Medical Practitioners Disciplinary Tribunal

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All Correspondence should be addressed to The Secretary

PLEASE NOTE:

NAME OF PATIENT

OR ANY PARTICULARS

OF HER AFFAIRS NOT

FOR PUBLICATION

DECISION NO: 82/99/45D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against **COLIN FREDERICK WAKEFIELD** medical practitioner of Havelock North

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr P J Cartwright (Chair)

Mr P Budden, Dr R S J Gellatly, Dr J M McKenzie,

Dr D C Williams (Members)

Ms K G Davenport (Legal Assessor)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Napier on Wednesday 30 June 1999

APPEARANCES: Ms T W Davis, Director of Proceedings

Mr C J Hodson QC for Dr C F Wakefield.

1. THE CHARGE:

1.1 INITIALLY the Director of Proceedings charged Dr Wakefield that on or about 19 July 1998 whilst treating his patient, Mrs xx, he being a registered medical practitioner, acted in such a way that amounted to disgraceful conduct in a professional respect in that he provided services of an inappropriate professional standard.

1.2 PARTICULARISED the charge states:

"In particular you:

1) Touched your said patient's left and right legs with your lips;

and/or

2) Failed to obtain your said patient's informed consent to touch her legs with your lips."

1.3 AT the hearing the Director of Proceedings applied to amend the charge from disgraceful conduct in a professional respect to conduct unbecoming a medical practitioner which reflects adversely on fitness to practise medicine. Mr Hodson consented to the amended charge.

1.4 FOR the record it should be noted that an Order prohibiting the name or identification of any particulars of the affairs of Mrs xx was made in Decision No. 76/99/45D.

2. EVIDENCE:

2.1 **THERE** were three witnesses for the prosecution but only one gave oral evidence at the hearing.

2.2 **A** brief of evidence for Detective Constable Sutherland was filed with the Tribunal. He simply attached a statement that he took from Mrs xx.

2.3 **MRS** xx says in her statement that Dr Wakefield was brought to see her at the xx Hospital on 19 July 1998. Dr Wakefield knelt down by her feet on her left side. He kissed her leg from the foot up to the knee and back down and then did the same on the other one.

2.4 **MRS** xx was not called as a witness because she is now deceased.

2.5 **A** brief of evidence prepared on behalf of Dr Brian King was filed with the Tribunal. Dr King is currently in private practice in Wellington as a general practitioner and has been a general practitioner since 1988. He was asked by the Health & Disability Commissioner to provide her with his professional opinion about Dr Wakefield's treatment of Mrs xx.

2.6 **DR** King stated that in his opinion, in the clinical situation that Dr Wakefield was presented with, it was important to test for skin temperature. He said that the use of lips to test for skin temperature is highly unorthodox and inappropriate. He said he did not believe that there was any reference to the use of lips to test for skin temperature in any medical text on physical examination. Dr King said he considered that using the back of the hand should be sufficient.

2.7 **EVIDENCE** was given by Mrs Rosemary Roberts, a care giver at xx Hospital. She explained that on 18 and 19 July 1998 she was concerned about Mrs xx and the oedema of her legs. She reported her concerns to the registered nurse at xx Hospital who said that the on-call doctor should be called.

2.8 **MRS** Roberts said that on 19 July 1998 she met with Dr Wakefield at the hospital and took him to see Mrs xx. At the time Mrs xx was wearing stay-up stockings and a dress. Dr Wakefield removed the stockings and brushed his lips up and down one leg and then the other. Mrs Roberts said she saw that Dr Wakefield's lips were in contact with Mrs xx' skin several times during the examination. After doing this Dr Wakefield told Mrs Roberts that he had been feeling for heat.

2.9 **MRS** Roberts told the Tribunal that she subsequently reported the incident to her seniors.

2.10 **DR** Wakefield explained to the Tribunal that Mrs xx' legs were badly swollen; particularly the right one. Given the level of swelling, he was concerned to exclude congestive heart failure as a diagnosis, so he firstly examined her lungs and heart, and neck. Her lungs showed basal crepitations. He then checked her heart rate by placing his stethoscope down the front of her clothing.

2.11 **HE** then examined her legs. She had dependent oedema in her right leg to the knee, and moderately in her left leg to the knee.

2.12 **HE** was concerned that a diagnosis of cellulitus had already been made, noting that cellulitus generally involves significant heat redness and swelling, although extreme oedema, (such as Mrs xx had) can make it difficult to feel the heat.

2.13 **DR** Wakefield said he could not remember Mrs xx wearing any stockings. He said he certainly would not have pulled them down, unless they were at knee level.

2.14 **DR** Wakefield examined Mrs xx' legs with the flats of his fingers to see if he could feel heat. He could not. Further there was no redness of the legs.

2.15 **NEVERTHELESS** being very concerned to exclude the diagnosis of cellulitus, and given his understanding that the lips are the most heat sensitive area of the body, he agreed that he briefly applied his lips to Mrs xx' left leg and shin to see if he could feel any heat. Accepting that both legs were examined in the same manner, Dr Wakefield said he did not intend to cause any concern or embarrassment to Mrs xx.

2.16 **HAVING** completed research into temperature testing, Dr Wakefield acknowledged there is no reference material to suggest what is the correct way of testing temperature on the skin. However Dr Wakefield said he accepted that the manner in which he tested Mrs xx' skin was inappropriate.

3. DISCUSSION AND FINDING:

3.1 **THE** burden of proof is on the Director of Proceedings. It is for her to establish that Dr Wakefield is guilty of the charge, and to produce the evidence that proves the facts upon which

the charge is based. It is well established in professional disciplinary cases that the civil, rather than the criminal, standard of proof is required, mainly proof to the satisfaction of the Tribunal, in this case the Medical Practitioners Disciplinary Tribunal on the balance of probabilities. At the same time, however, the cases recognise that the degree of satisfaction which is called for will vary according to the gravity of the allegations.

3.2 **THE** Tribunal must determine in relation to the charge, and in relation to each particular of the charge, whether the facts alleged have been proved to the required standard.

3.3 **IF** proved, the Tribunal must go on to determine whether the conduct established by the proven facts amounts to conduct unbecoming which reflects adversely on fitness to practise medicine.

3.4 **THE** first particular of the charge is that Dr Wakefield touched Mrs xx' left and right legs with his lips.

3.5 **AFTER** a careful assessment of the evidence we are satisfied that this particular has been established to the required standard.

3.6 **THE** only possible variance in the evidence, is the degree of application of lips to the legs of Mrs xx. Mrs Roberts said she saw Dr Wakefield's lips make contact with Mrs xx' legs *"several times"*.

3.7 **ON** the other hand Dr Wakefield said he could not agree with the way it had been set out in the brief of evidence of Mrs Roberts that he brushed his lips up and down Mrs xx' legs. He added *"This certainly did not occur"*.

3.8 **WE** find it is not necessary for us to determine exactly how many times Dr Wakefield's lips made contact with Mrs xx' legs. The fact of the matter is that Dr Wakefield's use of lips to test for skin temperature changes, was considered by Dr King to be *"highly unorthodox and inappropriate"*. This evidence is unchallenged and is accepted by us.

3.9 **THE** only other possible variance in the evidence which arises out of a consideration of the first particular of the charge, is whether Mrs xx was wearing stockings.

3.10 **MRS** Roberts was clear in her recollection that Mrs xx was wearing what she described as *"stay-up stockings"*. Responding to Mr Hodson's suggestion that it would have been surprising for Mrs xx to have been wearing stockings given the condition her legs were in, Mrs Roberts clarified that *"old people are creatures of habit"* and that Mrs xx *"didn't feel dressed unless she had her stockings on"*.

3.11 **IN** examination in chief Dr Wakefield acknowledged to Mr Hodson although his recollection was that Mrs xx was not wearing stockings, that he would think Mrs Roberts was probably the more correct in her recollection that knee length stockings were being worn at the time by Mrs xx.

3.12 **IN** itself whether or not Mrs xx was wearing stockings at the time, is not of great consequence. On the evidence, however, we conclude that Mrs xx probably was wearing knee length

stockings, which Dr Wakefield probably assisted in the removal of so that he could more conveniently examine the condition of her legs.

3.13 **THE** second particular of the charge is that Dr Wakefield failed to obtain the informed consent of Mrs xx to touch her legs with his lips.

3.14 **AGAIN** after a careful assessment of all the evidence, we are satisfied that this particular has been established to the required standard.

3.15 **ALTHOUGH** Dr Wakefield said he could specifically remember asking Mrs xx for her consent to drop his stethoscope down her dress to listen to both the lung fields and heart sounds, Dr Wakefield acknowledged he could not recall specifically what he said to Mrs xx concerning the lip test he used on her legs.

3.16 **IN** cross-examination by the Director of Proceedings, Dr Wakefield agreed it was likely that if he had asked to examine Mrs xx' legs, that he would not have gone further to say how he would have examined them.

3.17 **DR** Wakefield acknowledged to the Director of Proceedings that using his lips to test for skin temperature was *"unorthodox"*.

3.18 **FURTHER** Dr Wakefield acknowledged to the Director he accepted that if he were to use an unorthodox technique on a patient, that it was incumbent on him as the doctor to specifically

obtain the patient's consent for the use of such a technique. Dr Wakefield added *"I accept now I should not have used that technique"*.

3.19 **IN** accepting the evidence of Dr Wakefield in relation to the second particular of the charge, we find it has been established to the required standard.

4. DETERMINATION:

4.1 **HAVING** made findings that the facts alleged in each particular of the charge have been proved to the required standard, the Tribunal must now go on to determine whether the conduct established by the proven facts, amounts to conduct unbecoming which reflects adversely on fitness to practise medicine.

4.2 **THERE** are now a number of Decisions defining conduct unbecoming, and more recently *"reflecting adversely on the practitioner's fitness to practise medicine"*. (The rider).

4.3 **THE** most commonly referred to ruling setting out the essential features of conduct unbecoming was made by Elias J (as she then was) in *B v Medical Council* (High Court, Auckland, 11/1996, 8 July 1996) at p 15:

"There is little authority on what comprises "conduct unbecoming." The classification requires assessment of degree. But it needs to be recognised that conduct which attracts professional discipline, even at the lower end of the scale, must be conduct which departs from acceptable professional standards. That departure must be significant enough to attract sanction for the purposes of protecting the public. Such protection is the basis upon which registration under the Act, with its privileges, is available. I accept the submission ... that a finding of conduct unbecoming is not required in every case where error is shown. To require the wisdom available with hindsight would impose a standard which it is unfair to impose. The question is not whether error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations. The threshold is inevitably one of degree. .... The structure of the disciplinary processes set up by the Act, which rely in large part upon judgment by a practitioner's peers,

emphasises that the best guide to what is acceptable professional conduct is the standards applied by competent, ethical, and responsible practitioners. ..."

4.4 **FROM** this statement three basic and essential principles emerge:

(a) The departure must be significant enough to attract sanction for the purposes of protecting the public.

(b) A finding of conduct unbecoming is not required in every case where error is shown.

(c) The question is not whether error was made, but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations.

4.5 **THE** rider has been the subject of a Decision in the District Court, Doogue DCJ *Complaints Assessment Committee v Colin David Mantell* District Court Auckland NP 4533/98 7 May 1999. At page 16 His Honour says:

"The focus of the enquiry is whether the conduct is of such a kind that it puts in issue whether or not the practitioner whose conduct it is, is a fit person to practise medicine. In order to satisfy the requirements of the rider, it is not necessary that the proven conduct should conclusively demonstrate that the practitioner is unfit to practise. The conduct will need to be of a kind that is consistent with what might be expected from a practitioner who acts in compliance with the standards normally observed by those who are fit to practise medicine. But not every divergence from recognised standard will reflect adversely on a practitioner's fitness to practise. It is a matter of degree."

4.6 **FOR** Dr Wakefield Mr Hodson acknowledged there was no argument at all that the method of temperature testing adopted by Dr Wakefield was unorthodox, and certainly no argument that Dr Wakefield should, at the very least, have discussed it with Mrs xx before hand.

4.7 **THAT** said, Mr Hodson sought to have the Tribunal focus on all the good points arising out of Dr Wakefield's examination of Mrs xx, a proper examination, a correct diagnosis, appropriate prescribing, and overall, correct management of his patient.

4.8 **IMPORTANTLY** Mr Hodson stressed that this case has not uncovered an on-going feature of unacceptable practice, that this was a one-off event which it is unlikely will ever happen again.

4.9 **IN** the context of the Tribunal's assessment as to whether the conduct in question reflects adversely on fitness to practice, Mr Hodson categorised the lip test undertaken by Dr Wakefield as *"an unacceptable manoeuvre"* which initially, when publicised, had sinister connotations. Mr Hodson expressed relief on behalf of Dr Wakefield that the Director of Proceedings was not now contending any improper motive on the part of Dr Wakefield.

4.10 **MR** Hodson went on to remind us of the carefully chosen words of Elias J (as she then was) in *B* that the *"... departure must be significant enough to attract sanction for the purposes of protecting the public ..."* and *"... a finding of conduct unbecoming is not required in every case where error is shown ..."* and *"... the question is not whether error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations. The threshold is inevitably one of degree ..."*.

4.11 **AS** was indicated by us at the conclusion of the hearing, it is our determination that the unbecoming conduct under focus does reflect adversely on Dr Wakefield's fitness to practise medicine.

4.12 **WE** are agreed that a letter produced in evidence by Mr Hodson on behalf of Dr Wakefield (without objection by the Director of Proceedings), is a helpful document. While we acknowledge Ms Davenport's direction that the letter is not directly relevant to our

considerations, it does give us an overview of what Dr Stormer took some pains to describe as Dr Wakefield's *"distinctive personality"* and *"meticulous ... attention to detail"*.

4.13 **AGAIN** relevant in the context of our considerations is the following passage from Dr Stormer's letter:

"- it is unfortunate that the potential for alternative interpretation of that physical contact (or even concerns of personal safety) did not inhibit him from proceeding with a technique for which peer recognition is lacking. Having spoken with him about this particular case, it is apparent to me that Colin recognises that he has acted unwisely and inappropriately. I do not believe that there would have been any other motivation than making a correct diagnosis."

4.14 **IF** we had been able to restrict our considerations only to Dr Wakefield's motivation in making a correct diagnosis, then it is unlikely that the rider of *"reflecting adversely on the practitioner's fitness to practise medicine"* would have been found to apply. In our view Dr Wakefield's failure to seek and obtain the consent of his patient to the lip temperature test, is the principal reason for us having to make an adverse determination against him. It is noted that Mr Hodson's submissions barely touched on this aspect of the matter.

4.15 **IN** contrast the submissions made by the Director of Proceedings covered the aspect of communication and informed consent more than adequately.

4.16 **THE** leading case on informed consent is the High Court of Australia's judgment in *Rogers v Whittaker* 175CLR 479 (1992).

4.17 **IN** *Rogers v Whittaker* the Court accepted that medical practitioners are under a duty to exercise reasonable skill and care, not only in treatment but also in the provision of information. A practitioner owes a duty of care to his or her patient to disclose *"information required by a reasonable patient in the position of the actual patient"*. This is an objective test that recognises the particular circumstances of the actual patient.

4.18 **THE** judgment in *Rogers v Whittaker* was applied in New Zealand *B v The Medical Council of New Zealand* (supra).

4.19 **FURTHER** assistance is given by comments made by Elias CJ in her paper presented at the recent Brookfields Medical Law Symposium held in June 1999. Elias CJ commented at page 13, paragraph 36 that

"It seems to me that the reality is that the Courts will not defer to clinical judgement of medical practitioners as to what the patient should be told. Informed consent to treatment is a precondition of such treatment. The patient's right imposes a concomitant duty on the medical practitioner to inform".

4.20 **RIGHT** 5 of the Code of Health & Disability Services Consumers' Rights (the Code) gives every patient the right to effective communication in a form, language and manner that enables the consumer to understand the information provided. This right cannot be overlooked in disciplinary procedures such as this. In a *Complaints Assessment Committee v Mantell* (MPDT Decision No. 47/98/25C) this Tribunal affirmed the above approach to informed consent in *B v The Medical Council* and *Rogers v Whittaker* (both supra). The Tribunal said that rights 6 and 7 of the Code of Rights reinforced the common law concerning informed choice and informed consent.

4.21 **THE** rights of a patient to receive information are confirmed by the Statement for the Medical Profession on Information and Consent (the Statement) published by the Medical Council of New Zealand in 1995. This Statement makes the offering of suitable advice to patients a mandatory prerequisite to any medical procedure instituted by a medical practitioner.

4.22 **FROM** the evidence it is clear that Dr Wakefield accepts, especially given that he used an unorthodox method of testing for skin temperature, that he should have specifically obtained the consent of Mrs xx to use his lips, something which he neglected to do. The impression is that a good knowledge and awareness of his obligations by reference to patient communication is, or was not Dr Wakefield's strong suit at the time the complaint was made to the Health & Disability Commissioner on behalf of Mrs xx.

4.23 **IT** occurs to us to suggest, notwithstanding the acknowledged unorthodox nature of the test used by Dr Wakefield, that if he had obtained Mrs xx' consent, it may be arguable that any complaint made would have progressed beyond that stage.

4.24 **THERE** are issues of public safety arising out of obligations imposed on medical practitioners to be effective in their communications with patients. In this instance we determine that Dr Wakefield's unbecoming conduct towards the late Mrs xx, does reflect adversely on his fitness to practise medicine.

4.25 COUNSEL are invited to address the Tribunal on the question of penalties. The Director of Proceedings is asked to provide written submissions by **Tuesday 10 August 1999** followed by written submissions from Mr Hodson by **Tuesday 24 August 1999**.

DATED at Auckland this 26th day of July 1999

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P J Cartwright

Chair

Medical Practitioners Disciplinary Tribunal