MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

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DECISION NO: 155/00/65D

IN THE MATTER of the Medical Practitioners Act 1995

-AND-

IN THE MATTER of a charge laid by Director of Proceedings pursuant to Section 102 and 109 of the Act against **ANTHONY RUSSELL WILES** medical practitioner

BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

TRIBUNAL: Mr G D Pearson (Chair)

Mr P Budden, Dr J C Cullen, Dr J M McKenzie,

Associate Professor Dame Norma Restieaux (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held on Tuesday 12 and Wednesday 13 December 2000

APPEARANCES: Ms T Baker, for the Director of Proceedings

Mr H Waalkens for Dr Wiles.

MAJORITY DECISION OF: Mr G D Pearson, Mr P Budden, Dr J C Cullen, and Associate Professor Dame Norma Restieaux

1. THE CHARGE:

1.1 **THE** Director of Proceedings has brought a charge against Dr Wiles. The charge states that the Director of Proceedings has reason to believe that grounds exist entitling the Tribunal to exercise its powers under Section 109 of the Medical Practitioners Act 1995 ("the Act").

1.2 **THE** substance of the ground believed to exist, and the particulars of the charge against Dr Wiles, as notified to him are that:

"[Dr Wiles] being a registered medical practitioner acted in such a way that amounted to disgraceful conduct in that [he] had an intimate and sexual relationship with [his] patient [Ms "XYZ"]."

Immediately prior to the close of the hearing the charge was amended to conclude "[his] patient or former patient [Ms "XYZ"]".

1.3 **MS** "XYZ" is not the complainant in these proceedings, her husband is the complainant.

2. CONDUCT OF HEARING IN PRIVATE:

2.1 **THE** hearing of the charge took place in a private hearing, with an order suppressing the names of Ms "XYZ" and Dr Wiles, and any information or fact that might identify them. That order is dated 14 November 2000. The reason for conducting the hearing in private was that the Tribunal was satisfied it was necessary to do that to protect Ms "XYZ". It was clear that the evidence in support of the charge was extremely personal, and that Ms "XYZ" believed if personal information was disclosed she would be harmed. Furthermore, Ms "XYZ" believed a suppression order, or orders made at the hearing pursuant to s.107 of the Act, would not be sufficient to protect her privacy in her particular circumstances.

3. THE HEARING:

3.1 **DR** Wiles denied the charge, and the matter proceeded to hearing. There was no dispute that Ms "XYZ" had been Dr Wiles' patient, and that they went on to have an intimate and sexual relationship. Dr Wiles however contended that the circumstances did not amount to a disciplinary offence.

3.2 **AT** the outset the Tribunal records that there is no allegation or evidence that suggests Dr Wiles behaved inappropriately toward Ms "XYZ" in the course of a doctor/patient consultation.

3.3 **THE** burden of proving the disputed facts is borne by the Director of Proceedings. It is well established that the standard of proof in disciplinary proceedings is the civil standard, namely, the Tribunal must be satisfied on the balance of probabilities that the material facts are proved. It is equally well established that the standard of proof will vary according to the gravity of the allegations, and the level of the charge. The facts must be proved to a standard commensurate with the gravity of what is alleged: *Ongley v Medical Council of New Zealand* [1984] 4 NZAR 369 @ 375-376.

3.4 **THE** Director of Proceedings called three witnesses, namely:

- Ms "XYZ".
- Professor Grant Gillett, who is the Professor of Medical Ethics at the University of Otago Medical School. Professor Gillett expressed his opinion regarding the ethical issues arising in these proceedings.
- Dr Hugh Oswald Clarkson, who is a psychiatrist. Dr Clarkson expressed an opinion regarding Ms "XYZ"'s mental state and vulnerability during periods of time material to the present proceedings.
- Dr Douglas Donald Baird, who is a general practitioner. Dr Baird gave evidence regarding the pattern of consultations Ms "XYZ" had at Dr Wiles' surgery over a 10 year period prior to Dr Wiles and Ms "XYZ" forming an intimate relationship. Dr Baird expressed the view that the pattern of attendances, and the nature of the attendances was indicative of Ms "XYZ" having a greater than normal need for general practitioner services.

3.5 **DR** Wiles gave evidence and called an additional four witnesses:

- Dr Brian Joseph Linehan, a medical practitioner vocationally registered as a pathologist, with professional experience in dealing with medical ethics. Dr Linehan's experience includes time as the Chairperson of the New Zealand Medical Association, and also being a member and chairperson of the Associations' ethics committee. Dr Linehan expressed a view regarding the ethical issues arising in the case.
- Professor Murray William Tilyard, a medical practitioner and Professor of General Practice at the Otago Medical School. Professor Tilyard gave evidence regarding his views as to some of the ethical issues, and the pattern of consultations Ms "XYZ" had with Dr Wiles.
- Ms "FJK", a friend of Ms "XYZ" and Dr Wiles. Ms "FJK" lives in another city, and gave evidence through the medium of a video link.

3.6 **IN** addition to the oral evidence an agreed bundle of documents was admitted by consent.

4. OVERVIEW OF THE EVENTS:

Preliminary:

4.1 **DR** Wiles is a medical practitioner in general practice. Dr Wiles completed his initial medical training in the mid 1970s, and has been in general practice in a New Zealand city since 1980.

4.2 **THE** course of events may be divided into three phases. First a period of several years during which Ms "XYZ" consulted Dr Wiles as a patient without any other dimension to the relationship. Second a period of some months, during these months Ms "XYZ" did

not consult Dr Wiles as a medical practitioner. At this time Ms "XYZ" worked in a professional services practice in a building were Dr Wiles frequently attended. During this phase Dr Wiles and Ms "XYZ" had a friendship that involved day to day contact, and ultimately the relationship became a sexual one. The third phase is from the commencement of the sexual relationship to its conclusion, and subsequent events.

First phase:

4.3 **MS** "XYZ" first consulted Dr Wiles in the latter part of the 1980s. Ms "XYZ" is married, she and her husband have children. The first child was born during the late 1980s, and the second child was born in the latter part of the 1990s.

4.4 **DR** Wiles was also the doctor for Ms "XYZ"'s children.

4.5 **IN** her evidence Ms "XYZ" emphasised a number of factors in her relationship with Dr Wiles, which she considered demonstrated that she relied on him heavily. Ms "XYZ" said: *"I relied on [Dr Wiles] heavily. He was the person I confided in. I told him about things that I didn't tell anyone else about."* Speaking of this period before there was an intimate relationship, Ms "XYZ" did however say: *"Like any doctor, I thought that [Dr Wiles] was a blank wall. I could tell him anything and he would move on to the next patient."*

4.6 **MS** "XYZ" detailed the history of her dealings with Dr Wiles from the time she consulted him until the last consultation she had with him as a medical practitioner in his surgery

during the latter part of the 1990s. The matters Ms "XYZ" considered particularly significant included:

- Dr Wiles was the lead maternity caregiver during her pregnancy and delivered her first child,
- During and after the pregnancy there were frequent consultations regarding Ms "XYZ"'s health, and her child's health,
- Following the birth of her first child, Ms "XYZ" was very "stressed and depressed",
- In the mid 1990s Ms "XYZ" had a pregnancy that resulted in a miscarriage in circumstances that caused Ms "XYZ" a great deal of distress and anguish. Dr Wiles gave evidence that he was not aware of the extent of Ms "XYZ"'s concerns about this issue.
- Ms "XYZ" referred to a number of events both of a medical nature, and other things that made her vulnerable during the years she consulted Dr Wiles. Ms "XYZ" detailed employment stresses, various minor health issues, post-natal depression, colposcopy, a health problem her child suffered from, difficulties in her relationship with her husband, her feelings about the miscarriage, difficulties with an employee, and coping with young children.

4.7 **DR** Baird examined the clinical files recording Ms "XYZ"'s consultations with Dr Wiles. In essence Dr Baird concluded the records did not show any inappropriate questioning or examination, nor any indication that *"any advice or treatment given was other than professional"*. Dr Baird did conclude that Ms "XYZ"'s visits were more frequent than a typical woman of her age (though the methodology for reaching the conclusion was less

than robust). Dr Baird commented that it was clear that Ms "XYZ" had discussed the unsatisfactory state of her marriage with Dr Wiles over the years. He therefore said *"Given these circumstances Mrs "XYZ" could be described as more 'vulnerable' than a patient who was in a stable marriage"*. Dr Wiles said *"I stress that there is no incontrovertible evidence that Mrs "XYZ" was a needy and vulnerable woman giving an apparently caring and sympathetic doctor an opportunity to exploit her."*

4.8 **PROFESSOR** Tilyard analysed the frequency of consultations, and concluded that while higher than the average number for a woman of her age (using figures for women of Ms "XYZ"'s current age), Ms "XYZ"'s consultations with Dr Wiles were within the normal range. We accept this evidence, but do not consider any great insight into Ms "XYZ"'s medical needs and the nature of her relationship with Dr Wiles can be gained by analysing the frequency of consultations.

4.9 **WE** have considered all of the evidence regarding Ms "XYZ"'s consultations with Dr Wiles down to the time when they ended. We are satisfied that Ms "XYZ" was a needy person, who was having difficulties in her marriage, and had other pressures with which she had to cope, and that Dr Wiles was aware of that (including being aware of some specific details of the difficulties in the marriage). However, Ms "XYZ" was not an extremely vulnerable patient. Ms "XYZ" has referred to post-natal depression, feeling "*weak and powerless*", and suffering from insomnia. However Ms "XYZ" was not referred to a mental health professional, and Dr Wiles did not treat her for any psychiatric condition, including post-natal depression. We accept Dr Wiles' evidence that Ms "XYZ" did not have the clinical condition of post-natal depression. In reaching this conclusion we have

had careful regard to the evidence we heard from Ms "XYZ", Dr Wiles and Dr Clarkson. We accept that Ms "XYZ" certainly discussed with Dr Wiles the difficulties she faced in coping with a new-born child, and other pressures she struggled to cope with. The evidence establishes that Ms "XYZ" suffered from pressures of a kind and degree that many patients would present to a doctor with whom they had been consulting over a ten year period. It is a daily reality for people to experience difficulties in their marriages, and other pressures. While Ms "XYZ" no doubt genuinely expressed her feelings of vulnerability to the Tribunal, during the relevant period she pursued her profession, apparently with significant success. As discussed later, Ms "XYZ" provided professional services to the practice of which Dr Wiles is a member. Dr Wiles was aware Ms "XYZ" had difficulties in her marriage, and would have at least known of the consequences of other pressures on her. We have considered all the evidence, particularly the oral evidence that Ms "XYZ" and Dr Wiles gave to the Tribunal. The Tribunal is satisfied Dr Wiles perceived Ms "XYZ" as a capable professional woman, who thought and acted rationally, and that was in fact the case. We have given full consideration to the evidence of Dr Clarkson regarding Ms "XYZ"'s history and mental state. That evidence was based on an interview of Ms "XYZ" by Dr Clarkson. In some respects the evidence we have heard from Ms "XYZ" and others has a different emphasis from the impression Dr Clarkson gained in his interview. Our findings have relied on the evidence we have heard where there is a difference.

4.10 **WE** are satisfied that Ms "XYZ" was a long-term patient of Dr Wiles. She saw him regarding a range of health matters. The consultations included gynaecological and obstetric issues; furthermore Ms "XYZ" confided in Dr Wiles and they discussed a range

of issues that were troubling Ms "XYZ". The evidence gives no basis for considering that the consultations were other than professional, and dealing with issues normally dealt with by general practitioners and their patients.

Second phase

4.11 **AT** the last medical consultation Ms "XYZ" had with Dr Wiles, she presented with a relatively minor medical problem. In evidence Dr Wiles described a discussion that took place at the end of that consultation. That led to the professional services practice in which Ms "XYZ" worked moving to a building that Dr Wiles frequently attended.

4.12 **FROM** this point the relationship between Ms "XYZ" and Dr Wiles developed in multiple ways. The first was day to day contact that arose from the relocation of the practice in which Ms "XYZ" worked. That proximity led to virtually daily social contact. Ms "XYZ" said in her evidence that *"I suppose it was [two months after the last medical consultation] that I became aware that the relationship was turning into a friendship"*. We are satisfied that during the three months after the last medical consultation Ms "XYZ" and Dr Wiles developed a close relationship, and in the course of it discussed a range of issues, including the fact that neither of them were happy in their marriages.

4.13 **IN** addition to the friendship that developed Ms "XYZ" also provided professional services to the Medical Centre in which Dr Wiles practises. This occurred soon after the last medical consultation.

4.14 **MS** "XYZ" was somewhat equivocal in her evidence regarding how she viewed the Medical Centre as regards ongoing treatment for her and her children after the last consultation. Ms "XYZ" said "*it did cross my mind that it wouldn't be nice to have a cervical smear taken at one stage and in the afternoon [provide professional advice]"*. Ms "XYZ" also said *"During [this time] I did not consult Anton [Dr Wiles] at all. One of the reasons for this was that I now had a professional relationship with [Dr Wiles] outside our doctor/patient relationship. I always confided in him to such an extent, that it no longer seemed appropriate. I felt it was unprofessional."* It appears that during this time Ms "XYZ" had contemplated continuing to have her children treated at the Medical Centre, and find another doctor to treat her. We do not consider that Ms "XYZ" ever fully resolved the issue in her own mind, as there was nothing that occurred that made it necessary to do so. After Ms "XYZ"'s last medical consultation, the only consultation involved Ms "XYZ"'s child becoming ill, the child was treated at the Medical Centre (by a doctor other than Dr Wiles), and Ms "XYZ" was not entirely satisfied with how the problem was handled.

4.15 **THE** relationship between Dr Wiles and Ms "XYZ" changed from social friendship to an intimate friendship on about 76 days after the last medical consultation. On or about that day there was a conversation in which each indicated to the other possible interest in an intimate relationship. There is considerable conflict in the evidence about the details of how the relationship developed, and particularly the timing of various events. Ms "XYZ" says that there was a kiss on or about that day, the next morning they met, kissed and cuddled, and continued with further contact, including intimate touching, until they had sexual intercourse about 5 weeks later. Dr Wiles denies that there was any intimate

physical contact until there was a discussion and Ms "XYZ" and her children's medical notes were transferred to another doctor. Ms "XYZ"'s notes being transferred about 11 days after the day on which the first kiss occurred, and the children's notes were transferred shortly after that. On Dr Wiles' evidence it was only after the transfer of the notes that they would *"hold hands, kiss and cuddle"*, and that sexual intercourse took place for the first time a little short of 3 months after the transfer of the medical notes. There was some circumstantial documentary evidence produced to support the timing Dr Wiles contended for.

4.16 **WE** are satisfied that Dr Wiles and Ms "XYZ" entered into an intimate relationship about 76 days after the last medical consultation, and that sexual intercourse took place at some point between 5 weeks and some 3 months after the relationship first became intimate. We are also satisfied that in the interval there was intimate sexual contact. However, we do not consider that the outcome of the charge before us turns on the detail of the timing of those events. For reasons we will discuss, the timing of the transfer of notes to another doctor does not have the significance the parties appeared to attach to it at the hearing. Furthermore, the difference between sexual intercourse first occurring 5 weeks after the relationship became intimate and some 3 months after that point is not a difference that significantly alters Dr Wiles' ethical obligations.

4.17 **MS** "XYZ" said in evidence that Dr Wiles supplied her with contraceptive pills prior to sexual intercourse taking place, and there was evidence another doctor prescribed the contraceptive pill subsequent to that. Improper supply of contraceptive pills was not the subject of a charge, and clearly it would have been improper for Dr Wiles to act as a

doctor in these circumstances. Dr Wiles denied the incident took place. We have considered the opposing claims from Ms "XYZ" and Dr Wiles, and we are not satisfied on the balance of probabilities that Dr Wiles did supply contraceptives.

4.18 **WE** are satisfied that Dr Wiles genuinely admired Ms "XYZ", considering, as he said in evidence, that *"she was a confident and most competent, capable woman, able to make her own decisions"*. We do not consider that there was any question of Dr Wiles perceiving that Ms "XYZ" was vulnerable and needy, and exploiting those characteristics.

Third phase:

4.19 **AFTER** sexual intercourse first took place, Dr Wiles and Ms "XYZ" had an ongoing sexual relationship that continued for something like a year. They continued to see each other most days during that year. The relationship was clandestine, as Ms "XYZ" and Dr Wiles were still living with their respective spouses, who were not aware of the relationship between Ms "XYZ" and Dr Wiles. In evidence both Dr Wiles and Ms "XYZ" said they believed that they were very much in love with each other during this period of time, and they discussed a future together. It appears that keeping the relationship secret became more difficult about a year after the relationship became intimate, because Ms "XYZ"'s husband's work commitments changed. The relationship however continued, with regular meetings before, during and after work, most weekday lunchtimes, and routinely there were multiple telephone calls each day.

4.20 **THE** relationship ceased to be secret due to developments at a social function which Dr Wiles and Ms "XYZ" attended. Ms "XYZ"'s closest female friend was Ms "FJK", she

was the only person in whom Ms "XYZ" had confided about her relationship with Dr Wiles. At the function Ms "FJK" said something to Ms "XYZ"'s husband to make him suspect the true nature of the relationship between Ms "XYZ" and Dr Wiles. By the following day Ms "XYZ"'s husband knew of the relationship.

4.21 **DR** Wiles described what subsequently happened to the relationship in the following way:

"Once [Ms "XYZ"'s husband] knew of my relationship with [Ms "XYZ"], contact between [Ms "XYZ"] and I carried on but it was extremely difficult. I had very much wanted to continue my relationship with [Ms "XYZ"], who I was totally in love with (as she was with me). She however did not feel she could leave her marriage without giving it a final attempt at reconciling. [Ms "XYZ"] left her husband [more than once], seeking my help and support each time. She returned to him [on each occasion], leaving me shattered.

…

Although [Ms "XYZ"] and I continued telephone, personal and other contact, and met at various times, she gradually grew more and more distant towards me.

At various stages she made it clear that she did not want me to wait around for her and that I should get on with my own life, whilst at other times she would hint that she still hoped for a future with me.

This was a ghastly time for me and I struggled immensely with [Ms "XYZ"]'s rejection of our relationship. I very much wanted it to continue."

4.22 **THERE** was a good deal of evidence regarding the details of what happened during this period. It is unnecessary to explore the details. It suffices to say that in general terms Dr Wiles separated from his wife some two weeks after the fact of his relationship with Ms "XYZ" became open, and Dr Wiles wished to commit himself to the relationship with Ms "XYZ". Ms "XYZ" however ultimately committed herself to her marriage, and rejected the relationship with Dr Wiles.

4.23 **IN** relation to the present circumstances Ms "XYZ" gave this evidence:

"Q. And in terms of the marriage as at today's date it is much improved isn't it?

A. It is wonderful. It's far superior. It was something, if any good has come out of this whole thing is that [my husband] and I have a much stronger relationship. … I'm delighted that my husband persevered and that we both are now in a strong position.

Q. And just by comparison Mrs "XYZ", you are aware aren't you that Anton Wiles' marriage is seemingly in ruins.

A. I am aware that Dr Wiles and his wife are no longer together. I am and have expressed my deep regret at that."

4.24 **THERE** were various issues in respect of which Ms "XYZ" considered Dr Wiles' actions were upsetting and unfair, following the breakdown of the relationship between them. That included Dr Wiles' ongoing contact with Ms "XYZ"'s mother, and Ms "FJK", and other issues.

The ethical issues:

4.25 **PROFESSOR** Gillett gave evidence to the Tribunal detailing his view of the principles underlying the ethical issues that arise in sexual relationships between doctors and their patients or former patients. There are three elements that Professor Gillett identified:

- Imbalance of power - the doctor is always in a position of power compared with the patient,
- The potential abuse of medical information, and
- The issue of unfair messages conveyed to the patient in the doctor/patient relationship. In essence, the doctor is a paid professional whose job involves caring, listening to patients' concerns, and placing the patient's interests above all else in decisions made affecting the patient. Professor Gillett concluded that "*This creates*

a relationship in which the doctor is at quite an advantage over any other potential romantic partner for that patient. In fact the advantage clouds the possibility of the patient making a clear assessment of the quality of the doctor as a potential romantic partner."

4.26 **WE** accept this evidence; the three issues identified are all material issues, which relate to relationships between doctors and patients or former patients. However, the issues are not absolutes and a full consideration of the particular circumstances is necessary in each case. For example there are occasions when ethical issues arise from patients exercising power over a doctor, for example using persuasive threats to induce the doctor to prescribe inappropriately.

4.27 **IN** the present case we are very mindful of the fact that in some clinical relationships a doctor has a great deal of power, even though the doctor may be unaware of that. Indeed a doctor in such circumstances may **feel** quite powerless, and personally vulnerable. Professor Gillett correctly pointed out that a doctor is not well placed to exercise the judgment of whether a patient's interests will be served by the doctor having a relationship with the patient. The Tribunal agrees with his comment *"we are all quite adept at deceiving ourselves as to the nobility and purity of our intentions and thoughts."* The ethical issues relate to the objective reality of power in the doctor/patient relationship.

4.28 **THE** use of medical information is one of the aspects of power in the doctor/patient relationship, and it is clearly wrong for a doctor to misuse patient information to meet their own needs or objectives.

4.29 **THE** Tribunal accepts that Professor Gillett is correct to point out the issue of unfair messages, and idealisation of the doctor in the mind of the patient. However, the Tribunal sees this also as principally an aspect of the issue of imbalance of power. Issues of transference, and misperception in the course of psychotherapy are very serious ones, which can place a great deal of power in the hands of the doctor, and a correspondingly great obligation of trust not to abuse it. However, the idealisation that is common in the early stages of a romantic relationship is not likely to be greatly affected by the fact that the parties were at one time doctor/patient in a consultation over a minor physical ailment.

4.30 **IN** addition to the factors Professor Gillett identified, patients are entitled to consult a medical practitioner without the practitioner taking it as an opportunity to attempt to initiate a relationship. Furthermore, the actuality or possibility of a personal relationship can compromise the ability of a doctor to provide appropriate or optimum care for a patient.

4.31 **PROFESSOR** Gillett went on to say that having regard to the factors he identified *"the Medical Council, the profession as a whole, and ethicists who are interested in this issue throughout the world have recommended a zero tolerance stance on the blurring of this particular professional boundary."*

4.32 **THE** issues however are not as absolute as the words *"zero tolerance"* would suggest, and Professor Gillett did not suggest that the issues are that simple. In relation to questions of power, use of information obtained in a clinical setting, and false perceptions there are issues of degree. Pursuing or accepting a sexual relationship with a patient can be one of the most gross breaches of the trust reposed in a doctor. There are other instances where

it would be an affront to common-sense and the rights of mature people to conduct their lives as they see fit to apply the zero-tolerance principle. In the latter category is the example of a single consultation for a minor physical health problem, and a subsequent meeting in a social setting from which a relationship develops.

4.33 **THE** clinical relationships that doctors and their patients have vary enormously, and the differences are significant in respect of them forming other relationships. The relationships are as varied as a pathologist analysing a specimen who may never see the patient, to a psychiatrist who may have to deal with the most private and intimate details of an extremely vulnerable patient's life. The Medical Council has produced guidelines in respect of relationships with former patients, the text reads:

"Any complaint that a doctor entered a sexual relationship with a former patient will be considered individually, but the Medical Council starts with the following premise:

A sexual relationship between a doctor and a former patient will be presumed to be unethical if any of the following apply:

- *the doctor/patient relationship involved psychotherapy, or long term counselling and support*
- *the patient suffered a disorder likely to impair judgment or hinder decision making,*
- *the doctor knew that the patient had been sexually abused in the past*
- *the patient was under the age of 20 when the doctor/patient relationship ended.*
- *In any of these cases the presumption could be rebutted by evidence that there was no exploitation of the former patient's vulnerability.*

In every case a sexual relationship between a doctor and a former patient will be deemed unethical if it can be shown that the doctor exploited any power imbalance, or exploited any knowledge and influence gained within the professional relationship."

4.34 **IN** our view the guidelines are a very sound indication of the principles to be applied in respect of relationships with former patients, recognising as the guidelines do, that each case must be considered on its merits. There is no doubt that psychotherapy, and comparable treatment and support, by their nature, put the doctor in a position of considerable power. Awareness of vulnerability, by reason of past sexual abuse, youth, or impairment of judgment similarly put the doctor in a position of power, and there is a corresponding obligation of trust to ensure that the patient is respected and protected.

4.35 **ONE** of the issues that is material is the difference between a patient and a former patient. As a general principle the zero tolerance approach to a sexual relationship with a current patient will apply. Having said that we received evidence that there are occasions when practitioners in remote locations sometimes have to treat their spouses and families for minor conditions as a matter of necessity. Putting aside those circumstances, relationships with current patients have in addition to the other issues:

- Abuse of the clinical setting, the doctor gains access to the patient by purporting to provide a professional service in a safe environment, and then acts in a way that meets the doctors objectives not the patients needs,
- The doctor cannot provide objective treatment by reason of personal involvement, and is almost certainly going to make responses that have more to do with keeping the sexual activity secret than providing optimal care for the patient.

4.36 **IN** the present case there was a question of when the doctor/patient relationship terminated. Some significance was attached to the point in time when Ms "XYZ"'s notes were transferred to another doctor. The Tribunal does not attach a great deal of

significance to that step. A doctor and/or their patient cannot take a formal step of that kind and remove the significance of the doctor/patient relationship. Whatever steps Dr Wiles and Ms "XYZ" took after the last clinical consultation took place, it could not alter the fact that there had been a doctor/patient relationship for more than 10 years. Certainly, continuing the doctor/patient relationship after the intimate relationship developed would have been a serious ethical breach; but there is no process by which the past is removed.

4.37 **THE** concept of defining when a patient becomes a "former patient" is not a precise one, nor a concept on which this case turns. The uncertainties of life are such that doctors and patients never know whether there will in fact be further consultations. There are certainly instances where patients formally terminate their relationship with a doctor, and ask that their records be transferred to another doctor. There are also many occasions when patients, for example, move to another area and see no need to have notes transferred, the notes are never transferred, and the original doctor is never notified that the patient has moved. Similarly, a patient may see more than one doctor, such as when they live and work in different areas. Patients also often see locums, or doctors in after-hours clinics where there may or may not be further contact.

4.38 **THE** Tribunal can envisage situations where a doctor/patient relationship would make it a gross breach of trust for the doctor to ever have a sexual relationship with a former patient, regardless of the passage of time. An example could arise in the context of psychotherapy in respect of sexual abuse. In other circumstances, the passage of time between the last doctor/patient consultation and the forming of a new relationship will be material as to

whether the relationship is a proper one. The events that take place during that interval may also be relevant.

5. DECISION:

Legal principles:

5.1 **SECTION** 109 of the Medical Practitioners Act 1995 provides that this Tribunal can impose disciplinary sanctions in the following circumstances:

> *"(1) Subject to subsections (3) and (4) of this section, if the Tribunal, after conducting a hearing on a charge laid under section 102 of this Act against a medical practitioner, is satisfied that the practitioner—*
>
> *(a) Has been guilty of disgraceful conduct in a professional respect; or*
> *(b) Has been guilty of professional misconduct; or*
> *(c) Has been guilty of conduct unbecoming a medical practitioner, and that conduct reflects adversely on the practitioner's fitness to practise medicine; …"*

There are certain other circumstances also, but they are not material to the present case. Each of the sub-paragraphs (a) to (c) has particular elements in the definition of conduct that affects its application. In addition, there is a decreasing level of seriousness of the charge, paragraph (a) dealing with "disgraceful conduct" being the most serious, reducing down to paragraph (c) dealing with "conduct unbecoming" (Refer: *Brake v PPC of the Medical Council of New Zealand* [1997] 1 NZLR 71 - dealing with former legislation with the same hierarchy of charges).

5.2 **THE** charge was brought at the highest of the three levels, disgraceful conduct. However, the Tribunal has the power to amend charges in accordance with the principles discussed

in *M* (MPDT Decision No. 97/99/48D) We have accordingly considered whether the facts proved establish a charge at any of the three levels.

5.3 **WE** have concluded that in the present case the conduct does not meet the threshold for the lowest of the three levels of charge, accordingly we direct our attention to meeting that level rather than the higher levels of charge. We have applied the principles in *B v Medical Council of New Zealand* (High Court, Auckland, 11/1996, Elias J, 8 July 1996), and in particular these observations:

> *"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 that lower end of the scale, must be conduct which departs from acceptable professional standard. That departure must be significant enough to attract sanction for the purpose 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 [counsel for the Practitioner] that a finding of conduct unbecoming is not required in every case where error is shown. … The question is not whether error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations. … The structure of the disciplinary processes set up by the Act, which rely in large part upon judgment by a practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standards applied by competent, ethical, and responsible practitioners. But the inclusion of lay representatives in the disciplinary process and the right of appeal to this court to determine, taking into account all the circumstances including not only usual practice but also patient interests and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards."*

5.4 **THE** Tribunal is very conscious in this case that it must consider both the ethical standards of the profession, and also the need to set standards having regard to patient interests and community expectations.

The facts of this case:

5.5 **WE** have considered the circumstances in this case as a whole. We have concluded that the facts do not reach the threshold for disciplinary action. We have not done so without hesitation, and not without concluding that Dr Wiles' pursuance of his relationship with Ms "XYZ" was unwise in the extreme, but in the judgment of the Tribunal it falls short of the threshold for disciplinary action. In accordance with the principles in *M* (MPDT Decision No. 97/99/48D), the Tribunal has power to amend charges, and we have considered whether the threshold has been met for the most serious level, disgraceful conduct, which is the charge, and also professional misconduct and conduct unbecoming. We have concluded that the threshold is not met for the charge to be upheld at any level.

5.6 **THERE** are certain matters that were not part of the facts in this case, and the Tribunal emphasises that had they been present there can be no doubt that a disciplinary offence would have been established. We emphasise that we have specifically found:

- There is no evidence that either Dr Wiles or Ms "XYZ" initiated any sexual, or romantic contact in the clinical setting.
- There was no doctor/patient consultation after Dr Wiles and Ms "XYZ" became involved in a romantic relationship.
- Dr Wiles never treated Ms "XYZ" for a psychiatric condition, or provided psychotherapy, or provided formal counselling. Dr Wiles did discuss and advise on personal difficulties, and we discuss that below.

5.7 **IN** our view the critical events occurring, which prevent the facts of this case reaching the threshold for disciplinary action occurred in the period between the last medical

consultation, and the point when the relationship became sexualised. That is sexualised, in the sense of mutual recognition of interest in development of a romantic relationship, and physical contact in the form of a kiss - it is not necessary for sexual intercourse to occur for there to be an intimate relationship involving disciplinary issues. Dr Wiles' action in developing day to day contact with a former patient could be considered unwise, but without the benefit of hindsight it would not be fair to attach more significance than that, to that fact. Having heard both Ms "XYZ" and Dr Wiles give evidence we are satisfied that the friendship that developed was a very genuine one, that became progressively more intimate in the sense of sharing information about each other's lives, and lending emotional support to each other. During this time before the relationship became sexualised there is no doubt that Ms "XYZ" and Dr Wiles both shared information with each other about the state of their respective marriages, and their attitudes to their respective spouses. The evidence has satisfied us that when the relationship became sexualised, that development did not arise out of the relationship of doctor/patient, or as a result of any information that was conveyed in the course of the doctor/patient relationship. The sexualisation of the relationship was a product of a close non-sexual friendship between two people in virtually daily contact over a period of some two months. Dr Wiles and Ms "XYZ" were both very unhappy in their respective marriages at that time, they plainly found each other an attractive person, and the sexualisation of the relationship was a consequence of that. The evidence does not support the sexualisation of the relationship having developed out of the doctor/patient relationship. The principal significance of the doctor/patient relationship was the causative link that "but for" the doctor/patient relationship, Dr Wiles and Ms "XYZ" may not have had the opportunity for the professional, commercial and social relationships that developed. None-the-less we must consider the effect of the various dimensions of

power in the doctor/patient relationship, which could be said to have been "held over" despite the intervention of an intimate friendship before it became sexualised. It is certainly no answer to the charge that Dr Wiles was "in love", or acting for genuine motives as he understood them. Regardless of a doctor's feelings, the doctor has an obligation to put the patient's interests first. We agree with this comment made by Professor Gillett:

"There are times in our professional lives when we are extremely vulnerable ourselves. There are times when we have deep and unmet needs in our own personal lives. The rules are there so that those needs and our own vulnerabilities do not endanger the wellbeing of our patients.

And is that so even if the doctor is in love with the patient? I believe so. I am not, thankfully, having to deliver a judgment on this issue, but I do believe that the ethics of the profession are as harsh as they are because doctors in love can do a great deal of mischief, without intending to, and in the belief that everything is under control and people are going to come out the other end just as intact as they came out at the beginning."

5.8 **WE** are satisfied after considering the evidence given by Ms "XYZ" and Dr Wiles that the issues of power in the doctor/patient relationship had at least been substantially dissipated by the intervention of the friendship that had developed. We are satisfied that by the time the relationship first became intimate, Ms "XYZ" had ceased to regard Dr Wiles as her doctor, and Dr Wiles had ceased to regard Ms "XYZ" as his patient. There was no consultation during that time, and in view of the friendship that had developed it is difficult to imagine how such a consultation could have taken place on a professional footing. Accordingly, Dr Wiles could not exert any influence as a doctor, whatever he said or did was as a friend by this time. Certainly Dr Wiles was a doctor, and may well have had more influence in some matters by virtue of that fact. For example, Ms "XYZ" may well have had more respect for his views on personal relationships because he was a health professional who discussed patients' relationship difficulties with them. However, the

evidence does not indicate that influence of that kind was significantly enhanced by the fact that Dr Wiles had been Ms "XYZ"'s doctor. We have also considered the issue raised by Professor Gillett regarding unfair messages when dealing with a patient professionally, and the difficulties of idealisation of perceptions that can occur. While fully acknowledging the significance of the issue, in our view that was substantially or fully dissipated by the daily contact in a different setting for some two months. We have no doubt that there was a great deal of idealisation of perceptions on the part of both Ms "XYZ" and Dr Wiles. It is a common, if not universal, feature of developing romantic relationships, but we do not consider that it can be related back to the doctor/patient relationship. In short we are satisfied on the evidence that had Ms "XYZ" been located where she saw Dr Wiles on a day to day basis, without having formerly been a patient of Dr Wiles, exactly the same outcome would, or could, have occurred after they began to spend time together.

5.9 **WE** have indicated that despite the fact we consider the facts of this case fall short of justifying disciplinary action, Dr Wiles' actions have been most unwise, and indeed fall just short of the disciplinary threshold. Our criticism is because at the point where the relationship became sexualised, Dr Wiles could have acted in a way that would have protected him and Ms "XYZ".

5.10 **THE** doctor/patient relationship in the present case was long in duration, and it involved a range of significant health issues, and giving and receiving advice related to Ms "XYZ"'s psychological wellbeing. Had Ms "XYZ" attended at Dr Wiles' surgery for the first time in respect of a minor physical ailment, and the contact and all the other events followed after that, we do not consider that there could be any professional criticism of Dr Wiles for

sexualising the relationship when he did. In this case we consider that a great deal of caution was required on the part of Dr Wiles, because he was not in a position to evaluate whether the relationship was one that could be pursued properly. We refer again to the comments made by Professor Gillett about the capacity for self-deception regarding the nobility of our actions.

5.11 **IN** our view when Dr Wiles and Ms "XYZ" recognised that there was a mutual interest in pursuing a romantic relationship, Dr Wiles should have frankly told Ms "XYZ" that the fact they had been doctor/patient was an issue he had a professional obligation to face. To an extent Dr Wiles did that by discussing, and effecting the transfer of medical records of Ms "XYZ" and her children. However, that was not the issue, while there were no ongoing consultations the transfer of records did not "wipe the slate clean". At that point Ms "XYZ" should at least have been advised of the issue regarding possible harm to her from a relationship with her former doctor. As it happens, it appears that the relationship may have left Dr Wiles in more difficult circumstances than Ms "XYZ", that is not usual. In both cases there was considerable harm done, but it was harm caused by two people with partners and families having an affair, not the product of the former doctor/patient relationship. Of course, the fortunate or unfortunate outcome is not relevant to whether a charge is established, but it does have a bearing on a doctor's ethical obligations. The Tribunal is very conscious that where there is a sexual relationship with a doctor and a former patient, where the doctor/patient relationship has been a significant one, it is very common indeed for the former patient to be badly harmed emotionally in the relationship.

5.12 **THERE** are many respects in which professional obligations on doctors are difficult, and impose restrictions that are not imposed on other members of society. The area of forming romantic or sexual relationships with patients and former patients is one of them. The Tribunal is well aware of the difficulty in making rational decisions that withstand dispassionate scrutiny in respect of new and developing relationships. It is for that reason that guidelines have been formulated, including the well recognised principle that it is improper to pursue a romantic or sexual relationship and continue a doctor/patient relationship. In respect of a former patient where there has been a significant doctor/patient relationship we consider that unless there has been a period of six months where there has been no contact, the doctor places him or herself at risk. However harsh or impracticable that may appear, Dr Wiles should have taken that course, indeed when giving evidence Dr Wiles accepted that was the course he should have followed. The situation could also have been ameliorated by ensuring that Ms "XYZ" had counselling from a competent, and genuinely independent third party. Failure to do those things were not the subject of a charge, and nor should they have been. They were prudent steps that doctors should consider before or at the point there is the possibility of a relationship with a former patient becoming sexualised. In making those comments, nothing we say should be taken as indicating that time or professional support will necessarily ever permit a legitimate relationship where there has been psychotherapy, counselling, any condition impairing judgment, a history of sexual abuse, or a young patient.

5.13 **WE** also emphasise that it is the responsibility of the doctor to maintain boundaries in the doctor/patient relationship, and to ensure that the interests of the patient or former patient are protected.

5.14 **HAVING** made these comments we emphasise that every case must be considered on its own merits. In this case we consider that Dr Wiles' actions did not reach the threshold for disciplinary action, because the particular relationship Dr Wiles and Ms "XYZ" developed from the last medical consultation to the time the relationship became intimate placed sufficient distance between the doctor/patient and the sexual relationship. In making that decision we have had regard to the facts as a whole, the nature of the doctor/patient relationship, the amount of time spent together on a virtually daily basis during the two months, the type of communication and emotional interaction during the two months, and the personal qualities of Dr Wiles and Ms "XYZ" (both intelligent professional people in their middle years of life). Carefully weighing all of those factors we have concluded that there was sufficient distance between the doctor/patient relationship and the intimate and sexual relationship to fall short of a disciplinary offence. We have considered the issue from the perspective of what is accepted by the profession, the interests of patients, and community expectations. That consideration has taken account of the Tribunal's obligation to "set standards of conduct" in the interests of patients and the community.

5.15 **ACCORDINGLY** we do not find the charge established.

6. SUBMISSIONS ON ISSUES OF CONFIDENTIALITY:

6.1 **AT** the present time there are orders of the Tribunal suppressing the names of Ms "XYZ" Dr Wiles, and any information or fact that might identify them, pending further order of the Tribunal.

6.2 **THE** Tribunal will reconsider these orders after receiving submissions from the parties. Ms "XYZ" may make submissions through her own counsel rather than the Director of Proceedings if she wishes to do so.

6.3 **THE** Tribunal reminds the parties and any person receiving this decision that the orders relating to suppression of identity remain in full force and effect. Provided that Ms "XYZ" may disclose the decision to her husband, and any persons necessary to obtain legal advice. It is a matter for Ms "XYZ" whether she does wish to disclose the decision in that way, and if she does so, those persons are bound by the existing orders of the Tribunal.

6.4 **WE** invite counsel for both parties to make written submissions on any issues arising in respect of publication of this decision in accordance with the following timetable:

- The Director of Proceedings to file submissions with the Secretary, and serve it on the solicitors for Dr Wiles not later than 14 days from the receipt of this decision,
- Dr Wiles to file submissions with the Secretary, and serve them on the Director of Proceedings not later than 14 days from the receipt of the Director of Proceeding's submissions.
- Ms "XYZ" or her legal representative may obtain copies of the submissions by request directed to the Secretary of the Tribunal. If Ms "XYZ" wishes to make submissions in addition to submissions made by the Director of Proceedings, they are to be filed by the same time the submissions for Dr Wiles are required (14 days after the Director of Proceedings submissions are filed).

MINORITY DECISION OF DR J M McKENZIE

7. Preliminary:

7.1 **THE** charge and the background facts are set out in the decision of the majority, which I have seen in draft form. The majority decision accurately sets out the background facts. I have a different view regarding the nature of the doctor/patient relationship, and of the issues around "termination" of the doctor/patient relationship. I accordingly express my own view of those matters, and the consequences regarding the charge.

7.2 **THE** majority decision also correctly records that facts must be proved on the balance of probabilities, but to a standard commensurate with the gravity of what is alleged: *Ongley v Medical Council of New Zealand* [1984] 4 NZAR 369 @ 375-376.

The doctor/patient relationship - Dr Wiles and Ms "XYZ":

7.3 **I** am satisfied that the evidence establishes the doctor/patient relationship in this case was a very significant one, in which the patient was vulnerable mainly because of the power imbalance created by the relationship. Dr Wiles accordingly had a commensurate obligation of trust to protect his patient.

7.4 **THERE** are features of the doctor/patient relationship I consider of particular significance. I am satisfied Ms "XYZ"'s relationship with Dr Wiles as her general practitioner was important in terms of the amount of reliance she placed on him. In that regard, it was established in the evidence that Ms "XYZ" had at the upper limit of the usual number of consultations expected of a woman in her circumstances. Many of the consultations are for

relatively minor health problems, with recurring consultations apparently related to psychological stresses being manifest in various ways for example, Ms "XYZ" said in evidence that after her miscarriage she was distressed, experienced feelings of guilt, and consulted Dr Wiles about her emotional state. Ms "XYZ" said that Dr Wiles was the only person in whom she confided about her feelings regarding that issue. I am satisfied Ms "XYZ" looked to Dr Wiles as a confidante, and provider of emotional support and advice. I am also satisfied that Dr Wiles was, or ought to have been, aware that Ms "XYZ" depended on him in that way.

7.5 **THE** circumstances I have described are in my view determinative in characterising the doctor/patient relationship as a very significant one, where there would be an associated power imbalance. Ms "XYZ" therefore could be seen as vulnerable. That gave rise to particular obligations on Dr Wiles. There are a number of other matters in the evidence supporting my view of the significance of the doctor/patient relationship, they include:

- The long period of time over which Ms "XYZ" was Dr Wiles' patient,
- Dr Wiles being the lead maternity caregiver during Ms "XYZ"'s pregnancy, and delivering her first child,
- Being the doctor providing primary health care for Ms "XYZ"'s children as well as her own health,
- Events of a medical nature - colposcopy, a health problem her child suffered from, concern about a particular disease she thought she might be suffering from (as well as the matters referred to earlier), and non-medical issues such as employment stresses, difficulties in her relationship with her husband, difficulties with an employee

in the practice where she worked, and coping with young children, all contributed to her vulnerability.

7.6 **MS** "XYZ" did consult Dr Wiles in respect of aspects of her mental health. I accept Ms "XYZ"'s evidence that Dr Wiles diagnosed her as having a mild form of depression after the birth of her first child; I prefer that view to the contrary assertion by Dr Wiles. Ms "XYZ"'s account of suffering depression at that time, and it being recognised, is consistent with her evidence of her history, and experiences given in evidence. Ms "XYZ" gave evidence of a family history of depression, low mood, loss of confidence, fatigue, and also difficulty in making effective decisions and carrying them out in the 7-8 months after the birth of her first child. In addition, Dr Clarkson a psychiatrist who interviewed Ms "XYZ", formed the view that she was likely to have been depressed following the birth of her child, and at other times while she consulted Dr Wiles. In forming my view regarding the depressive condition which I am satisfied Ms "XYZ" presented to Dr Wiles, I am conscious that Dr Wiles' clinical notes do not contain a clear diagnosis of clinical depression, but do contain references to marital difficulties, *"Psych: problems at home. Discussed."*, and *"Psych: problems over weekend, but starting to talk things over."* Accordingly, it appears that Ms "XYZ"'s view that Dr Wiles recognised her condition as a mild depressive condition, which she could manage herself, without either medication or referral for counselling, or other treatment, is accurate. Accordingly, I am satisfied Dr Wiles was, and knew he was, dealing with a patient who had issues relating to her mental health, he had the responsibility to treat his patient in a way that recognised her vulnerability.

7.7 **IN** my view the last medical consultation Ms "XYZ" had with Dr Wiles cannot be regarded as in any sense ending the doctor/patient relationship. Dr Wiles and Ms "XYZ" had been involved in boundary crossings in the doctor/patient relationship from the time that Ms "XYZ" assisted Dr Wiles' wife. Ms "XYZ" gave evidence that:

"I knew he was married, and [in the mid 1990s] I met his wife. [Dr Wiles] asked me to [give some professional assistance to an organisation his wife was involved with]. I can't remember whether I rang her or she rang me. I met her and I introduced her to a friend of mine … to help her with this business. As a result sporadically [this] organisation asked [for my professional assistance]."

While the action on the part of Dr Wiles may have been proper, it should be recognised as a crossing of the professional boundary in a doctor/patient relationship. Improper relationships between doctors and their patients will usually develop through a series of steps in which the professional boundary is breached. The present case is no exception. The next crossing of the boundary is the evidence of Ms "XYZ" becoming involved in professional and commercial relationships with Dr Wiles and his colleagues after the time of the last medical consultation. Soon after that Ms "XYZ" and Dr Wiles had become close friends. At this point, in my view, the doctor/patient relationship should be regarded as still present. Ms "XYZ" had at least doubted that it would be appropriate to continue consulting Dr Wiles as a doctor; and I am prepared to infer that Dr Wiles may not have felt comfortable treating Ms "XYZ" as a patient, however Dr Wiles had done nothing at this point to terminate the doctor/patient relationship. In my view where the doctor/patient boundaries are breached, or where the doctor knows a breach is intended, the doctor has a clear obligation to terminate the doctor/patient relationship through positive action.

7.8 **ACCORDINGLY**, I consider that there was an existing doctor/patient relationship at the time the relationship between Dr Wiles and Ms "XYZ" became sexualised. I am satisfied the evidence establishes Dr Wiles and Ms "XYZ" entered into an intimate relationship in the 76, or so, days after the last medical consultation. That is in the sense that there was at least a sexual kiss and embracing at that point. I am satisfied on the evidence that sexual intercourse took place at some point between 5 weeks and 3 months later, the evidence does not, on the balance of probabilities, admit of more precision. Between the time of the first kiss and sexual intercourse occurring there was other intimate sexual contact.

7.9 **MS** "XYZ"'s medical notes were transferred on soon after the first intimate contact, and her children's notes a few days later. In a sense this may be seen as terminating the doctor/patient relationship, but I do not regard the step as being adequate in the circumstances. The evidence leads me to the view that the step was taken on the initiative of Dr Wiles as a protective measure, intended as a kind of authorisation for the relationship he had entered into with his patient. The responsibility for terminating a doctor/patient relationship when professional boundaries have been broken, and effecting all reasonable steps to protect the patient, is the responsibility of the doctor. Dr Wiles did little or nothing more than persuade Ms "XYZ" to take her, and her children's, medical notes elsewhere. The range and complexity of doctor/patient relationships is such that it is often difficult to identify the time when the relationship concludes. I do not consider the doctor patient relationship ended just because the notes are transferred as in this case. Whether that is correct or not, the relationship was already sexualised by that point. More important, termination of the doctor/patient relationship would not alter the significance of the type of doctor/patient relationship that had existed down to that point. Whether the doctor/patient

relationship continued or not, the power imbalance, and vulnerability of Ms "XYZ", certainly continued. I consider that by the time the medical records were transferred Dr Wiles was in a sexual relationship with a patient, in respect of whom he carried very significant responsibilities by virtue of his patient's vulnerabilities and the nature of the care he had provided.

The ethical issues:

7.10 **I** accept the evidence of Professor Gillett regarding the ethical issues that arise in sexual relationships between doctors and their patients or former patients. There are three principles Professor Gillett identified:

- Imbalance of power - the doctor is in a position of power compared with the patient. He expressed it in these terms:

  "There will always be a power imbalance, there will always be an influence, sometimes that will be completely minimal because any professional contact between doctor/patient has in fact been minimal – sometimes i.e. when the patient has been a patient for very many years or through a number of difficult life crises there will be a great deal of influence, knowledge and power imbalance."

- Potential abuse of medical information, and
- In the doctor/patient relationship unfair messages are conveyed to the patient. The doctor is a professional responsible for caring, listening to patients' concerns, and giving the patient's interests priority. Professor Gillett stated "*This creates a relationship in which the doctor is at quite an advantage over any other potential romantic partner for that patient. In fact the advantage clouds the possibility of the patient making a clear assessment of the quality of the doctor as a potential romantic partner."*

7.11 **IN** my view the facts of the present case were ones where each of those factors was present to a significant degree. It is important to recognise that the imbalance of power is an objective one, and there was evidence suggesting Dr Wiles was himself quite vulnerable at the time the relationship with Ms "XYZ" became sexualised. It is however important to recognise that a doctor's ethical response cannot be governed by the doctor's subjective views, or emotional state. They may be matters that to a degree mitigate unethical conduct, but they do not determine what is the proper ethical response. I accept Professor Gillett's evidence that a doctor is not well placed to exercise the judgment of whether a patient's interests will be served by the doctor having a relationship with the patient, and particularly his comment

"We are all quite adept at deceiving ourselves as to the nobility and purity of our intentions and thoughts."

7.12 **DR** Wiles in the course of the doctor/patient relationship had been privy to information regarding the difficulties in Ms "XYZ"'s marriage, and also acted as a caring confidant in respect of those difficulties. In my view Ms "XYZ" required, and was entitled to be, protected from the potential for Dr Wiles to consciously or unconsciously exploit the information he had, the relationship he had formed in his role as a doctor, or the emotions carried over from that relationship. I do not consider that the evidence gives any support for the view that Dr Wiles intentionally set out to exploit a vulnerable patient. I am satisfied that Dr Wiles did believe he formed a genuine relationship, with a woman who he sincerely regarded as an equal partner in the relationship. That however does not make the conduct ethical, but it does have relevance in determining the gravity of the ethical breach.

7.13 **PROFESSOR** Gillett said *"the Medical Council, the profession as a whole, and ethicists who are interested in this issue throughout the world have recommended a zero tolerance stance on the blurring of this particular professional boundary."* But that rather begs the question, as Professor Gillett recognised, of what you are not tolerating. In my view the concept of "zero tolerance" has the value of marking out for practitioners a bright line test that identifies conduct as wrong. The difficulty for practitioners is the one I discussed earlier, improper relationships begin with boundaries being crossed, and initially the crossing may be insignificant, or readily explained as a caring and considerate action. However, over time a relationship can readily develop that is wholly incompatible with a doctor/patient relationship, and expose the patient to the risk of serious emotional harm. There is a great deal of value in having a very clear line where practitioners know that their action has become unambiguously unethical and potentially worthy of discipline. The concept of zero tolerance is aimed at providing that clear line.

7.14 **THE** difficulty remains of identifying what is not being tolerated, for some actions that is clear and unequivocal. There, is and can be, no tolerance for any sexual contact whatever in the course of a doctor/patient consultation; or to use the consultation as an opportunity to promote potential sexual contact. There is no tolerance for beginning or continuing to treat a patient with whom a practitioner is in a sexual relationship.

7.15 **THE** facts of the present case do not fall into the area of zero tolerance, where a simple bright line test can be applied. There was no sexual contact in the course of a consultation, a consultation was never used as an opportunity to develop a sexual relationship, and there were no further consultations after the relationship became sexual. There are situations

where a doctor may properly become involved in a sexual relationship with a former patient, when the sexual relationship follows from separate social contact. The common instance given being a couple living in a remote location where the practitioner has treated the patient for minor physical problems (as will be the case for most of the practitioner's social contacts). Accordingly, on the facts of this case an element of judgment is required, without the benefit of the certainty of zero tolerance. However, even without the benefit of a bright line test, practitioners must be in no doubt that sexual relationships with former patients impose great responsibility on the practitioner. Furthermore, practitioners should be in no doubt that due to his or her own emotional involvement the practitioner will not be well placed to make sound objective judgments.

7.16 **THE** Medical Council has guidelines in respect of relationships with former patients, the text reads:

"Any complaint that a doctor entered a sexual relationship with a former patient will be considered individually, but the Medical Council starts with the following premise:

A sexual relationship between a doctor and a former patient will be presumed to be unethical if any of the following apply:

- *the doctor/patient relationship involved psychotherapy, or long term counselling and support*
- *the patient suffered a disorder likely to impair judgment or hinder decision making,*
- *the doctor knew that the patient had been sexually abused in the past*
- *the patient was under the age of 20 when the doctor/patient relationship ended.*

In any of these cases the presumption could be rebutted by evidence that there was no exploitation of the former patient's vulnerability.

In every case a sexual relationship between a doctor and a former patient will be deemed unethical if it can be shown that the doctor exploited any power imbalance,

or exploited any knowledge and influence gained within the professional relationship."

7.17 **IN** my view the guidelines should be seen as no more than guidelines. In particular, the guidelines are not a licence to engage in a relationship with any patient who does not come within the "unethical presumption". The guidelines certainly identify the most common areas of patient vulnerability. In my view the facts of this case do come within the presumption in the guideline, as Dr Wiles was involved in providing long term counselling and support for Ms "XYZ".

Decision:

7.18 **THE** material parts of section 109 of the Medical Practitioners Act 1995 provide that this Tribunal can impose disciplinary sanctions in the following circumstances:

"(1) Subject to subsections (3) and (4) of this section, if the Tribunal, after conducting a hearing on a charge laid under section 102 of this Act against a medical practitioner, is satisfied that the practitioner —

(a) Has been guilty of disgraceful conduct in a professional respect; or
(b) Has been guilty of professional misconduct; or
(c) Has been guilty of conduct unbecoming a medical practitioner, and that conduct reflects adversely on the practitioner's fitness to practise medicine; …"

There is a decreasing level of seriousness of the charge, paragraph (a) "disgraceful conduct" is the most serious, and it reduces down to paragraph (c) dealing with "conduct unbecoming" which is the least serious (*B v Medical Council of New Zealand* (High Court, Auckland, 11/1996, Elias J, 8 July 1996) – former legislation with the same progressive structure of charges).

7.19 **THE** charge was brought at the highest of the three levels, disgraceful conduct. The Tribunal has the power to amend charges in accordance with the principles in *M* (MPDT Decision No. 97/99/48D). I have accordingly considered whether the charge is established at any of the three levels.

7.20 **I** am satisfied that the charge is made out on the facts, but only at the lowest of the three levels of charge. I have applied the principles in *B v Medical Council of New Zealand* (High Court, Auckland, 11/1996, Elias J, 8 July 1996), and in particular these observations:

"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 that lower end of the scale, must be conduct which departs from acceptable professional standard. That departure must be significant enough to attract sanction for the purpose 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 [counsel for the Practitioner] that a finding of conduct unbecoming is not required in every case where error is shown. … The question is not whether error was made but whether the practitioner's conduct was an acceptable discharge of his or her professional obligations. … The structure of the disciplinary processes set up by the Act, which rely in large part upon judgment by a practitioner's peers, emphasises that the best guide to what is acceptable professional conduct is the standards applied by competent, ethical, and responsible practitioners. But the inclusion of lay representatives in the disciplinary process and the right of appeal to this court to determine, taking into account all the circumstances including not only usual practice but also patient interests and community expectations, including the expectation that professional standards are not to be permitted to lag. The disciplinary process in part is one of setting standards."

7.21 **THE** facts of this case are difficult, in that they cannot simply be put into the "zero tolerance" area. The divergent views of the members of the Tribunal in the present case indicate that applying the principle of what "is acceptable professional conduct [by] the standards applied by competent, ethical, and responsible practitioners", does not provide

a clear answer. The views of such practitioners vary in cases such as the present one. However, I am satisfied that having regard to the interests of patients, and the obligation the Tribunal has to set standards, the facts of this case do establish a charge of conduct unbecoming a medical practitioner, and that conduct reflects adversely on the practitioner's fitness to practise medicine.

7.22 **IN** this case, for the reasons I have discussed, I consider that there was a very significant doctor/patient relationship, and a vulnerable patient. There are multiple factors that lead inexorably to that conclusion, the length of time the doctor/patient relationship inured, the numerous consultations, the significant events dealt with (e.g. childbirth, and a miscarriage in difficult circumstances), the significant psycho-social component in the consultations, the presentation of mental health issues, and the confidant/adviser role Dr Wiles played. In addition, while Ms "XYZ" was not an extremely vulnerable person, she was needy.

7.23 **IN** these circumstances I consider that Dr Wiles placed himself in an invidious position when he created the situation where Ms "XYZ" had a professional and commercial relationship with his practice, and ultimately became a close friend. To that point, unwise as the actions may have been, I do not regard them as a professional disciplinary issue. However, I consider Dr Wiles should have been in no doubt during that time he had a professional obligation to Ms "XYZ" and her children. He was their doctor, and nothing had changed that position. Dr Wiles was still Ms "XYZ"'s doctor when he caused the relationship to become sexualised. Having regard to the significance of the doctor/patient relationship that was wrong, and there was a very high risk that Ms "XYZ" would be seriously harmed. At the point where there was a recognised mutual interest in a romantic

relationship, in the circumstances of this case, I consider that the only effective action Dr Wiles could have taken was to terminate the relationship, and cease any significant contact for a period of two years. In expressing that view I am conscious that it may be seen as harsh, and demanding. However, it is one of many onerous obligations that medical practitioners must accept if they are to give proper priority to the interests of their patients. The likely result of a sexual relationship between a doctor and a former patient is that the patient will be harmed. There are exceptions, but the practitioner involved will not be well equipped to identify the true nature of the relationship he or she is involved in. Indeed it may be very unpredictable for the most objective and informed observer to predict what the result will be. The interests of patients demand that where there has been a significant doctor/patient relationship and a vulnerable patient, it will be a serious breach of the doctor's professional obligations to allow a sexual relationship unless there has been a gap of 2 years or more since the end of the doctor/patient relationship. A gap of that length provides some isolation from the danger that emotions derived from the former professional relationship will be abused. I emphasise however, that some doctor/patient relationships, particularly those involving psychotherapy, may leave enduring effects so that it will never be appropriate for the doctor and patient to enter a sexual or romantic relationship. I agree with the following comments of Professor Gillett which he made in the course of his evidence:

"There are times in our professional lives when we are extremely vulnerable ourselves. There are times when we have deep and unmet needs in our own personal lives. The rules are there so that those needs and our own vulnerabilities do not endanger the wellbeing of our patients.

And is that so even if the doctor is in love with the patient? I believe so. I am not, thankfully, having to deliver a judgment on this issue, but I do believe that the ethics of the profession are as harsh as they are because doctors in love can do a great deal of mischief, without intending to, and in the belief that everything is under

control and people are going to come out the other end just as intact as they came out at the beginning."

7.24 **DR** Wiles did not take the only proper steps open to him when the relationship with his patient became sexualised, and in my view the initial sexualisation of the relationship, and the ongoing sexual relationship establishes the charge at the level of conduct unbecoming.

7.25 **HOWEVER**, I do not consider that the facts of this case can be viewed as being more serious than a charge of conduct unbecoming. In different legislation the description of the threshold of professional misconduct, the next level of charge above conduct unbecoming, has been described in these terms:

*"The threshold of professional misconduct has often been illustrated by reference to such words as 'reprehensible', 'inexcusable', 'disgraceful', 'deplorable', or 'dishonourable'". (**Haye v Psychologists Board** [1998] 1 NZLR 591)*

7.26 **THE** most common formulation of the standard being that of Jefferies J in *Ongley v Medical Council of New Zealand* [1984] 4 NZAR 369, dealing with former legislation:

"Has the practitioner so behaved in a professional capacity that the established acts under scrutiny would reasonably be regarded by his colleagues as constituting professional misconduct? With proper diffidence it is suggested that the test is objective and seeks to gauge the given conduct by measurement against the judgment of professional brethren of acknowledged good repute and competency, bearing in mind the composition of the tribunals which examine the conduct. Instead of using synonyms for the two words the focus is on the given conduct which is judged by the application of it to reputable, experienced medical minds supported by a layperson at the committee stage."

7.27 **I** consider that on the application of either the approach in the *Haye* or the *Ongley* case it is clear the facts in the present case fall short of professional misconduct. The facts of this case amount to an unacceptable error of judgment on the part of Dr Wiles, there is no

element of intentional exploitation, and I do not consider the conduct could be characterised as reckless.

7.28 **I** am however satisfied that Dr Wiles' conduct in the present case does cross the threshold for disciplinary action because it fell short of the standards necessary to protect patients, and set standards for the profession. It was conduct in respect of which colleagues would have a range of views, some would take the view it did not reach the threshold for disciplinary action, others would consider it did so. I do not consider that the normal range of views would extend to regarding the conduct as professional misconduct, and neither is that necessary or appropriate to protect patients and set standards for the profession.

7.29 **I** would find the charge established at the level of conduct unbecoming a medical practitioner, and being conduct that reflects adversely on the practitioner's fitness to practise medicine.

DATED at Wellington this 5th day of March 2001

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G D Pearson

Deputy Chair

Medical Practitioners Disciplinary Tribunal