaints Assessment Committee, has said she was contacted by another South African doctor who happened to be a urologist. Dr Swart says in her report "Dr van Rhyn was not in the referring picture at all – from memory".

55. Mrs van Rhyn saw Dr Swart on 3 February 1997. Dr Swart concluded Mrs van Rhyn was suffering from "a severe major depressive disorder (in a person) with underlying perfectionist traits" and that "some psychiatric/psychological intervention [was] urgently indicated". Dr Swart conveyed her concerns to Mrs van Rhyn and later telephoned Dr van Rhyn to inform him of her concerns.

56. On 4 February 1997 Dr van Rhyn arranged for Mrs van Rhyn's admission to Waikato Hospital. The events surrounding the admission process can be commented on briefly. Apparently Dr van Rhyn wanted to avoid any resistance his wife may have had to being assessed at Waikato Hospital. He therefore took her to the hospital on the pretext that they were going to pick up one of their daughters from a dance class. Dr van Rhyn had previously arranged with the admitting officers at the hospital for Mrs van Rhyn to be assessed.

57. Mrs van Rhyn was assessed at Waikato Hospital and was unlikely to have been admitted unless Dr van Rhyn had persuaded the Register on duty to keep Mrs van Rhyn in hospital for observation.

58. Mrs van Rhyn remained in Waikato Hospital from 4 February 1997 until 2 April 1997. Initially Mrs van Rhyn was admitted as a voluntary patient. She later became a "involuntary patient" and she was treated pursuant to the Mental Health (Compulsory Assessment and Treatment) Act 1993. Mrs van Rhyn's hospital status changed to involuntary patient when it was thought she had reached the stage of "willingness" to accept treatment, including ECT.

59. The Complaints Assessment Committee has raised concerns about Dr van Rhyn's continued role in Mrs van Rhyn's medical management while she was a patient at Waikato Hospital. The nursing notes certainly suggest Dr van Rhyn continued to play a role in Mrs van Rhyn's

care even when she was in hospital. The Complaints Assessment Committee's concerns can be illustrated by reference to the following two entries in the nursing notes:

- A nursing note for 18 February records that Imovane was charted at Dr van Rhyn's request. The same note says that Dr van Rhyn would like ECT to be administered "unilateral".[3]
- A nursing note for what appears to be 6 March 1997 shows Dr van Rhyn conducted a physical examination of Mrs van Rhyn and recommended administration of a diuretic (Lasix).

60. There are also entries in the nursing notes recording at least one nurse's concern about Dr van Rhyn's continued attempts to play a role in Mrs van Rhyn's medical management while she was in hospital. Two nurses recorded their concerns in the nursing notes about Dr van Rhyn being Mrs van Rhyn's general practitioner. The community Psychiatric nurse's referral form also noted this concern. A copy of that form was sent to Dr van Rhyn but, as will be seen, Dr van Rhyn continued to act as his wife's general practitioner.

61. Counsel for Dr van Rhyn questioned whether or not Imovane was charted for Mrs van Rhyn at Dr van Rhyn's insistence. It may be that Mrs van Rhyn did not receive Imovane as a result of her husband's actions. Nevertheless the nursing note clearly suggests Dr van Rhyn was attempting to influence the medical management of his wife whilst she was in hospital. Dr Walshe thought it was unwise for Dr van Rhyn to have undertaken the physical examination of his wife on 6 March which is referred to in the nursing notes.

62. Dr van Rhyn's blurring of his roles as husband and medical practitioner in relation to his wife is a recurring concern for the Tribunal, even when Mrs van Rhyn was in hospital and under the care of independent and suitably qualified specialists Dr van Rhyn continued to assert influence over aspects of Mrs van Rhyn's care.

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[3] Meaning the electrodes are placed on one side, rather than both sides of the patient's head.

Post Admission

63. Following her discharge from Waikato Hospital on 2 April 1997 Mrs van Rhyn was placed in the care of the Community Mental Health Service. The consultant psychiatrist with overall responsibility for Mrs van Rhyn's care whilst under the health services was Dr Willamune. A community health nurse, Val Milne, was Mrs van Rhyn's primary contact person within the Community Health Service.

64. The Complaints Assessment Committee have raised a number of legitimate concerns about Dr van Rhyn's continued role in the management of his wife's illness following her discharge from Waikato Hospital. Those points can be briefly summarised:

- There is some evidence that in May 1997 Dr van Rhyn issued an additional prescription for Clomipramine over and above that prescribed by Dr Willamune.
- In August 1997 Dr van Rhyn appears to have reintroduced Mrs van Rhyn to Aropax.
- In September 1997 Dr van Rhyn appears to have started to administer Aurorix to Mrs van Rhyn.

65. None of these changes and alterations to Mrs van Rhyn's medication regime are documented in any significant way. Nor is there any evidence of Dr van Rhyn discussing these changes with Dr Willamune.

66. On 2 December 1997 Mrs van Rhyn travelled back to South Africa. Dr van Rhyn issued a prescription for a benzodiazepine, Serapax. Again, the clinical justification for this medication is not explained in any notes made by Dr van Rhyn at the time.

67. Whilst Mrs van Rhyn was back in South Africa Dr van Rhyn decided their marriage was at an end. It is not necessary to traverse the unfortunate and acrimonious dispute which culminated in the protagonists marriage being formally dissolved on 23 August 2000.

Ethical Obligations

68. The Tribunal is grateful for the evidence it heard from Professor Gillett, a neurosurgeon who also enjoys an international reputation as an authority on medical ethics.

69. Professor Gillett explained to the Tribunal that it is a fundamental tenet of medical ethics that a doctor should not treat members of his or her own immediate family. There are exceptions to this ethical obligation, namely:

- Instances of emergency
- Cases where little or no professional judgment is required
- When it is necessary because no other option is available.[4]

70. The ethical obligation which enjoins a doctor from treating immediate members of his or her family is part of a doctor's broad obligation to ensure the discharge of their professional responsibilities is never compromised.

71. In commenting on Dr van Rhyn's dual roles as doctor and husband to Mrs van Rhyn, Professor Gillett said that Dr van Rhyn's professional ethics should have allowed him to see "… that no good can come from him mixing roles in the way the situation seemed to demand of him and that a great deal of harm was possible".

72. Drs Honeyman and Bradley were also very clear in their views that Dr van Rhyn should simply not have attempted to diagnose and treat Mrs van Rhyn's serious illness. Dr Honeyman was able to provide the Tribunal with instances of statements from the Medical Council and Codes of Conduct from overseas jurisdictions which make it clear that except in the three instances referred to in paragraph 69 of this decision, a doctor should not treat immediate members of their family.

73. Professor Gillett explained that the ethical obligation under consideration dates back to the time of Hippocrates. Professor Gillett acknowledged however that none of the ancient

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[4] Professor Gillett thought cases of necessity might be embraced by the emergency exception. There is a subtle distinction between necessity and an emergency. The Tribunal prefers to adhere to the three categories of exceptions set out in paragraph 69 of this decision.

medical oaths and prayers[5] specifically warn doctors not to treat immediate members of their own family. Nevertheless Professor Gillett explained "there is a general tenet in the Hippocratic writings that one should exercise the most diligent, informed and objective judgment in dealing with patients". Professor Gillett explained that this requirement was breached when a doctor provided professional services to an immediate member of his or her family, except in cases governed by one of the three exceptions described in paragraph 69 of this decision.

74. It would also appear none of the modern codes of ethics for doctors in New Zealand specifically warn doctors about their duty not to treat immediate members of their family.[6] The South African Medical and Dental Council: "Rules of Conduct for Medical Practitioners and Dentists" promulgated by Government Orders in 1976 and 1977 also make no specific reference to the ethical duty under consideration.[7]

75. Medical authorities have, however, not been completely silent on this topic. In 1991 the then Chairwoman of the New Zealand Medical Council said in the Council's newsletter[8]

> *"It is strongly recommended that doctors do not prescribe for themselves or their close families except for the most minor episode. Treatment of oneself or one's nearest and dearest leads to the loss of the objectivity needed for safe decision making.*

76. The College of Physicians and Surgeons of British Columbia have been more specific. Their policy manual states:

> *"Medical management of a physician or a physician's family should be conducted by a colleague except where emergency circumstances prohibit, or the conditions are minor and self limiting".*

77. During the Tribunal's hearing attention focused on paragraph 18.4.3 of a 1995 publication called "Medical Practice in New Zealand: A Guide to Doctors Entering practice". That

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5 Oath of Hippocrates (4th Century BC), Prayer of Maimonides (12th Century), Five Commandments and Ten Requirements (a 17th Century statement on medical ethics from China).

6 International Code of Medical Ethics of the World Medical Association, 1949, 1968 and 1983; Declaration of Geneva, 1948; Declaration of Lisbon, 1981; New Zealand Medical Association Codes of Ethics.

7 Refer "Doctors Medicine and the Law", Strauss (1984) Annexure 1.

8 Issue No. 3, December 1991.

publication was prepared for the Medical Council of New Zealand by Professor David Cole, for many years one of New Zealand's leading authorities on medical ethics. In his book Professor Cole says:

> *"18.4.3 The Doctor's family and relatives.*
>
> *There are no legal sanctions against managing illness in one's own family [although GMS and ACC cannot be claimed; nor for a partner's family] and it is not misconduct to do so. However the prudent doctor, mindful of the fallibilities of clinical judgment that may occur when one considers the ill health of a close family member, does not provide initial prescriptions nor take significant clinical decisions in these circumstances. All medical families must have an independent GP who shall be consulted even with major problems, for going to a specialist directly is perhaps discourteous and breaches continuity of care". (emphasis added)*

78. The Tribunal is obliged to make the following observations about paragraph 18.4.3 of Professor Cole's book.

- Contrary to the suggestions of some during the course of the hearing, Professor Cole's book is not a Code of Ethics. It is a very helpful expression of opinion intended to be nothing more than a "Guide to Doctors Entering Practice".
- It is unfortunate if the wording of the first sentence in paragraph 18.4.3 has given rise to confusion. There may not be any legislative prohibitions against a doctor managing illness in the doctor's family but it does not necessarily follow that it is ethical for a doctor to treat an immediate member of their family. Furthermore, as this decision demonstrates, there may be legal sanctions imposed against a doctor who breaches their ethical obligations by choosing to treat a member of their immediate family except where one of the established exceptions exists.

79. For the sake of completeness the Tribunal records that in 2001 the Medical Council of New Zealand issued a comprehensive "Statement of Self Care and Family Care". That statement is, in the Tribunal's view, a sound reproduction of doctors' ethical obligations in this area: the introduction states:

> *"It is generally unwise for medical practitioners to care for themselves or their family members in all but minor and emergency health matters. Self care and family care is neither prudent nor practical due to the lack of objectivity and*

discontinuity of care. The Medical Council recognises that there are some situations where family treatment may occur but maintains that this should only occur when overall management of patient care is being monitored by the family's practitioner."

80. Dr van Rhyn acknowledged to the Tribunal that when he graduated from the University of Pretoria in 1973 he was fully conversant with the doctor's ethical obligation not to treat immediate members of his family, except in the limited circumstances set out in paragraph 69 of this decision. Furthermore, Dr van Rhyn knew that by September 1996 (by which time his wife's illness was serious) he was facing an ethical dilemma by continuing to treat his wife.

81. The Tribunal is in no doubt Dr van Rhyn was fully cognisant of his ethical duty not to treat his seriously ill wife. He could not simultaneously discharge his functions as a husband and comply with his professional obligations as a doctor when he elected to treat his wife from at least September 1996 to December 1997. The Tribunal is unanimously of the view Dr van Rhyn seriously breached his ethical obligations by treating his wife's serious illness during the period referred to.

Disciplinary Threshold

Disgraceful Conduct

82. The amended notice of charge alleges Dr van Rhyn's acts and omissions constituted disgraceful conduct in a professional respect. Disgraceful conduct is the most serious of all categories of disciplinary offence set out in s109 of the Medical Practitioners Act 1995. A doctor found guilty of disgraceful conduct risks having their name removed from the Register of Medical Practitioners. It was observed in *Duncan v Medical Practitioners Disciplinary Committee*[9] that:

"A charge of disgraceful conduct in a professional respect has been described by the Privy Council as alleging conduct deserving of the most strongest reprobation".[10]

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9 [1986] 1 NZLR 513

10 Citing *Felix v General Dental Council* [1960] AC 704*; McEniff v General Dental Council* [1980] 1 All ER 461.

83. The Tribunal is unanimous in its conclusion Dr van Rhyn's breaches of his ethical obligations are serious but do not deserve "the strongest reprobation".

Professional Misconduct

84. In recent years, those attempting to define professional misconduct have invariably commenced their analysis by reference to the judgment of Jefferies J in *Ongley v Medical Council of New Zealand*[11]. In that case his Honour formulated the test as a question:

> *"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would be reasonably regarded by his colleagues as constituting professional misconduct? … The test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the position of the Tribunal which examined the conduct."*

There are close parallels between this test, and the test as to whether or not a practitioner has breached the "duty of care" component of the tort of negligence.[12]

85. In *Pillai v Messiter* [No.2][13] the New South Wales Court of Appeal signalled a slightly different approach to judging professional misconduct from the test articulated in *Ongley*. In that case the President of the New South Wales Court of Appeal considered the use of the word "misconduct" in the context of the phrase "misconduct in a professional respect". In his view, the test required more than mere negligence. At page 200 of the judgment Kirby P. stated:

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

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11 (1984) 4 NZAR 369 at 375.

12 *Bolem v Friern Hospital Management Committee* [1957] 1 WLR 582

13 (1989) 16 NSWLR 197.

86. In *B v The Medical Council*[14] Elias J said in relation to a charge of "conduct unbecoming" that:

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

Her honour then proceeded to state:

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

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

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

87. In *Staite v Psychologists Board*[15] Young J traversed recent decisions on the meaning of professional misconduct and concluded that the test articulated by Kirby P in *Pillai* was the appropriate test for New Zealand.

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

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14 (Unreported HC Auckland , HC11/96, 8 July 1996)

15 (1998) 18 FRNZ 18.

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

89. In *Tan v Accident Rehabilitation Insurance Commission*[16] Gendall and Durie JJ considered the legal test for "professional misconduct" in a medical setting That case related to doctor's inappropriate claims for ACC payments. Their Honours referred to *Ongley* and *B v Medical Council of New Zealand.* Reference was also made in that judgment to *Pillai v Messiter* and the judgment of Young J in *Staite v Psychologists Registration Board.*

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

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

91. In the Tribunal's view, the test as to what constitutes professional misconduct has changed since Jefferies J. delivered his judgment in *Ongley*. In the Tribunal's view the following are the crucial considerations when determining whether or not conduct constitutes professional misconduct:

- The first portion of the test involves answering the following question:

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

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16 (1999) NZAR 369

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

92. The words "representatives of the community" in the first limb of the test are essential because today those who sit in judgment on doctors comprise three members of the medical profession, a lay representative and chairperson who must be a lawyer. The composition of the medical disciplinary body has altered since Jeffries J delivered his seminal decision in *Ongley*. The new statutory body must assess a doctor's conduct against the expectations of the profession and society. Sight must never be lost of the fact that in part, the Tribunal's role is one of setting standards and that in some cases the communities' expectations may require the Tribunal to be critical of the usual standards of the profession.[17]

93. This second limb to the test recognises the observations in *Pillai v Messiter, B v Medical Council, Staite v Psychologists Board* and *Tan v ARIC* that not all acts or omissions which constitute a failure to adhere to the standards expected of a doctor will in themselves constitute professional misconduct.

94. The Tribunal has assessed Dr van Rhyn's conduct by answering the questions posed in paragraph 91 in relation to each particular allegation in the amended notice of charge.

Conduct unbecoming a Medical Practitioner

95. For the sake of completeness the Tribunal records it gave consideration to finding Dr van Rhyn guilty of conduct unbecoming a medical practitioner[18] but believes Dr van Rhyns acts and omissions fit squarely within the boundaries of professional misconduct.

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

[18] Section 109(1)(c) Medical Practitioners Act 1995

Tribunal's Decision in Relation to Each Particularised Allegation of the Charge

First Particularised Allegation

96. The Complaints Assessment Committee alleged Dr van Rhyn failed to obtain Mrs van Rhyn's "… informed consent to forcibly administer psychotropic medications and antidepressants to her when no committal order was in existence at the time".

97. There is a minor deficiency in the wording of this aspect of the charge. Antidepressants are "psychotropic medications". It would have been better to describe the medication administered to Mrs van Rhyn as "psychoactive drugs".

98. A majority of the Tribunal has concluded Dr van Rhyn did forcibly administer psychoactive drugs to Mrs van Rhyn prior to her admission to Waikato Hospital.

99. Dr van Rhyn cajoled, threatened and intimated Mrs van Rhyn into taking Aropax and Oxazepan. He did not physically restrain her and physically force her to ingest these drugs but he did go to extraordinary lengths to ensure she took the medication he was prescribing her. The word "force" is defined in the Shorter Oxford Dictionary to include the coercing or compelling of a person to do something against their will. In this sense Dr van Rhyn did force Mrs van Rhyn to take psychoactive drugs without her consent.

100. An indication of the lengths Dr van Rhyn took to ensure his wife took the drugs he was prescribing can be found in his affidavit sworn in 1999 and filed in the Hamilton Family Court. He said:

> *"It was frustrating to see [Mrs van Rhyn] refuse medication or counselling and I recall holding [Mrs van Rhyn] by the shoulders and slightly shaking her on two occasions out of sheer frustration a few times in an attempt to wake her up out of her depressive pseudo/dementia but this was certainly not meant to be violent and did not cause any physical injuries whatsoever …"*

101. Paula and Renee van Rhyn also explained to the Tribunal that their father went to extreme lengths to coerce Mrs van Rhyn to taking the medication prescribed by Dr van Rhyn.

102. A majority of the Tribunal is of the view Dr van Rhyn failed to adhere to the standards which the profession and the community expect of a doctor when he coerced (forced) his wife to take medication against her wishes. The fact Dr van Rhyn was also acting in his capacity as Mrs van Rhyn's husband at the time he was coercing her into taking the medication does not excuse him from his professional obligations. He chose to be his wife's doctor in circumstances where he should not have acted in a professional capacity. Dr van Rhyn failed to maintain appropriate boundaries between his professional role and his role as a husband. He cannot now suggest that when he forced his wife to take medication he was acting solely in his capacity as Mrs van Rhyn's husband. When it came to the administration of medication he cannot say that he was her husband for some purposes and her doctor for others. It was Dr van Rhyn's failure to draw appropriate boundaries between his role as husband and his role as a doctor which is the central point of this case.

103. A majority of the Tribunal believes Dr van Rhyn's actions and omissions relating to the first particular of the charge constitute professional misconduct and justify a disciplinary finding.

Second Particularised Allegation

104. The second particularised allegation is that Dr van Rhyn did not inform Waikato Hospital by admission note when his wife was admitted on or about 3 February 1997 that he had been prescribing benzodiazepines for a prolonged period.

105. It is correct Dr van Rhyn did not provide Waikato Hospital with an admission note concerning his wife. However Dr van Rhyn did attend with his wife when she was admitted and explained to the Registrar on duty, Dr Reece, the circumstances which led to Mrs van Rhyn's admission, including the mediation she had been prescribed. The failure to record this in an admission note does not constitute a disciplinary offence.

Third Particularised Allegation

106. The third particular in the amended notice of charge alleges Dr van Rhyn failed to keep a full and accurate record of Mrs van Rhyn's mental state, his diagnosis and his prescribed treatment plan for her.

107. The Tribunal has already commented on Dr van Rhyn's inept records.[19] The two notes Dr van Rhyn made in December and on 17 January 1997 were an unsatisfactory record of Dr van Rhyn's diagnosis and treatment plan for his wife. It is a fundamental component of a doctor's duty to fully and accurately record their diagnosis and treatment plans – particularly in cases of serious mental illness.

108. The Tribunal unanimously believes Dr van Rhyn's actions and omissions as alleged in the third particular of the amended notice of charge constitute professional misconduct and warrant a disciplinary finding against him.

Fourth Particularised Allegation

109. The fourth particularised allegation focuses on Dr van Rhyn's prescription of sleeping tablets (Imovane) for himself. The Complaints Assessment Committee believed this occurred over "a few months" without any supervision or monitoring by another practitioner.

110. The Complaints Assessment Committee had good grounds for concern. In a letter dated 14 July 2000 to the Medical Council Dr van Rhyn said:

> *"I admit that I have had prescriptions for sleeping tablets usually before long overseas flights and towards the end of my relationship with the claimant and <u>I had to take a sleeping tablet on most nights</u> because the claimant, having stayed in bed most days, simply would not allow me any sleep." (emphasis added)*

111. In his evidence before the Tribunal Dr van Rhyn changed his story to say:

> *"Our last rental house was too close to the Chartwell Tavern which played extremely loud music until about 3 or 4 am every Thursday, Friday, Saturday and Sunday. There were no houses between the tavern and our main bedroom. The position of the main bedroom also seemed to amplify the noise and the wind direction would affect the volume. On many nights it was impossible to go to sleep and I would phone the noise control officer of the Hamilton City Council. On many nights I phoned the Tavern to complain about the noise and requesting them to turn down the volume of the music. At other times I would go to the Tavern to ask them to turn down the volume of the base and drums but although I was inside the Tavern standing face-to-face to the barman, he could not hear me even if I shouted. I tried*

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[19] See paragraphs 39-42 inclusive.

plugging my ears with thick cotton wool, and sleeping with a pillow over my head but nothing helped. I have always been a light sleeper. My problem with the noise of the Chartwell Tavern was well known. I refer to a letter dated 23 October 2001 from Hamilton City Council Noise Control regarding complaints made by me (and others) about the noise from the Chartwell Tavern. It is document 5 at page 13 of the bundle of documents filed upon my behalf. The letter records that I made 6 complaints to the City Council between 3 November 1994 and 5 January 1996. There were twenty seven additional investigations carried out following complaints from other residents about the excessive noise levels from the Chartwell Tavern. The Chartwell Tavern's licence was not renewed when it expired and a new shopping centre was erected on the premises.

In December 1994 I wrote myself a prescription for Imovane, 60 tablets. These lasted until February 1996. I would take these as required. I never took more than one half tablet when needed and took it only intermittently on the nights when the noise was excessive. I was taking a low dose."

112. The majority of the Tribunal have not been satisfied to the requisite standard Dr van Rhyn was taking sleeping tablets for a few months and/or that his taking of sleeping tablets in the circumstances without supervision or monitoring by another practitioner constitutes a disciplinary offence.

113. Although this aspect of the charge has not been proven the Tribunal wishes to stress that any medical practitioner taking sleeping tablets on a regular basis should consult with another practitioner to ensure they are safely prescribing. The Tribunal endorses the warning contained in the Medical Council's 2001 "Statement of Self Care and Family Care":

"A doctor should never sign a prescription for himself when the substance is potentially addictive".

Fifth Particularised Allegation

114. The Complaints Assessment Committee also alleged Dr van Rhyn administered psychoactive drugs, antidepressants and tranquillisers from drug company samples without the drugs being formally prescribed and documented.

115. The Tribunal is concerned that many of the drugs in question came from drug company samples intended to be used as trials for treatment. Use of these medications contributed to

Dr van Rhyn's failure to properly document the medication regime he put in place. The Tribunal has already expressed its views about Dr van Rhyn's failures to document the medication he was prescribing for Mrs van Rhyn. A formal finding in relation to this particular of the charge would in essence constitute a repetition of the findings made in relation to the third particular of the charge. The Tribunal does not wish to duplicate what it has already determined and accordingly makes no finding in relation to particular five of the charge.

Sixth Particularised Allegation

116. The Complaints Assessment Committee explained that the sixth particularised allegation was "the crux of the case" against Dr van Rhyn. The sixth particular alleges Dr van Rhyn treated Mrs van Rhyn in circumstances where his clinical judgment was or could have been impaired, and where it was in the best interests of the patient to refer on to an independent general practitioner.

117. The Tribunal is in no doubt Dr van Rhyn was under considerable stress during the latter part of 1996 and 1997. His family were struggling to come to terms with their new country. Mrs van Rhyn's health deteriorated to the point where she became seriously unwell. Dr van Rhyn was endeavouring to establish a medical practice in a new environment. The van Rhyns' marriage may also have been under stress at this time.

118. Dr van Rhyn blurred the boundaries that he needed to maintain between being a doctor and fulfilling his role as Mrs van Rhyn's husband. His judgment in these circumstances could well have been impaired. It was certainly not in Mrs van Rhyn's best interest for her husband to continue to be her general practitioner. The circumstances surrounding her being coerced into taking medication illustrate the difficulties in Dr van Rhyn treating his wife.

119. The Tribunal is unanimously of the view Dr van Rhyn's acts and omissions as described in the sixth particular of the amended charge have been established and that his acts and omissions constitute professional misconduct. The Tribunal also believes Dr van Rhyn's acts and omissions warrant a disciplinary finding against him.

Summary of Findings

120. The Tribunal concludes Dr van Rhyn's acts and omissions as particularised in the first, third and sixth particularised allegations of the amended notice of charge individually and cumulatively amount to professional misconduct and justify a disciplinary finding against him.

For the sake of clarity the Tribunal emphasises that it is making an omnibus finding of professional misconduct against Dr van Rhyn.

Penalty

No Suspension

121. At the conclusion of the hearing on 25 October the Tribunal advised the parties the Tribunal did not consider it necessary to suspend Dr van Rhyn pursuant to s110(1)(b) of the Medical Practitioners Act 1995. The Tribunal records it does not believe the established acts and omissions justify suspending Dr van Rhyn from practising medicine.

Practice in accordance with conditions

122. The Tribunal has given considerable thought to exercising its powers under s.110(1)(c) Medical Practitioners Act 1995 to require Dr van Rhyn to practise in accordance with conditions imposed by the Tribunal.

123. The Complaints Assessment Committee has invited the Tribunal to place two conditions on Dr van Rhyn's terms of practise, namely:

- That Dr van Rhyn not prescribe any medication to any immediate members of his family except in a life threatening emergency; and
- That Dr van Rhyn not prescribe for himself under any circumstances.

124. The Tribunal believes it highly unlikely Dr van Rhyn will be tempted to provide non emergency medical services to members of his family in the future. Dr van Rhyn no longer lives with Mrs van Rhyn and their daughters. In any event, the Tribunal believes the

experience of the disciplinary process will dissuade Dr van Rhyn from ever transgressing along the lines identified in this decision.

125. It would not be appropriate for the Tribunal to impose conditions on Dr van Rhyn's prescribing for himself when a majority of the Tribunal have not been satisfied to the requisite standard that Dr van Rhyn committed a disciplinary offence when he prescribed Imovane for himself.

126. The Complaints Assessment Committee has also invited the Tribunal to refer Dr van Rhyn for a competence review. Again, the Tribunal cannot accede to this suggestion. A majority of the Tribunal are not satisfied there was evidence of a sufficient quality before the Tribunal to justify recommending a competence review.

127. The Tribunal does believe it appropriate to impose a condition on Dr van Rhyn's ability to practice medicine for 12 months from the date of this decision. Before describing that condition the Tribunal will explain why it believes that condition needs to be imposed.

128. The Tribunal is concerned Dr van Rhyn may not be as vigilant as he should be in identifying and addressing ethical issues associated with the practice of medicine in this country. This decision graphically highlights Dr van Rhyn was unable to come to terms with and manage a very fundamental ethical obligation he had not to treat his wife during 1996 and 1997. The Tribunal was concerned Dr van Rhyn may not have had in place appropriate support mechanisms to assist him identify and manage the ethical problems he encountered when treating his wife.

129. The Tribunal was surprised to learn Dr van Rhyn was not subject to general oversight during 1996 and 1997. The Tribunal's understanding of s.20 Medical Practitioners Act 1995 leads it to believe Dr van Rhyn should have been practising subject to the general oversight of a person who was vocationally registered during the time focussed on in this decision. The Tribunal was provided with a letter from Dr van Rhyn to the Medical Council dated 13 December 1996 concerning general oversight. Dr van Rhyn told the Medical Council that he did not believe he required general oversight. In his letter Dr van Rhyn said amongst other things:

"Although this may seem arrogant, one of my problems is that I am better qualified and have vastly more experience than the general practitioners I approach for general oversight …

I work at our local after hours surgery in Hamilton doing all my rostered shifts as well as those of my colleague. I also help out frequently when rostered doctors are unavailable due to unforeseen circumstances. At many of those sessions I am the one who gets consulted by other doctors to help reach a diagnosis or handle a difficult case.

I have extensive experience and have been able to diagnose many a patient where even the specialists at Waikato Hospital failed to reach a diagnosis …"

It is ironic that Dr van Rhyn wrote this letter when he was in the midst of mis-managing a significant and fundamental ethical issue.

130. The Tribunal understands Dr van Rhyn is now subject to general oversight. It would be highly desirable if the person providing general oversight could satisfy themselves over the next 12 months that Dr van Rhyn understands how to identify and manage ethical problems which confront general practitioners in New Zealand. A starting point would be for Dr van Rhyn to provide his "overseer" with a copy of the Tribunal's decision so the person providing oversight can understand the Tribunal's concern. The Tribunal orders that as part of the continuing education component of Dr van Rhyn's general oversight he focus on ethical issues which confront general practitioners in New Zealand. The Tribunal also invites the Medical Council to audit Dr van Rhyn's progress in identifying and managing ethical issues to the standards expected of a general medical practitioner in New Zealand. The Tribunal suggests that if the person providing oversight has concerns about Dr van Rhyn's ability to practice within ethical boundaries then the person providing oversight should convey their concerns directly to the Medical Council.

Censure

131. Counsel for Dr van Rhyn appropriately acknowledged that it would be normal to censure a doctor found guilty of professional misconduct. The Tribunal agrees and orders Dr van Rhyn be censured.

Fine

132. The Tribunal invited submissions on Dr van Rhyn's financial circumstances before deciding whether or not to impose a fine. On 14 November, Counsel for Dr van Rhyn wrote to the Tribunal enclosing a single page statement from Dr van Rhyn's accountant stating in one line that for the financial year ending 31 March 2002 Dr van Rhyn's gross income was $40,000. No explanation was given as to why Dr van Rhyn's gross income was so low. The accountant said Dr van Rhyn's surplus monthly income was just $300.90 and that his assets amount to $8,382.

133. The Tribunal believes it is appropriate to impose a fine pursuant to s110(1)(e). The maximum fine that can be imposed is $20,000. In this case Dr van Rhyn has successfully defended the charge of disgraceful conduct but has been found guilty of professional misconduct. There are a number of mitigating factors which the Tribunal have taken into account in deciding on the level of fine it will impose. The mitigating factors include:

- The unenviable circumstances which Dr van Rhyn found himself in when trying to care for his seriously ill wife.
- Dr van Rhyn's apparent impecuniosity.

134. Notwithstanding the factors in mitigation urged upon the Tribunal, the Tribunal believes it important to impose a fine which reflects the seriousness of Dr van Rhyn's professional misconduct. In doing so the Tribunal has balanced Dr van Rhyn's circumstances and interests with the wider expectations of society and the medical profession of ensuring serious breaches of professional standards will be punished with an appropriate penalty.

135. Having regard to all the circumstances of the case, the Tribunal fines Dr van Rhyn $5,000.

Costs

136. The costs incurred in relation to this case comprise:

- The costs of the Complaints Assessment Committee's Inquiry $37,015.98
- The prosecution of Dr van Rhyn before the Tribunal $31,079.14

- The costs of the hearing by the Tribunal $44,124.19

TOTAL **$112,219.31**

137. It is usual in cases of this kind for the practitioner to be ordered to pay between 30% to 40% of the total costs incurred.

138. In this case, having regard to:

- the fact that the charge of disgraceful conduct was not proven; and
- that not all particulars of the charge were established; and
- the mitigating factors urged upon the Tribunal,

the Tribunal orders Dr van Rhyn pay 25% of the costs identified in paragraph 136 of this decision. That is to say Dr van Rhyn is to pay $28,054.83 by way of costs.

Publication

139. The hearing was held in public and no request has been made to prohibit publication of this decision.

140. The Tribunal invited Mrs van Rhyn to apply for her evidence to be heard in private in accordance with s107(1)(b) of the Medical Practitioners Act 1995. Mrs van Rhyn declined that opportunity. The Tribunal has given consideration to suppressing publication of details of Mrs van Rhyn's medical history. In light of the fact Mrs van Rhyn was willing to have her evidence heard in public the Tribunal does not propose to restrict publication of any feature of this decision.

Summary

141. The Tribunal finds Dr van Rhyn's acts and omissions constitute professional misconduct. He is:

(a) To practise subject to a condition that for a period of one year from the date of this decision Dr van Rhyn identify and manage ethical issues in a manner consistent with

the standards expected of a general medical practitioner in New Zealand as part of the continuing education component of general oversight.

(b) Censured

(c) Fined $5,000

(d) Ordered to pay costs of $28,054.83

(e) The Tribunal orders publication of the above orders in the New Zealand Medical Journal pursuant to Section 138 of the Act.

DATED at Wellington this 26th day of November 2002

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D B Collins QC

Chair

Medical Practitioners Disciplinary Tribunal