MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 201/00/61C/01/84C

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 **BERIS FORD** medical practitioner of Whangarei

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mrs W N Brandon (Chair)

Mrs J Courtney, Dr J C Cullen, Dr A R G Humphrey, Dr U Manukulasuriya (Members)

Mr B A Corkill (Legal Assessor)

Ms K L Davies (Hearing Officer)

Mrs G Rogers (Stenographer)

Hearing held at Whangarei on Monday 4 to Friday 8 and Monday 11 to Friday 15 March 2002

APPEARANCES: Ms K P McDonald QC and Ms J Daniels for a Complaints Assessment Committee ("the CAC").

Mr A J Knowsley and Mr J Johnston for Dr B Ford.

The Charges

1. At the hearing commenced at Whangarei on Monday 4 March 2002, the Tribunal heard evidence in relation to five charges laid against Dr Ford by Complaints Assessment Committees, established under section 88 of the Medical Practitioners Act 1995.

2. The charges were laid at the level of disgraceful conduct or professional misconduct (Mrs P); professional misconduct (Ms D and Ms W) and conduct unbecoming a medical practitioner and that conduct reflects adversely on the practitioner's fitness to practise medicine (Ms R and Mrs S). The allegations giving rise to the charges are in many respects broadly similar and, in general terms, allege that Dr Ford carried out inappropriate and unnecessary examinations; that he made inappropriate comments of a personal and/or sexual nature, and that he failed to obtain proper, informed consent before carrying out certain examinations.

Background to the charges

Mrs P

3. Dr Ford is a general practitioner who has practised as a general practitioner in Whangarei for approximately 30 years. He has been a member of the College of General Practitioners for 25 years, and a Fellow since 1987. For many years Dr Ford was also a police doctor.

4. Dr Ford was Mrs P's general practitioner from approximately January 1989 to September 1992. The allegations giving rise to the charge against Dr Ford arise in the context of several of the consultations which occurred during that period. In particular, Mrs P alleges that in or about 1989, she started experiencing problems with Dr Ford. She described feeling "*wedged in*" when Dr Ford moved very close to her during consultations. Dr Ford was apparently in the habit of sitting on a chair with wheels and Mrs P alleged that he would slide over to her and move very close, often placing his hands on her knees. Mrs P complained that Dr Ford would position his legs so that they were touching hers and sometimes his legs would be between her legs with his hand on her knees or on her lower thigh.

5. Mrs P was unable to move back or pull away because of the position of the chair provided for patients, which was placed in the corner between Dr Ford's desk and the wall of the consultation room. Mrs P also alleged that Dr Ford often stared directly at her breasts and that he made comments which her made her feel embarrassed and uneasy in his presence. Mrs P also complained that Dr Ford touched her inappropriately on a number of occasions and there were also occasions when she asked for a chaperone but her request was refused on the basis that the nurse was too busy or otherwise unable to leave what she was doing to come into the consultation.

Ms D

6. This charge alleges that at a consultation with Ms D in 1984, Dr Ford carried out an inappropriate and unnecessary breast examination. It was Ms D's evidence that this was the only occasion on which she saw Dr Ford and that she went to see him for a sore throat. At the consultation Dr Ford told her that a breast examination was required. While this seemed strange to Ms D at the time, she thought that possibly her sore throat was a symptom of breast cancer or something similar. She assumed that Dr Ford knew what he was doing and she accepted his instructions to remove her clothing and to lie on the examination bed, so that she was completely exposed from the waist up. She was given no privacy while removing her clothes and she was very embarrassed.

7. Ms D told the Tribunal that she could not recall Dr Ford actually examining her throat at all during the consultation and no explanation was given to her as to why it was necessary to remove her clothing and submit to the breast examination. Ms D had not previously had a breast examination but believed that the examination carried out by Dr Ford was "*not right*". It made her feel very anxious and uncomfortable.

8. At the conclusion of the examination, Dr Ford helped her put her bra back on and he watched as she got dressed. Dr Ford also asked Ms D if she needed a smear, but she declined. It is her belief that Dr Ford used his position as a doctor to take advantage of her.

Ms W

9. Ms W saw Dr Ford in or around December 1981/January 1982 when she was about 16 years old. At that time, she wanted to go on the contraceptive pill and because she was afraid that her family doctor would tell her parents that she was on the pill, she went to see Dr Ford.

10. Dr Ford told Ms W that he needed to do a breast examination and although she found the whole experience of disrobing particularly embarrassing, she assumed that Dr Ford knew what he was doing and she allowed him to examine her breasts. It was Ms W's impression that Dr Ford fondled her breasts. She also stated that she has subsequently had breast examinations done and these were nothing like what she experienced with Dr Ford.

11. At the conclusion of the breast examination and after she had put her clothes back on, Dr Ford told Ms W that it would be necessary for her to have an internal examination. However because she had become extremely anxious as a result of the breast examination, she declined.

12. The central allegation made by Ms W is that Dr Ford's examination of her and the comments he made about matters of a sexual nature in the course of the consultation were

inappropriate and caused her enormous embarrassment and distress. She was both shocked and scared and she never went back to see him again.

Ms R

13. Ms R was 16 years old when she consulted Dr Ford on 24 October 1984. At that time he was her family doctor but this was the first occasion on which she visited Dr Ford on her own. Previously she had been accompanied by her mother.

14. Ms R went to see Dr Ford because she had a sore throat. In the course of the consultation Dr Ford asked her to take her clothes off so that he could examine her. Ms R was wearing her school uniform at the time and she was shocked and embarrassed by Dr Ford's instruction. She did not know why she needed to take off her clothes for a sore throat but was too shy and embarrassed to object. Dr Ford did not offer any explanation, nor did he offer her any privacy although Ms R was adamant that he must have been very aware of her embarrassment and discomfort. Ms R lay on the examination bed for the examination, during which time she was fully exposed to Dr Ford being clothed only in her underpants.

15. In carrying out the examination Dr Ford checked the glands under Ms R's arm but did not examine her throat in any way or carry out any other examination. As she was getting dressed he made the comment that she was "*developing nicely*". Ms R was extremely embarrassed and said that she has never gotten over the experience. She never returned to see Dr Ford and indeed she has never been to any other male doctor for any sort of female examination since that consultation.

Mrs S

16. Mrs S consulted Dr Ford on 8 November 1999. Mrs S went to see Dr Ford with ear pain. She told him that the pain seemed to be coming from inside her ear and by her cheek. Dr Ford checked her ears and said they both seemed to be fine. He suggested that she see a dentist for a dental examination. She agreed to do so. Dr Ford then proceeded to ask her questions of a more general and sexual nature, particularly about her late husband and they discussed his death from melanoma in 1996.

17. Mrs S alleged that Dr Ford insisted on carrying out an examination for melanoma although this was against her wishes. Mrs S said that she told Dr Ford that such an examination was unnecessary as she checked herself regularly in any event. Dr Ford asked Mrs S questions about her sex life which made her feel very uncomfortable and she believed the questions to be inappropriate and unprofessional.

18. Dr Ford then directed Mrs S to get onto the examination bed so that he could examine her. Initially, Mrs S removed only her top and left her bra on however when Dr Ford returned to the consultation room he told her to also take off her bra. She did so, but felt embarrassed and humiliated. Dr Ford's nurse came in to the consultation room as a chaperone during the examination. Mrs S was very uncomfortable and angry that she had gone to see Dr Ford for a sore ear and 'had come out with a breast examination'.

Evidence for the CAC

19. Evidence for the CAC was given by the complainants referred to above; Dr Shane Reti, general practitioner of Whangarei, and five witnesses who gave evidence in the nature of similar fact evidence. The names and identifying details of all of the witnesses who gave evidence that involved the disclosure of personal information are suppressed.

Evidence for Dr Ford

20. Evidence for Dr Ford was given by Dr and Mrs Ford; Dr Daphne Climie, general practitioner of Whangarei; Dr Catherine Bowden, retired medical practitioner of Tutukaka and Dr Anthony Nixon, urologist of Whangarei. A number of Dr Ford's former and current practice nurses also gave evidence on his behalf, as did a number of patients.

21. Also submitted as evidence in support of Dr Ford's defence of the charges were a number of statements of evidence from medical practitioners, practice nurses and receptionists, all of whom have worked with Dr Ford, and from nurses who are, or have been, patients of Dr Ford's; statements (63) given by patients; copies of cards and letters expressing support for Dr Ford, and a petition signed by approximately 480 patients. All of this evidence was received and has been considered by the Tribunal.

Legal issues

22. Prior to the hearing, counsel identified a number of contested issues. Most of these related to the admissibility of evidence, especially the evidence in the nature of similar fact evidence. The Tribunal appointed Mr Bruce Corkill, barrister, of Wellington, to attend the hearing and to advise the Tribunal during the course of the hearing as required.

23. The CAC lead five witnesses of similar fact and submitted that the facts and circumstances described in the evidence given by them, and the facts and circumstances of the offending described by the complainants, were significantly similar. Therefore, the CAC submitted, the evidence of the similar fact witnesses was of probative value and reliable.

24. **Paragraph deleted by Order of the Tribunal**.

25. Of the other witnesses of similar fact (one male, the others female), one witness gave evidence that was also given in support of her complaint to the Medical Council regarding Dr Ford's examination of her in 1986 when she was 15 years old. That complaint resulted in a charge of conduct unbecoming, which charge was the subject of a hearing by the Medical Practitioners Disciplinary Committee in April 1987. The charge was not upheld.

26. In terms of Dr Ford's conduct of the various consultations described by all of the witnesses, the allegations made by them were indeed 'strikingly similar'. There was no evidence of any collusion between the witnesses, or even that they knew each other. All of the witnesses gave evidence that:

- Dr Ford made inappropriate comments of a personal and/or sexual nature;

- he requested them to remove clothing and submit to personal and intimate examinations (usually breast examinations) without being given any explanation;

- he carried out breast examinations which involved the massaging, rubbing, fondling and/or manipulation of their breasts (and in one case, the witness's genitals) in such a way that the witnesses were embarrassed and/or angry and/or confused;

- feelings of shame and/or confusion on the part of the witnesses after the consultations;
- the age of the female witnesses at the time of the consultations complained of were broadly similar (i.e. they were young women);
- Dr Ford tweaked their nipples, and
- complaints and/or anger about the examinations were made or expressed to other persons and/or authorities shortly after the consultations in question.

27. Ms McDonald for the CAC submitted that in this case the evidence of each of the complainants and each of the similar fact witnesses demonstrated a system or underlying unity of conduct which demonstrated special characteristics or a common thread running through all of the evidence that made it sufficient for it to be used and relied on as similar fact evidence. Ms McDonald told the Tribunal that the similar fact evidence was advanced for the following three purposes:

(a) the evidence is of a high probative value and shows that Dr Ford has a propensity to engage in conduct of the type alleged by the complainants. Refer *R v Tulisi* (2000) 18 CRNZ 418 where Fisher J said at P.421:

> *"Anything which makes it more likely that the accused was guilty has probative value. It is more likely that an accused committed the offence charged if he has demonstrated a propensity for behaving in the same general way on other occasions. Old habits die hard. Only a small proportion of the community indulge in burglaries. Therefore a person who has already committed one or more burglaries is more likely to commit a burglary than another member of the community selected at random. This much has always been obvious to the public, if not always to lawyers. …Showing the accused's propensities is the whole point of similar fact evidence."*

(b) The evidence is also relied on and becomes admissible to rebut Dr Ford's defence. It is submitted that the evidence can be relied on to meet any argument by the defence that the complainants have fabricated their evidence or were mistaken in the

nature of their allegations. Refer *R v W* (11/6/99; CA 132/99).

(c) The evidence is also relied on to show a window on Dr Ford's "*character*". It is particularly important in this case to bear the evidence of similar fact in mind when considering the character evidence led by Dr Ford.

28. Ms McDonald provided a comprehensive analysis of the similar fact evidence under the following headings:

(i) Age;
(ii) Vulnerability;
(iii) First consultation;
(iv) Nature of consultation;
(v) Nipple tweaking;
(vi) Inappropriate comments;
(vii) Invasion of personal space/exposure;
(viii) Lack of explanation; and
(ix) Impact.

29. Ultimately, Mr Knowsley, on behalf of Dr Ford, did not challenge the admissibility of the evidence of similar fact. Similarly, he did not contest the similarity of the evidence given in any global way but focussed rather on the evidence given by each of the witnesses, and submitted that Dr Ford either denied, or could provide an explanation for, all of the allegations made against him.

30. For completeness, the Tribunal sets out in full Mr Corkill's advice in relation to the evidence of similar fact:

"While labels such as "similar facts" and "strikingly similar" are convenient, the real question is always whether as a matter of common sense the evidence is sufficiently supportive of a particular charge. Other epithets which have been used are whether there is some "significant additional feature which lifts the evidence above showing only bad character or disposition to offend generally"; is there "some special characteristic or pattern emerging from the evidence" or "some underlying unity between the separate events".

Differences almost always exist when one case is compared with another, for the purposes of this type of evidence, however, the focus must necessarily be on the similarity of the factors to establish the sufficiency of a factual link. (R v T, CA 393/98, 30.3.99)

However, you need to be careful how you approach the question of "sufficient similarity". There must be much more, for example, than the fact that the complainants are women, or girls, who have been subjected to alleged improper conduct. There must be a discernible pattern in the detail of what each complainant or similar fact witness says, which gives their individual account such a distinctive similarly as to reinforce what each says.

"Mere propensity" reasoning is not permissible; propensity to commit offences, even offences of a particular type is not sufficient, there must be a greater focus than that. One High Court Judge has put it in this way:

> *Anything which makes it more likely that the accused was guilty has probative value. It is more likely that an accused committed the offence charged if he has demonstrated a propensity for behaving in the same general way in other occasions. Old habits die hard. Only a small proportion of the community indulge in burglary. Therefore a person who has already committed one or more burglaries is more likely to commit a burglary than another member of the community selected at random. This much has always been obvious to the public, if not always to lawyers.*
>
> *Showing the accused's propensities is the whole point of similar fact evidence.* (R v Tuisi (2000) 18 CRNZ 418).

So, reasoning based on propensity, when its probative value is sufficiently high (or striking, or having a special characteristic or pattern), can assist.

If you are not satisfied of the existence of a necessary distinctive similarity in the account of a particular complainant who is the subject of a charge, then you may not use the evidence of "external" complainants or similar fact witnesses in relation to that charge. In those circumstances the evidence of the other complainants or similar fact witnesses would have to be put entirely to one side.

You must, obviously, separately consider each charge, and bring in a separate decision in relation to each.

If you are satisfied that one particular charge is made out, it is an unsafe and improper process of reasoning to conclude that the Respondent must therefore be guilty of other matters with which he is charged. The fact that a Respondent may have done something bad on one occasion, does not of itself mean he has done something bad on another, and in relation to a different complainant.

I have already referred to the possibility of collusion and the necessity of considering that issue. Similarly, there may be some other reason for discarding the evidence of another complainant or "similar fact" witness, for example where although there is no collusion, the witness may have had his/her own purpose in giving supporting evidence.

You will have to move through each charge on a methodical basis, carrying out the evaluation, assessing whether the evidence of any of the other complainants, or the "similar fact" witnesses assist with regard to a particular complainant."

31. The Tribunal accepts that advice and in its deliberations, it took the evidence into account in the manner suggested by Mr Corkill. However, with the exception of the Tribunal's finding that Dr Ford has a propensity to make comments of a personal and/or sexual nature, the Tribunal ultimately was satisfied that it was possible to determine each of the charges on their own facts, and on the basis of the evidence given in relation thereto; and even its finding of Dr Ford's propensity to make such comments rested as much on the credibility of the relevant witnesses as on the weight of the evidence.

The standard of proof

32. The standard of proof in professional disciplinary proceedings is the civil standard, the balance of probabilities. However the standard of proof will vary according to the gravity of the allegations founding the charge, and may vary within a single case, particularly where the charge involves allegations of serious professional misconduct and/or the charges are brought at the most serious level of professional disciplinary offences, and (such as in this case) where the credibility of witnesses is an issue and much of the evidence is contested.

33. All of the elements of a charge must be proved to a standard commensurate with the gravity of the facts to be proved; *Ongley v Medical Council of New Zealand* [1984] 4 NZAR 369, 375-376.

34. It is also relevant that some of the charges under consideration in this hearing related to events which occurred a number of years ago. The Tribunal has borne in mind that the standard against which Dr Ford is to be judged is that of a reasonable general practitioner practising at the time, or during the period, to which each of the charges relate. This is particularly the case in relation to the charges which allege that Dr Ford failed to obtain the

complainants' informed consent and/or to provide an adequate explanation for the examinations he carried out.

Test for professional disciplinary offences

35. The charges cover the full range of disciplinary findings available to the Tribunal pursuant to section 109 of the Act: disgraceful conduct, professional misconduct and conduct unbecoming a medical practitioner and that conduct reflects adversely on his fitness to practice.

36. In terms of the test for 'disgraceful conduct in a professional respect', this Tribunal has consistently applied the findings of the High Court (Tompkins, Cartwright and Williams JJ) in *Brake v Preliminary Proceedings Committee* [1997] 1 NZLR 71, in which the Court held:

> *"The test for "disgraceful conduct in a professional respect" was said by the Court of Appeal in Allison v General Council of Medical Education and Registration [1894] 1 QB 750, 763 to be met:*
>
> > *"If it is shown that a medical man, in the pursuit of his profession, has done something with regard to it which would be reasonably regarded as disgraceful or dishonourable by his professional brethren of good repute and competency…".*
>
> *It is apparent from this test, and from the later cases in which it has been adopted, that it is an objective test to be judged by the standards of the profession at the relevant time.*
>
> *Mr Vickerman referred to the decision of the Privy Council in Felix v General Dental Council [1960] AC 704. The Council was concerned with a charge of infamous conduct in a professional respect. It said that to consitute infamous conduct there must be some "element of moral turpitude of fraud or dishonesty" in the conduct complained of. Mr Vickerman submitted that the test for "disgraceful conduct" should be the same and that moral turpitude, fraud or dishonesty must be proved.*
>
> *We do not accept that submission. In Doughty v General Dental Council [1987] 2 ALL ER 843 at P 847, the Privy Council adopted the following passage from the judgment of Scrutton LJ in R v General Council of Medical Education and Registration of the United Kingdom [1930] 1 KB 562 at p 569:*

> *"It is a great pity that the word 'infamous' is used to describe the conduct of a medical practitioner who advertises. As in the case of the Bar so in the medical profession advertising is serious misconduct in a professional respect and that is all that is meant by the phrase 'infamous conduct'; it means no more than serious misconduct judged according to the rules written or unwritten governing the profession." (Emphasis added)*

In our view the same test should be applied in judging disgraceful conduct. In Doughty the Privy Council pointed out that Lord Jenkins' observation in Felix was in the context of a case in which dishonesty was very much the issue.

In considering whether conduct falls within the category, regard should be had to the three levels of misconduct referred to in the Act, namely disgraceful conduct in a professional respect, s58(1)(b); professional misconduct, s43(2); and unbecoming conduct, s42B(2). Obviously, for conduct to be disgraceful, it must be considered significantly more culpable than professional misconduct, that is, conduct that would reasonably be regarded by a practitioner's colleagues as constituting unprofessional conduct, or as it was put in Pillai v Messiter (No 2) (1989) 16 NSWLR 197, 2000, 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."

37. That passage setting out the test for disgraceful conduct has subsequently been adopted by this Tribunal in *White* (1) Decision No. 63/98/24C; *White* (2) Decision No. 69/98/36C, and most recently in *Parry*, (Decision No. 139/00/62D), but bearing in mind that the decision in the latter case involved conduct occurring in the context of Dr Parry's clinical management of his patient's care and treatment only. There was no suggestion of any professional impropriety in that case therefore it involved different considerations to those present in this case.

38. However it is relevant to record that in *Parry* the appellate Court confirmed that, when determining the appropriate test to apply, it is important to bear in mind that one of the main purposes of the Act (in fact the principal purpose, s.3) is to protect the health and safety of members of the public. That is certainly a significant consideration in the context of this case involving as it does a number of complainants and a number of similar fact witnesses. As was submitted by the CAC, the Tribunal has been given evidence of complaints about Dr Ford being dealt with on a piecemeal basis, and it was the CAC's submission that he has continued 'to fall between the cracks over the years in terms of his conduct'. Ms McDonald submitted that women have complained about Dr Ford over a

long period of time. Some of those women gave evidence to the Tribunal that they did so out of a concern that Dr Ford may continue to conduct himself improperly and to take advantage of vulnerable young women. It was the CAC's position that this is a case of significant public importance.

39. The principal purpose of the Act is consistent with the underlying purpose of the Medical Council's Statement to the Profession on Sexual Abuse In the Professional Relationship. As was said in that Statement, the medical profession has long recognised that the doctor/patient relationship is intended for the benefit of the patient. The proper conduct of the doctor/patient relationship requires the doctor to ensure that every interaction with a patient is conducted in a sensitive and appropriate manner, with full information and consent. The profession and the community properly expect total integrity on the part of doctors. All forms of sexual abuse in the doctor/patient relationship are regarded as disgraceful conduct with severe consequences for the doctor. The Medical Council's Statement is expressed in terms of 'zero tolerance' and states that "*sexual behaviour in a professional context is abusive. Sexual behaviour comprises any words or actions designed or intended to arouse or gratify sexual desires...*".

40. The Medical Council's Statement defines sexual abuse under three categories: sexual impropriety, sexual transgression, and sexual violation. The Statement came into effect in June 1994, and therefore post-dates the charges, with the exception of the charge in respect of Mrs S, which relates to Dr Ford's consultation with her on or about 8 November 1999.

41. Notwithstanding, the Statement is expressed in terms of fundamental professional values. For example, it states, among other things, that:

- *the onus is on the doctor to behave in a professional manner;*

- *total integrity of doctors is the proper expectation of the community and of the profession;*

- *the community must be confident that personal boundaries will be maintained and that as patients they will not be at risk;*

- *the doctor in is a privileged position which requires physical and emotional proximity to the patient, this may increase the risk of boundaries being broken.*

- *Sexual misconduct by a doctor risks causing psychological damage to the patient."*

42. As was stated by Dr Robin Briant, the former chair of the Medical Council, in 1994 (newsletter of the Medical Council (No.9) March 1994) "*there is nothing new about Medical Council policy on sexual abuse and the doctor patient relationship*". In *Brake (supra),* the High Court also referred to the Council's Statement and took the approach that:

    "although the Statement was issued some two years after the events to which this appeal relates, we have no reason to doubt that it fairly states what have long been the rules of conduct recognised by the profession, any serious breach of which would be regarded as disgraceful conduct. This is confirmed by a consideration of reports of a number of cases published in the New Zealand Medical Journal where the Council have found doctors guilty of sexual intimacies of various kinds. Where the degree has been other than minor, the Council has consistently found the doctor's name has been removed from the register or the doctor has been suspended from practice".

43. On this basis therefore, the Tribunal considers that notwithstanding that the Medical Council's Statement came into effect in June 1994, the Statement does no more than make explicit long-held fundamental values and standards; the obligation to adhere to those values and standards did not commence in June 1994.

44. In terms of both professional misconduct and conduct unbecoming that reflects adversely on the practitioner's fitness to practice medicine, the 1996 case *B v Medical Council* (Auckland HC, 11/96, 8/7/96, Elias J) is relevant. It dealt with both professional misconduct and conduct unbecoming in the following terms:

    "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 of Mr Waalkens 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 of her professional obligations. The threshold is inevitably one of degree. Negligence may or may not (according to degree) be sufficient to constitute professional conduct (sic) or conduct unbecoming."

45. The test for professional misconduct most commonly adopted in the relevant cases, and consistently adopted by this Tribunal is that contained in *Ongley v Medical Council* (4 NZAR 369, 375) where Jefferies J stated the test this way:

"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."

46. To summarise, the 'assessment of degree' required in terms of the three levels of misconduct referred to in the Act, and in terms of the relevant standards, is ultimately a matter for this Tribunal in the exercise of its discretionary powers, and exercising its collective judgment comprising as it does a mix of lay members and medical practitioners.

47. The Tribunal has also proceeded on the basis that, notwithstanding that all of the charges currently laid against Dr Ford are being dealt with at the same hearing and they are supported, in effect, by a significant volume of similar fact evidence, each case must ultimately be considered on its own facts.

Submissions by CAC

48. Referring to the principal purpose of the Act and the significant public interest in this case, Ms McDonald submitted on behalf of the CAC that the public need to have confidence that matters of a recurring nature, as demonstrated in this case, are taken seriously and dealt with appropriately. It was Ms McDonald's submission that:

"Women have been complaining about Dr Ford for a number of years, as the evidence in this case has demonstrated. Each time he has said, as I understand his evidence in this hearing, that the patients have either lied or misinterpreted his conduct. All these complainants and similar fact witnesses cannot be wrong. They haven't all misinterpreted, they haven't all lied – in fact, none of them have. There

*is no evidence to suggest concoction, collusion or a conspiracy. Their evidence has demonstrated an overwhelming similarity and unity of conduct, and it is submitted that their evidence should not be ignored or brushed aside yet again. There is one matter at this stage that I would like to refer to [transcript, p413, line 1]. I asked Dr Ford whether there had been other complainants of a similar nature. He initially said no, and then there was some further pushing on my part. It is all recorded in the transcript. He eventually acknowledged that there were two matters which were the subject of a stay proceedings. Upon inquiry if there were any more he didn't remember, and when told about three other matters that went to the CAC he acknowledged those and acknowledged that there was a further matter relating to [**name deleted**] who made a complaint to the police and the Medical Council. That demonstrates his inability to be entirely frank with the Tribunal."*

49. Ms McDonald also submitted that little, if any, weight should be given to the many character witnesses and practice nurses who gave statements and who were called to give evidence at the hearing. As Ms McDonald said:

"They were not present at the consultations and do not know the extent of the allegations in these cases. They were specifically asked in cross-examination how much they knew, and they demonstrated they knew very little other than what they saw in the media. They have demonstrated a poor understanding of the case and that is not surprising given the complimentary things they have said about Dr Ford. As the Tribunal will be aware, we are often taken by surprise when we hear about the private conduct of people whose public image is beyond reproach. And I think we can all think of instances of that."

50. The CAC's submissions in relation to each of the charges are referred to in more detail in relation to each of the decisions. However, Ms McDonald also made submissions in relation to a number of general matters. First, in relation to chaperones which Ms McDonald submitted only becomes important in the context of inappropriate examinations of young girls in a first time setting. Ms McDonald submitted that, given the nature of the consultations involved in these charges, the Tribunal may consider that the absence of chaperones is of some significance. There was no doubt a degree of inconsistency between the evidence about chaperones, particularly the evidence of Practice Nurse N, who told the Tribunal that "*Dr Ford was very meticulous about having a chaperone except where well-known, long-term patients did not want one. Of all the general practitioners at Rust Avenue I would say that he was the most conscientious about having a chaperone. He was a stickler for doing things right*", and the evidence of the complainants and similar fact witnesses to the effect that (with the

exception of Mrs S where a chaperone was present) none of them had been offered a chaperone. In relation to one of the similar fact witnesses, the Tribunal was told that her mother who was present with her at Dr Ford's surgery was discouraged from accompanying her daughter into the consultation by Dr Ford.

51. Secondly, Ms McDonald urged the Tribunal to take some care in relying on the patient notes which were advanced in support of Dr Ford's defence. There were a number of examples throughout the notes where they were inaccurate and/or Dr Ford's evidence was based on assumptions and, in one case, no notes at all were available. Ms McDonald also referred to Dr Ford's heavy reliance on what he referred to as "*opportunistic screening*" (mainly for breast cancer in women who were prescribed the oral contraceptive pill) as justification for his conduct. It was the CAC's submission that these were not cases of legitimate medical opportunistic screening. Ms McDonald submitted that:

> *"These cases were unusual, they were treated differently for some reason, and there was no chaperone. These were all either young or vulnerable women. They were one off consultations, unique in some way except for Mrs P. She was older but none the less very vulnerable.*
>
> *As was put to Dr Climie, and she agreed, the opportunistic screening criteria as identified by Wilson and Yunger in a paper included – 1, that the test must be acceptable to the patient; and 2, there must be a significant risk of the disease you are checking in the age group. [Dr Climie] accepted that [*transcript, P 436, line 8*] this is a clear case of credibility. There is no medical justification for Dr Ford's conduct, and as I said in my opening, the public are entitled to be protected from inappropriate medical examinations and doctors who do not maintain professional standards".*

Submissions on behalf of Dr Ford

52. On behalf of Dr Ford, Mr Knowsley denied all of the allegations giving rise to the charges. It was submitted that Dr Ford has never acted improperly towards any patient; the examinations and consultations were conducted solely in accordance with proper medical practice at the time. Mr Knowsley submitted that the statements submitted from doctors, nurses and patients demonstrated a pattern of a very caring general practitioner who is well received by the vast majority of his patients. Mr Knowsley's submissions mainly

addressed the specific complaints giving rise to the charges, and are therefore also dealt with in more detail in the Tribunal's findings on each of the charges.

The Decisions

53. The Tribunal has carefully considered and taken into account all of the evidence presented to it, Counsels' submissions made on behalf of the CAC and Dr Ford, and Mr Corkill's advice. In relation to each of the charges the Tribunal finds as follows:

Mrs P

54. The Tribunal is satisfied that this charge is not established.

Ms D

55. The Tribunal is satisfied that this charge is established and that Dr Ford is guilty of conduct unbecoming and that conduct reflects adversely on his fitness to practise.

Ms W

56. The Tribunal is satisfied that, for the reasons given, the Particulars of the charge are proven but, overall, the charge is not established.

Ms R

57. The Tribunal is satisfied that this charge is established and Dr Ford is guilty of conduct unbecoming and that reflects adversely on his fitness to practise.

58. This finding is the finding of the majority of the members. Dr Cullen departs from the majority and is not satisfied that the charge is established.

Mrs S

59. For the reasons given, the Tribunal is satisfied that Particulars 1 and 3 of the charge are established; Particular 2 is not established, and, overall, the charge is established. Dr Ford is guilty of conduct unbecoming and that reflects adversely on his fitness to practise.

Reason for decisions

Mrs P

60. As stated above, the Tribunal is not satisfied that any of the Particulars of the charge laid against Dr Ford are established in relation to his conduct towards Mrs P over the four years she was his patient.

61. In making this finding, the Tribunal has taken into account that notwithstanding that she was Dr Ford's patient for a relatively lengthy period of time, it was clear from her evidence that she did not express any of her concerns or feelings to Dr Ford about the way in which he conducted himself towards her during consultations prior to her complaint made to the Medical Council in 1999. Mrs P did not, at the time, tell him that she was embarrassed by any of his gestures, comments or touching, or that she found them offensive.

62. On the basis of this finding the Tribunal is satisfied that it is more likely than not that Dr Ford was unaware of Mrs P's distress and/or feelings of embarrassment. Although the CAC was able to demonstrate some relatively minor discrepancies or errors in Mrs P's records maintained by Dr Ford, the record of her consultations produced to the Tribunal is relatively complete and comprehensive. The record evidences quite a straightforward account of Mrs P's presenting symptoms and clinical history over the period during which he was her general practitioner. The record does not indicate any complaint being made about Dr Ford's clinical care, and he appears to have referred her appropriately to other practitioners during the time she was his patient.

63. It was Dr Ford's evidence that his memory of Mrs P is very scant and limited to a few brief glimpses of recall. His evidence was mostly based on his notes and her records. Dr Ford also gave evidence that he sees between 40 and 50 patients per day and that Mrs P did not raise any complaint about the care she received from him until 1999 (approximately 7 years after her last consultation), when Mrs P made her complaint to the Medical Council. Mrs P was able to provide an explanation for not raising any complaint at the time, however the Tribunal does not think it unreasonable that Dr Ford is unable to remember specific details of the consultations which occurred between 1989 and 1992.

64. Dr Ford also provided possible explanations for the comments allegedly made, and for his manner toward Mrs P during the consultations which were the subject of complaint. While it is not possible now for Mrs P to prove beyond doubt any of the allegations made, or for Dr Ford to prove beyond doubt the evidence he gave in his defence, Dr Ford is, as a matter of law, entitled to be given the benefit of any doubts or uncertainties the Tribunal may have; the CAC bears the burden of proof.

65. It is also relevant that the charge is laid at the most serious level of the charges available, disgraceful conduct, and, in the alternative, professional misconduct. The so-called 'sliding scale' in terms of the standard of proof applies notwithstanding that the Tribunal may, in its discretion, find Dr Ford guilty of a lesser charge than that charged; the standard of proof remains at all times, the balance of probabilities.

66. Given the clinical context and taking into account all of the evidence presented to it, the Tribunal is satisfied, on the balance of probabilities, that it is more likely than not that Dr Ford did conduct himself as alleged in Particulars 1(a), 1(b) and Particular 2 but the Tribunal is not satisfied that it is proven that Dr Ford's intent was prurient or improper or otherwise warrants the sanction of an adverse finding.

Particular 1(a): Between 10 October 1989 and 20 May 1992 during the course of one or more consultations at his surgery he inappropriately seated himself in close proximity to Mrs P without any clinical justification so that his knee interposed between her legs.

Particular 1(b): Between 10 October 1989 and 20 May 1992 during the course of consultations at his surgery he inappropriately and without clinical justification touched Mrs P on her knee and/or lower thigh when both were seated as described above.

67. The Tribunal is satisfied that there was sufficient evidence given at the hearing regarding Dr Ford's habit of pushing himself about the surgery on his wheeled chair that makes it more likely than not that the 'core facts' of Particulars 1(a) and (b) are established but not that his conduct was "inappropriate" in the circumstances. However, for the reasons given above, the Tribunal is not satisfied that it is proven that the established facts constitute a professional disciplinary offence, especially in circumstances where Mrs P was attending

for consultations on a regular basis without, on her evidence, expressing or indicating any complaint.

68. All of the complainant witnesses, and the witnesses giving evidence of similar fact, were questioned at length about the configuration of Dr Ford's consultation rooms, the furnishings, and windows. Ultimately, the Tribunal determined that this evidence is unhelpful as, with the exception of Mrs P, most of the witnesses only attended for a single consultation, and there was also evidence of chairs being moved between the consultation rooms from time to time, and of there being blinds which may or may not have been up or down, closed or open, from time to time. In a busy practice such as Dr Ford's, as a matter of common sense, practical exigencies, and the passage of time, the Tribunal considers that it is impossible for any of the witnesses to be categorical about what the configuration of any particular consulting room was at any particular time.

69. Notwithstanding, the Tribunal is satisfied, on the balance of probabilities, that Dr Ford did, or does, tend to move himself into a position in front of, and close to, patients but for the reasons already outlined, the Tribunal is not satisfied that Dr Ford's conduct in this regard constitutes a professional disciplinary offence.

Particular 2: Between 10 October 1989 and 20 May 1992 in the course of consultations at his surgery he made inappropriate comments to Mrs P concerning her body, particularly her breasts, legs and skin.

70. The Tribunal has carefully considered all of the evidence given in support of this Particular and has determined that the allegations are vague and uncertain, and it would be unsafe for it to make any finding that is adverse to Dr Ford.

71. For example, in support of the allegation that Dr Ford made inappropriate comments to Mrs P concerning her body, particularly her breasts, legs and skin, Mrs P gave evidence of one comment she recalled in relation to her breasts; one she recalled in relation to her having 'long shapely legs', and one to the effect that she had 'lovely English skin'. Each of these comments was alleged to have been made during the period October 1989 to May 1992.

72. The Tribunal has already referred to the clinical context in which these comments were said to have occurred. At the relevant time, Mrs P was, for various reasons, a relatively vulnerable patient. She had not lived in New Zealand for very long and she was suffering from a back injury exacerbated by an unpleasant and uncomfortable skin disease, both extending over several months. She was unable to work during most of this period. She was, understandably, often unhappy and depressed. In these circumstances, it is perhaps equally understandable that Dr Ford was inclined to offer her support and reassurance in addition to the medical care she required. He may have done this in a way that made Mrs P feel uncomfortable, but in the absence of any indication from her to the contrary, it would be unfair now for this Tribunal to find fault.

73. Mr Knowsley submitted that many of the comments Mrs P complained about were alleged to have occurred at the consultation on 10 October 1989, which was the fourth occasion on which Mrs P attended Dr Ford. Following that consultation, Mrs P attended for a further 30 consultations over the next two and a half years, to May 1992.

74. Mrs P was quite specific about the timing of the comment about her breasts. That comment, Mrs P told the Tribunal, occurred on 23 January 1992. Mrs P gave evidence that 'that was the straw that broke the camel's back and I basically thought I have to change doctors'. This comment was apparently made in the context of a conversation which began with Mrs P telling Dr Ford that she was upset because she had put more weight on. Mrs P alleged that throughout the conversation, Dr Ford 'persistently stared' at her breasts. Mrs P alleged that she was 'vulnerable at that time, but I wasn't stupid'. It was Mrs P's impression that the comment had sexual overtones, it wasn't a clinical comment, and it wasn't intended to make her feel good about herself.

75. The difficulty for the Tribunal in assessing Mrs P's complaint now, in the context of professional disciplinary proceedings, is that to the extent that Mrs P found Dr Ford's comments and conduct offensive, that was entirely subjective. By January 1992, the GP/patient relationship was relatively long-standing and Mrs P's clinical record indicates that she was attending for consultations with Dr Ford on a regular basis. The Tribunal must make an assessment of the doctor/patient relationship that existed at the time, and the clinical context, 'in the round'. It has determined that it would be unfair to consider

Dr Ford's conduct and comments out of context and/or removed from the clinical setting and relationship in which they are alleged to have occurred.

76. The Tribunal has from time to time taken the approach that the issue as to whether or not a practitioner's conduct towards his or her patients is subsequently found to have been improper will not depend on whether or not the patient raised any objection at the time, although that may be a relevant factor to be taken into account. For example, in a recent case (*CAC v Dr A,* Decision No. 181/01/78C) and on the basis of the facts in that case, the Tribunal determined that Dr A was not guilty of "failing to take account of and be sensitive to" his patient's distress, that was not disclosed to him at the time.

77. The Tribunal is satisfied that it is appropriate to apply similar reasoning in the present circumstances. It must, as a matter of fairness, take into account the fact that Mrs P's distress was not made known to Dr Ford until years after the conduct complained of occurred. While conduct that is alleged to be improper may subsequently be determined to be improper regardless of objection, and it matters not whether any objection is made at the time, shortly afterwards, or even years later, any such objection must be weighed against the explanation the practitioner may ultimately offer and the Tribunal must bear in mind that it is assessing the complaint with the benefit of hindsight. The practitioner's explanation must be weighed in the context of the relevant circumstances in which the conduct occurred, taking into account both the relevant standard and burden of proof.

78. In its deliberations in relation to Particular 2, the Tribunal has also taken into account the evidence of similar fact, in particular, the evidence of other witnesses that Dr Ford made inappropriate comments of a sexual and/or personal nature. In considering this evidence, the Tribunal has borne in mind the admonition that the Tribunal must separately consider each charge and make a decision in relation to each. Even if it is satisfied that Dr Ford is guilty of another charge involving similar facts, it would be an unsafe and improper process of reasoning for the Tribunal to conclude that he must therefore be guilty of all, or another, of the charges (*R v Sanders* (CA) [2001] 1 NZLR 257). "*Mere propensity*" reasoning is not sufficient. That is, the probative value of evidence that Dr Ford made comments of a similar nature to other complainants is not sufficient; there has to be an extra focus (*R v*

Tulisi 18 CRNZ 418), and, in relation to Particular 2 the Tribunal is not satisfied that a sufficient 'particular focus' is present.

79. If the Tribunal is not satisfied that the charge is established on its own merits, then it cannot use mere propensity reasoning as a 'make weight'. In the case of Mrs P, unlike other complainants, the comments were allegedly made in the context of a relatively long-standing GP/patient relationship, and in the context of a clinical picture which enables the comments to be put in context and for an explanation which is not wholly untenable, to be given.

80. On the basis of all of the above, the Tribunal is satisfied that Particular 2 is not established.

Particular 3: Between 10 October 1989 and 20 May 1992 on one or more occasions during the course of a consultation at his surgery he took Mrs P's temperature in the axilla in such a manner that his hand inappropriately touched her breast.

81. The Tribunal is satisfied that this allegation was not established. Although Mrs P was adamant that Dr Ford took her temperature in this manner on a number of occasions (and that he also took her daughter's temperature the same way), Dr Ford was equally adamant that while he could not specifically recall taking Mrs P's temperature at all, it was not his practice to take his patient's temperatures under the arm. Further, while the Tribunal accepts that on each of the occasions Mrs P says that her temperature was taken in this way no practice nurse was present, none of the practice nurses who gave evidence could recall seeing Dr Ford take a temperature under the arm. Indeed, one of the practice nurses could not recall seeing Dr Ford take a temperature at all.

82. In this latter regard, the practice nurses' evidence was consistent. It was their practice to see Dr Ford's patients into the consulting room prior to his entering the room for the consultation. It was their evidence that they prepared the patient for the consultation by ascertaining in a general way what the consultation was for, whether a chaperone was needed, they took the patient's blood pressure and/or temperature and carried out any other preliminary test or examinations, and recorded the results in the patient record, either at the time or after the consultation was completed.

83. Given Mrs P's presenting symptoms in relation to most of her consultations with Dr Ford, it does not appear that it would have been necessary for him to take her temperature. If he did take her temperature in the way she described, it would not have been clinically indicated, and it would have been inconsistent with his usual practice of leaving the taking of temperatures to his practice nurses. Further, there is no record in Mrs P's notes of any temperature recordings notwithstanding that the notes are otherwise quite comprehensive.

84. It is also a relevant consideration that the Tribunal that dealt with Dr Ford's application for a permanent stay of the charges permitted Mrs P's complaint to proceed to a hearing because the allegations were specific, Dr Ford's medical notes of the consultations were available, and because he had some general recollection of her case and some of the matters that took place during consultations. Further, his practice nurse during the period in question had confirmed to the Tribunal that she had close dealings with Dr Ford and his patients and was available to give evidence as to his style and manner of practice. It was the Tribunal's "*overall assessment*" that Dr Ford could obtain a fair hearing on this charge, and the Tribunal's decision was subsequently upheld on appeal.

85. In summary, notwithstanding that the conduct giving rise to the complaint occurred 10 or more years ago, the Tribunal hearing the stay application was satisfied that there was sufficient evidence available to permit a fair hearing of the charge. However none of the extraneous, or documentary evidence that persuaded the Tribunal that the charge could properly proceed to a hearing, ultimately lent any support to the allegations contained in Particular 3. Indeed it tended to favour Dr Ford's account. Similarly, none of the other witnesses gave evidence of having their temperature taken (under the arm) by Dr Ford.

86. Accordingly, the Tribunal is not satisfied that Particular 3 is established. On the basis of its findings in relation to each of the Particulars, the Tribunal determined that this charge should be dismissed.

Ms D

87. For the reasons that follow, and notwithstanding that the Tribunal has determined that Particular 1 only of the charge is established, the Tribunal is satisfied that this charge is established.

Particular 1: When Ms D was presenting with a persistent sore throat he performed a breast examination which was inappropriate and unnecessary.

88. The Tribunal is satisfied that given Ms D's presenting symptoms, it was inappropriate and unnecessary for Dr Ford to proceed to carry out a breast examination. It was Ms D's evidence that in or about September 1984 she had a persistent sore throat and because she was then living in Whangarei and her own GP was at xx some distance away, she went to see Dr Ford. At the time, she was 18 years old and she believes that this was the only occasion on which she saw Dr Ford.

89. At the consultation Ms D told Dr Ford that she had a throat infection and his response was to tell her that he had 'better do a breast examination'. Dr Ford offered no explanation and while Ms D thought this was unusual, she thought that possibly her sore throat was a symptom of breast cancer or something like that and that was why a breast examination was necessary. At no time did Dr Ford ask Ms D if she wanted to have a breast examination, he simply told her that one was required and she did what he asked.

90. Dr Ford instructed Ms D to remove her clothing and bra and to lie on the examination table. She was completely exposed and was offered no privacy while removing her clothing. She was very embarrassed at disrobing in front of Dr Ford, and she had not previously had a breast examination performed.

91. She thought it unusual that Dr Ford did not examine her throat at all during the consultation. She had previously had tonsillitis and had thought when she went to see him that all that was probably required was a prescription for some antibiotics.

92. Dr Ford examined her breasts by putting both hands on them, one hand on her right breast and the other on her left breast, and he manipulated her breasts with his fingers. It was

Ms D's evidence that Dr Ford was definitely not feeling for lumps because it was more of a massaging of her breasts rather than a firm clinical examination.

93. Ms D told the Tribunal that Dr Ford did not lift up her arms or check her glands. He did not use a stethoscope at all and his focus was entirely on her breasts. She felt very uncomfortable and avoided eye contact throughout the examination. Once Dr Ford finished massaging Ms D's breasts he suddenly and inexplicably pulled her nipples by tweaking them between his thumbs and forefingers. This made Ms D even more uncomfortable and anxious to leave the consultation. It was Ms D's recollection that Dr Ford helped her to put her bra back on as she was very nervous by that stage of the consultation and she was struggling to do up the hooks on her bra. She recalls that Dr Ford did this for her.

94. At this stage of the consultation Dr Ford asked her if she needed a smear taken. However she was becoming more and more anxious by that stage and was sure in her own mind that the consultation thus far was inappropriate. She told Dr Ford that Family Planning carried out these tests for her and that it was not necessary for her to have a smear taken at that time.

95. Since her experience with Dr Ford, Ms D has attended only female medical practitioners, although a male doctor delivered her baby and she went to him for follow-up visits in 1995, but on each occasion she insisted that her partner accompany her. Notwithstanding that the consultation occurred several years ago, Ms D still feels very strongly that what Dr Ford did at the time was wrong and that he used his position as a doctor to take advantage of her.

96. In his defence, Dr Ford told the Tribunal that he routinely undertook 'opportunistic' breast examinations on women who were on the contraceptive pill. It was his evidence that this was considered good practice in 1984. Dr Ford confirmed that Ms D did not have any family history of breast cancer that he was aware of. He accepted that it would have been "*entirely appropriate*" to have checked for a family history of breast cancer before conducting a breast examination on someone not presenting with any symptoms. The Tribunal also considered that it was relevant that, in Ms D's case, Dr Ford did not

prescribe her oral contraceptives, and she did not consult him for contraceptive advice or gynaecological treatment. Dr Ford had no recollection of the consultation, so could not recall whether there was any discussion about her breasts or family history, if there was no discussion then this would have been because he ascertained that she was on the pill. Alternatively, he may have asked her to undress for a chest examination because of her presenting symptoms. He denied Ms D's evidence that he did not use a stethoscope as with Ms D's presenting symptoms, which he said could indicate serious illness, he would always examine the chest; that would have been his usual practice.

97. In relation to the allegation that he had 'tweaked her nipples' he could not remember touching her nipples, but did not deny that that may have occurred. This was because he had been taught at medical school that it was good practice when doing a breast examination to check for tethering of the nipples. Notwithstanding that tethering of the nipples in a young woman is "*highly unlikely*" it was Dr Ford's evidence that such checking is (or should be) a routine part of the breast examination.

98. Ms McDonald suggested to Dr Ford that it would be "*extraordinarily rare for there to be tethering of the nipples without a lump*". On this point, Dr Ford was very evasive and did not accept that tethering of the nipples is a sign of advanced breast cancer. He did, however, accept that tethering of the nipples in a young woman is highly unlikely and that there was nothing about Ms D's presenting symptoms to suggest she had breast cancer.

99. The CAC did not present any expert evidence on this point, however both Dr Bowden and Dr Climie gave evidence as to then current practice in relation to the carrying out of 'opportunistic' breast examinations when a patient attended for consultations, particularly if the patient was known to be taking oral contraceptives. Dr Bowden gave evidence that "*respect for patients' privacy while undressing and for the provision of cover for all parts of the body not presently being examined is certainly an absolute requirement*". Dr Bowden also told the Tribunal that a "*more authoritarian approach to general practice*" was common 20 years ago and patients were not given explanations and choices to the extent which is now expected. It was Dr Bowden's view that an anxious patient might have misconstrued Dr Ford's conduct.

100. Dr Climie confirmed that during the 17 years that she was teaching general practitioners, she taught opportunistic screening especially for breast cancer and cervical smears. It was Dr Climie's evidence that she taught every young doctor that there are four parts to every consultation:

(a) Deal with the current problem.

(b) Deal with the ongoing issues.

(c) Deal with opportunistic screening.

(d) Give advice on health seeking behaviour – either to come quicker or there was no need to come at all.

101. Dr Climie told the Tribunal that breast examinations are part of the screening process and should be done as soon as patients are sexually mature, ie: aged 15 to 16 years.

102. However, Dr Climie also conceded that while she would "*probably do a breast examination*" if a 15 or 16 year old girl was undressed for another reason, she would probably not undertake such an examination otherwise. Whether or not the breast examination was carried out would depend on the particular situation. If she was examining the lymph nodes and spleen, for example if a 15 year old girl presented with a 'suspicious' throat so that she would be in the region of the breasts at the time, she might do a breast examination then. However she would not normally carry out opportunistic examinations in a busy after hours clinic, or if the patient was acutely ill or injured, and she was not the patient's own general practitioner.

103. Dr Ford's notes of the consultation record as follows:

"5.9.84 s. [symptoms] RTI, sore throat, headache, generally rather miserable, nausea, headaches,

o. [observation] has tonsillitis, but otherwise is okay, few nodes in legs [neck?], breasts normal,

p. [prescription] Amoxil 20."

104. As stated above, the Tribunal was satisfied that Dr Ford's record-keeping is, in general, quite comprehensive. On that basis, the record of Ms D's consultation appears to confirm Ms D's evidence that Dr Ford carried out a breast examination, rather than a chest examination. That is, the record confirms "*breasts normal*" rather than any findings in relation to her chest. To the extent that the record can be relied upon to prefer one account or the other, and because it was Dr Ford's evidence that he did not recall the consultation and therefore he could only rely on the record he made at the time as evidence as to what occurred, the Tribunal accepts Ms D's evidence that Dr Ford carried out a breast examination.

105. Ms D was cross-examined about a possible second consultation with Dr Ford in April 1995 in relation to pain in her left eye. She does not recall seeing Dr Ford on this occasion, but does recall making a request for Digesic. A letter written by Dr Ford to her eye specialist is contained in her patient record, but neither that letter or her patient record confirms that she attended for a consultation or was 'seen by' Dr Ford. Ms D's evidence was that she could have telephoned for a prescription, and the relevant documents are not inconsistent with a telephone request, rather than a consultation. In any event, the Tribunal is satisfied that nothing much turns on this and it is satisfied that Ms D was a credible witness with a good recollection of the September 1994 consultation and the impact that consultation has had on her over the years.

106. On that basis, the Tribunal considers that, notwithstanding the then current practice of conducting opportunistic examinations in some cases, the carrying out of the breast examination in the circumstances of Ms D's consultation was inappropriate and unnecessary; it was not warranted as an opportunistic examination, it was not requested, Ms D was not a regular patient, no explanation was given, and Dr Ford was not involved in her gynaecological care. The Tribunal is therefore satisfied that this Particular is established and, on its own, is conduct that warrants sanction.

Particular 2: At the end of the examination he watched as she undressed and assisted to do up her bra.

Particular 3: In telling Ms D that she would have to have a breast examination given the symptoms with which she presented, he did not obtain her informed consent for that examination.

107. The majority of the Tribunal members are satisfied that these two Particulars are not established. The Tribunal's finding in relation to Particular 2 is unanimous. In relation to Particular 3, the finding is a finding of the majority of the Tribunal's members. Mrs Brandon and Mrs Courtney depart from the other members and would have found Particular 3 established.

108. In relation to Particular 2, Dr Ford conceded that he may assist a patient to dress if she was having difficulty, particularly if the patient was elderly for example and the Tribunal finds it extremely difficult to make a finding adverse to Dr Ford in relation to such assistance, which he may or may not have provided to Ms D some 18 years ago.

109. The test against which Dr Ford's conduct must be measured is one of reasonableness. Dr Ford's conduct must be judged by the standards of his peers; the Tribunal must determine if, in the circumstances, Dr Ford acted in accordance with the standards of conduct reasonably to be expected from a competent general practitioner. In that context, the Tribunal considers that it would be unsafe to make any finding adverse to Dr Ford in circumstances where he does not recall the consultation in any detail and his motives for offering such assistance as is now complained of, may have been quite innocent.

110. The majority of the Tribunal would also apply that reasoning in relation to Particular 3, particularly in the circumstances that present in relation to this charge. All of the medical practitioners who gave evidence at the hearing acknowledged that accepted practice in relation to the giving of information to patients, and obtaining their consent to carry out examinations, is very different to practices which were acceptable in 1984.

111. As stated above, Mrs Brandon and Mrs Courtney depart from the majority in relation to Particular 3. It is the minority view that what is at issue in relation to this Particular is not so much the giving of information about risks, or the duty to inform the patient or draw to their attention some danger or risk which may be inherent in the care and/or treatment

offered. Rather, the allegation is that Dr Ford offered no explanation at all prior to carrying out an intimate examination on a young woman who:

(a) was not a regular patient;

(b) with whom he did not have an established doctor/patient relationship;

(c) without a chaperone;

(d) without giving her any explanation; and

(e) which the Tribunal is satisfied was unnecessary and inappropriate.

112. On that basis, the (1984) standards against which Dr Ford's conduct should be judged were not so significantly different to those which are currently accepted. Therefore, it is the minority view that Dr Ford's conduct in this regard fell below the standards reasonably expected of an experienced general practitioner.

113. However, as is also stated above, the Tribunal is satisfied that its finding in relation to Particular 1 alone warrants the sanction of adverse finding and, accordingly, the charge is proved and Dr Ford is guilty of conduct unbecoming and that reflects adversely on his fitness to practise. This finding is unanimous.

Ms W

114. Ms W similarly gave evidence of a single consultation with Dr Ford in the course of which Dr Ford carried out a breast examination.

Particular 1: Performed an unnecessary and inappropriate breast examination on [Ms W] who was then aged 16 who had consulted him for a prescription for the contraceptive pill.

Particular 2: During the examination he made an inappropriate comment that "a nipple would become erect in this way if it was aroused" or words to that effect.

115. This consultation occurred in or around December 1981/January 1982 when Ms W went to see Dr Ford specifically to ask for a prescription for oral contraceptive.

116. Dr Ford and Dr Climie gave evidence that, in 1981/82, it was considered good practice to carry out a breast examination as part of the history-taking of patients being prescribed the

contraceptive pill. Such examinations were regarded as 'baseline examinations'. No record of the consultation is available and Dr Ford has no recollection of it.

117. Ms W's evidence was, in many respects similar to Ms D's. At the time, she was a young woman and sexually inexperienced. At the commencement of the consultation, she told Dr Ford that she wanted a prescription for the contraceptive pill, and was told that she would need a breast examination and told to remove her top and bra. She was very embarrassed but complied and Dr Ford carried out the examination. She does not recall Dr Ford taking any history, nor did he ask her any questions about her background, health or sexual history prior to carrying out the examination. Notwithstanding that it was her first consultation, and on Dr Ford's evidence she required intimate examinations, he did not provide a chaperone, or any explanation of why the examination was necessary.

118. It was Ms W's impression that the breast examination was carried out in a sexual manner. She has since had breast examinations performed and these have been quite different to that carried out by Dr Ford. She described Dr Ford's examination as massaging her breasts and rolling her nipple with his fingers squeezing it and tweaking it between his thumb and forefinger. He then made the comment alleged in Particular 2.

119. Ms W was upset and anxious as a result of the examination, when Dr Ford told her that it would be necessary for her to also have an internal examination, she told him she was menstruating to avoid any further examination. The Tribunal also found Ms W to be a credible witness however, once again, the Tribunal was required to make an assessment of Dr Ford's conduct and to decide if it constituted a professional disciplinary offence almost 20 years after it occurred. While the Tribunal is not bound to accept the evidence of expert witnesses as to what were accepted standards at the relevant time, neither can it ignore such evidence. The professional standards against which Dr Ford must be judged are those which were acceptable at the time of the events giving rise to the charge. The Tribunal has also taken into account its finding (paragraph 43 herein) that the obligation to adhere to fundamental values and standards is long-standing, and pre-dates the Medical Council's Statement made in 1994. However the evidence in this regard given by the other general practitioners supported Dr Ford's evidence that it was considered to be

good practice for all women being prescribed the oral contraceptive pill to have a breast examination and internal examination carried out when the pill was prescribed.

120. The Tribunal is therefore satisfied, on the balance of probabilities, that Dr Ford did carry out the breast examination, and he did make the comment alleged in Particular 2, and that both Particulars are established.

121. In making this finding, the Tribunal relies not only on its finding that Ms W was a credible witness, but also the evidence of other witnesses, including comments contained in the evidence submitted on behalf of Dr Ford, to the effect that from time to time Dr Ford does make comments which some people may consider inappropriate. However, in this case, the Tribunal is not satisfied that its findings warrant the sanction of an adverse finding and accordingly, Dr Ford is not guilty of any professional disciplinary offence.

Ms R

122. The majority of the Tribunal members are satisfied that this charge is established. Dr Cullen departs from the majority because, notwithstanding that he is satisfied that the factual basis of the charge is established and that Dr Ford's conduct towards Ms R was inappropriate, he is not satisfied that the threshold for a professional disciplinary offence is reached.

Particular 1: When Ms R presented with a sore throat he required her to take off all her clothes apart from her underpants which was both inappropriate and unnecessary.

Particular 2: After performing an examination and Ms R had dressed, he commented that "she was developing nicely" or words to that effect.

123. The background to this charge set out above (paragraphs 13-15). The Tribunal is satisfied that the factual context giving rise to the allegations founding the charges in relation to Ms D, Ms W, and Ms R in particular, are strikingly similar. While Mrs P and Mrs S were relatively young women at the time of the consultations they complained of, they were both married women with children, in contrast to the other complainants who were very

young and inexperienced. Of these latter complainants, Ms R was particularly vulnerable and, because Dr Ford was also her family doctor and was aware of her clinical background, he ought to have been aware of her particular vulnerability and to have taken appropriate steps to reassure her and to take proper care of her.

124. Ms R presented for her consultation with Dr Ford with a relatively innocuous sore throat. Notwithstanding, Dr Ford required her to take off all of her clothes apart from her underpants; he did not offer or provide a chaperone, and he carried out an intimate examination without providing any explanation, or privacy. He did not offer or provide a chaperone notwithstanding her age, or that it was the first time she had gone to see him without her mother accompanying her. Further, his comment that she was "*developing nicely*" appears gratuitous, and caused her to feel distressed and anxious.

125. Ms R gave evidence that, at the time, she was very shy and sensitive. She recalls that she was wearing her school uniform, and she was sure that Dr Ford was aware of her embarrassment and discomfort. The Tribunal is satisfied that Dr Ford's conduct towards Ms R was insensitive, and, given her symptoms, unnecessary and inappropriate. The Tribunal is also satisfied that, even in 1984, patients, especially young, vulnerable, female patients, were entitled to have their privacy and particular needs respected.

126. Ms R gave evidence of feeling "*terribly wronged*" as a result of Dr Ford's conduct towards her. She told the Tribunal that she refused to see Dr Ford subsequently, and she has never been to a male doctor for any sort of female examination at all since that time.

127. Dr Ford's evidence was that he could not recall the consultation, and he agreed that given his record of her presenting symptoms, it would not have been necessary to ask her to remove her clothes and examine her in the way that he did. He accepted that there was no medical or clinical reason to ask to strip to her underpants.

128. Ms R's evidence was unshaken on cross-examination and she impressed the Tribunal as a credible and truthful witness who still feels angry and distressed about what occurred.

129. Dr Ford's explanation for the comment (Particular 2) was that this was related to Ms R's previous history of being small in stature and some behavioural problems for which she had received treatment in the past. However, Ms R's record demonstrates that the issue of stature arose some years previously and, at the time of the consultation, the Tribunal is satisfied there were no ongoing issues which required, or justified, any comment about her personal development.

130. Accordingly, the Tribunal is satisfied that the Particulars of the charge are established. These findings are unanimous. However as stated above, the Tribunal's finding that the charge is established and that Dr Ford is guilty of conduct unbecoming and that reflects adversely on his fitness to practise, is a finding of the majority.

Mrs S

131. The charge in relation to Mrs S is the most recent of the charges as the consultation which is the subject matter of this charge occurred in November 1999. Mrs S has a very clear recollection of what occurred at the consultation, and she also made a complaint to her workmates immediately following the consultation to the effect that she went to the doctor with a sore ear and got a breast examination. In relation to each of the Particulars of the charge, the Tribunal finds as follows:

Particular 1: When Mrs S was presenting with ear pain he asked inappropriate and unnecessary questions about her sex life "so you enjoy sex then" or words to that effect.

132. The Tribunal is satisfied that Dr Ford did make the comments complained of, and that the comments were inappropriate and offensive.

133. In making this finding, the Tribunal accepts Mrs S's evidence; it found Mrs S to be a credible witness who demonstrated good recall and her evidence was unshaken on cross-examination.

134. In making its finding in relation to Particular 1, the Tribunal has also taken into account the evidence of similar fact, particularly evidence given by other complainants that Dr Ford

made comments of a personal and sexual nature. As stated above, witnesses who provided evidence on behalf of Dr Ford (for example, Dr Bowden and Dr Nixon) also satisfied the Tribunal that Dr Ford does, on occasion, make comments which might be considered inappropriate. Other witnesses referred to his 'quirky' sense of humour.

135. It is also the case that a number of Dr Ford's patients who submitted statements in his support referred to his habit of touching their shoulder or patting their arm to give reassurance, for example one patient referred to Dr Ford as a "*touchy feely sort of guy with a slightly effeminate manner...*".

136. The Tribunal is satisfied, on the balance of probabilities, that Dr Ford did make comments complained of and that they were inappropriate and unnecessary.

Particular 2: Against the patient's wishes he insisted on carrying out an examination for melanoma which required her to undress the top half of her body. In the context of a consultation for ear infection this examination was unnecessary and inappropriate.

Particular 3: In carrying out this examination he failed to obtain the patient's informed consent.

137. Dr Ford was adamant that he did not carry out an examination for melanoma at the consultation. It was his evidence that Mrs S had indicated that she wanted to become a regular patient and she was issued with a patient identification number. He also was adamant that Mrs S definitely had a cough, and the reason for her consultation recorded in her notes was "*cough and sore face*". Because she was a new patient and he thought that she intended to transfer into his practice, his history-taking was wider than merely covering the presenting symptoms. Any questions he asked in relation to her sexual history or current sexual activity was related to that history-taking, and her past history of ectopic pregnancies.

138. Dr Ford also gave evidence that Mrs S told him that her brother had been depressed and that she thought she might have a fever. She also advised him of a family history of nervous problems and that she was due for a smear. Mrs S denied all of this evidence, including the evidence that she had a cough at the time of the consultation. It was her

evidence that her only presenting symptom was a sore ear/face and that Dr Ford almost immediately resolved that by suggesting that she should see a dentist and have her teeth checked.

139. In relation to the examination complained of in Particular 2, Dr Ford was adamant that he carried out a chest examination and listened to her heart and lungs because she had complained of a cough and dizziness. Potentially her overall symptoms could have indicated a more serious illness. He carried out a cardiac examination which involved listening to the apex beat of the heart, requiring him to lift the left breast out of the way to place the stethoscope underneath so that he could listen as close to the chest wall as possible.

140. This cardiac examination also requires the doctor to listen to the outer part of the left breast and it may be necessary to lift the breast up to place the stethoscope against the chest wall. The doctor also listens on either side of the sternum at intervals, and checks the apex beat check for the quality of the beat and possible enlargement of the heart. Palpating is done with the flat of the fingers, the breast is pushed up so that the doctor can feel the chest wall under the breast.

141. It was Dr Ford's evidence that Mrs S misunderstood the whole purpose of the examination of her chest. She complained of a cough and dizziness and loss of balance and therefore a cardiac examination was indicated. Dr Ford told the Tribunal that he would also have examined her abdomen given her history of ectopic pregnancies to check for any abnormal tenderness or masses. This examination would include specifically checking the liver and spleen and across the lower abdomen. He denied telling his nurse that the purpose of the examination was because Mrs S was concerned her husband had died of melanoma.

142. Dr Ford's nurse gave evidence of attending the consultation as chaperone during Dr Ford's examination, and she recalled a discussion about Mrs S's husband dying of melanoma.

143. Mrs S gave evidence of Dr Ford's initially checking her ears telling her that they both seemed fine, and recommending that she get a dentist to check her teeth, which she agreed to do. Mrs S's evidence was that there was a discussion about her husband dying from melanoma, and Dr Ford insisted on carrying out an examination, notwithstanding that she told him that a check was not necessary as she checked herself regularly. Dr Ford then asked her a number of questions about her 'sex life'. She felt very uncomfortable about these questions and considered them to be inappropriate and unprofessional.

144. It was Mrs S's evidence that Dr Ford then directed her to get onto the examination bed for 'a quick check' and he went to get a nurse to act as a chaperone. It was Mrs S's evidence that when Nurse A entered the consultation room, Dr Ford told her that he was checking for melanoma as she (Mrs S) was concerned because her husband had died of melanoma, or words to that effect. Before going out of the room to fetch his nurse, Dr Ford instructed Mrs S to take off her top and bra. She had not previously been told to remove her bra for an examination, so she left her bra on and only removed her top. However when Dr Ford returned to the consultation room and before Nurse A arrived, he directed that she take her bra off and she did so. Mrs S was very clear and definite in giving this evidence, and Nurse A confirmed that when she entered the room Mrs S was removing her bra and placing it on the bed behind her.

145. Mrs S did not recall Dr Ford using a stethoscope or examining her chest, rather it was her impression that he paid special attention to her breast and examined her skin and freckles. It was her view that Dr Ford's explanation to Nurse A was merely to justify the examination and she was angry when she heard it as she had expressly told Dr Ford that she did not want him to carry out a melanoma check. She felt uncomfortable and humiliated by Dr Ford's conduct.

146. As has occurred in relation to other Particulars of the charges, the Tribunal is satisfied that the factual basis of the Particulars is established, however it is not able to determine, to a requisite standard of proof, that the examination was "*unnecessary and inappropriate*". Given that Mrs S complied with Dr Ford's instruction to disrobe and to get on to the examination table, the majority of the Tribunal members are not satisfied that Dr Ford failed to obtain Mrs S's proper informed consent prior to carrying out the examination.

147. The Tribunal is satisfied that the consultation 'went off the rails' relatively early, and that there was a significant degree of miscommunication between Mrs S and Dr Ford. The presenting symptoms recorded in Mrs S's notes certainly record "*cough and sore face*", and the "*history*" recorded is relatively extensive and contains all of the details referred to by Dr Ford. Whether or not Mrs S's presenting symptoms in fact included a cough, the Tribunal is satisfied that this was the basis upon which Dr Ford proceeded with the consultation. If her presenting symptoms did not include a cough, then that is an error, most likely made by someone other than Dr Ford, but it is more likely than not that he mistakenly proceeded on the basis that he thought she had a cough, and that she was transferring into the practice to become a regular patient.

148. However Dr Ford's questioning regarding her sexual activity, whilst it may have been motivated by her past history, was carried out early in the consultation and prior to his establishing any sort of relationship with his patient. The questions discomforted Mrs S and made her feel uneasy, as did Dr Ford's subsequent instruction to her that she remove her bra so that he could examine her.

149. The Tribunal is satisfied that Dr Ford did not obtain any explicit consent from Mrs S prior to carrying out the examination. However she did not object (notwithstanding that she may have misunderstood the reason for it) and accordingly the Tribunal has determined that Dr Ford is entitled to the benefit of the doubt, and any failure to obtain informed consent, whilst established, was inadvertent and unintentional. Dr Ford's examination, and Mrs S's submission to it, was part of a matrix of misunderstanding and miscommunication which the Tribunal is satisfied characterised this consultation.

150. The finding that this Particular is not established is also a finding by the majority of the Tribunal. Mrs Brandon and Mrs Courtney depart from the majority, largely for reasons similar to those given in relation to Particular 3 of the charge relating to Ms D. In particular, notwithstanding that the examination occurred in 1999, some 15 years after Ms D's consultation, the Tribunal was satisfied that Dr Ford did not offer Mrs S any explanation for the examination, or, especially, for requiring Mrs S to remove her bra. It is the minority view that, while Mrs S acquiesced and permitted Dr Ford to examine her, she did not give her "informed consent". The minority members take the view that there is a

difference between "consent" and mere acquiescence, as is evidenced by Mrs S's subsequent complaint.

151. Mrs S could not give her "informed consent" because she was given no "information" about the reason for the examination, or why it was necessary to take her bra off. In terms of the evidence given about the examination by Mrs S, Dr Ford and Nurse A, the Tribunal prefers the evidence given by Mrs S. Nurse A's memory of the examination appeared sketchy at best. Also, there was evidence contained in her statement (details of Mrs S's presenting symptoms and an explanation of how a chest examination was carried out) that, in cross-examination she conceded was not direct evidence. For example, she did not show Mrs S into the consulting room and was not aware of her presenting symptoms at the time of the examination, and, when summoned by Dr Ford to attend the examination he simply told her that he 'needed a chaperone'. She was not given any other information.

152. She appeared to have no recollection of the examination beyond the discussion about melanoma and Ms S's husband dying from melanoma at the time of the examination - which evidence tends to support Mrs S's evidence. For example, she did not recall Dr Ford finding a small rash on Mrs S's body. The minority is also satisfied that Dr Ford equally had no specific recollection of this consultation and his evidence relied upon his notes. That is, rather than being direct evidence based on his memory of the consultation, his evidence was an account of what he 'would have done' based on the clinical record. The fact that Dr Ford and Nurse A have no clear recollection of the examination is not surprising or sinister, it simply reflects the likelihood that, in their minds, there was nothing out of the ordinary or untoward about the examination.

153. However, to the extent that Mrs S might have been confused about the purpose of the examination, i.e. she thought Dr Ford told the nurse he was checking for melanoma as a 'justification' for doing the examination, and, given her earlier refusal, she found that objectionable and became angry, that was due to the absence of an adequate explanation for the examination and what Dr Ford was checking for. In the circumstances, Dr Ford had only himself to blame if, according to his evidence, he carried out a relatively cursory opportunistic check of her skin while she had her clothing removed for the cardiac examination, and Ms S found that objectionable.

154. Also, Nurse A did not appear to understand the purpose of the examination, only that she was required to be present because Dr Ford was going to carry out an examination on a female patient. In those circumstances, the role of the chaperone is undermined - it is difficult to see how a chaperone can fulfil perhaps the most important task of a chaperone, that is, to assess and/or monitor the propriety of an intimate examination, if she does not know its purpose, and is not in a position to attest to whether or not it was 'appropriate' at some later time.

155. For all of these reasons, the minority would also find Particular 3 established.

156. The Tribunal is satisfied that its finding in relation to Particular 1 (separately) constitutes a professional disciplinary offence and that the charge is established and Dr Ford is guilty of conduct unbecoming a medical practitioner, which conduct reflects adversely on his fitness to practise medicine. This finding is unanimous.

Conclusion

157. As was stated at the outset, the Tribunal was ultimately able to determine each of the charges on their own facts. Notwithstanding the striking similarities which undoubtedly exist, the Tribunal considered each of the charges, and their Particulars, on a methodical basis and, having determined each of the Particulars of each charge it then assessed Dr Ford's conduct to determine, first, if it 'crossed the line', that is, if it was conduct which departs from the relevant acceptable professional standards, and, if so if any such departure was significant enough to attract sanction.

158. Having satisfied itself that certain of the conduct under scrutiny warrants sanction, the Tribunal then proceeded to carry out an 'assessment of degree' in terms of the three levels of misconduct referred to in Section 109 of the Act, taking into account the level at which each charge was laid.

159. Except as expressly stated in this decision, the Tribunal did not ultimately find it necessary to refer to the evidence of the similar fact witnesses to make its findings on each charge. However, the Tribunal did not disregard this evidence and records its concern at the

weight of the evidence presented against Dr Ford, and the pattern of conduct contained in the evidence.

160. In its deliberations, the Tribunal kept in mind that the principal purpose of the Act is to protect the health and safety of members of the public. Against that background, the Tribunal cannot ignore the fact that a significant number of women have complained about Dr Ford's conduct towards them over a long period of time, but complaints about him have been dealt with on a piecemeal basis and over extended periods of time.

161. Dr Ford is currently practising under conditions imposed by this Tribunal in July 2000, which conditions require Dr Ford to advise all female patients that they are entitled to have a chaperone or support person with them during examinations and/or consultations, and a notice to that effect is to be placed in the waiting room and consultation room of his practice room. Dr Ford is also required to verbally offer a chaperone to all female patients who are to undergo any examination of an intimate nature (unless the patient is already chaperoned).

162. In light of its findings in relation to the charges which were established, the Tribunal is satisfied that these conditions should remain in place until the final outcome of these charges is determined.

Orders

163. The Tribunal orders as follows:

(1) The charges laid against Dr Ford in relation to Ms D, Ms R and Mrs S are established and, in respect of each of those charges, Dr Ford is guilty of conduct unbecoming and that reflects adversely on his fitness to practise;

(2) The charges laid against Dr Ford in relation to Mrs P and Ms W are not upheld and the Tribunal is satisfied that Dr Ford is not guilty of either of those charges notwithstanding that certain of the Particulars of those charges were established;

(3) The names of all of the complainants, the witnesses who gave evidence of similar fact and the practice nurse-patient witnesses who gave evidence on behalf of Dr Ford, and any of those witnesses' identifying details, are not to be published or otherwise disclosed;

(4) The CAC is to file submissions as to penalty not later than 21 days after the receipt of this decision;

(5) Submissions as to penalty on behalf of Dr Ford are to be filed not later than 21 days thereafter;

(6) The orders made by this Tribunal in Decision No. 123/00/61C, dated 20 July 2000, are to remain in place pending the Tribunal's determination as to penalty in relation to the charges that have been upheld.

DATED at Wellington this 10th day of June 2002

....

W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal