MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL

PO Box 5249, Wellington • New Zealand
Ground Floor, NZMA Building • 28 The Terrace, Wellington
Telephone (04) 499 2044 • Fax (04) 499 2045
E-mail mpdt@mpdt.org.nz

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| **NAMES OF** | **DECISION NO:** | 170/01/72D |
| **COMPLAINANT,** | **IN THE MATTER** | of the Medical Practitioners Act |
| **COMPLAINANT'S** | | 1995 |
| **WITNESSES AND ANY** | | |
| **IDENTIFYING DETAILS** | | -AND- |
| **ARE NOT TO BE** | | |
| **PUBLISHED** | **IN THE MATTER** | of a charge laid by the Director of Proceedings pursuant to Section 102 of the Act against **LEWIS STEPHEN GRAY** medical practitioner of Balclutha |

**BEFORE THE MEDICAL PRACTITIONERS DISCIPLINARY TRIBUNAL**

**TRIBUNAL:** Mrs W N Brandon (Chair)

Dr F E Bennett, Dr U Manukulasuriya, Dr J M McKenzie,

Mr G Searancke (Members)

Ms G J Fraser (Secretary)

Mrs G Rogers (Stenographer)

Hearing held at Dunedin on Monday 30, Tuesday 31 July and Wednesday 1 August 2001

**APPEARANCES:** Mr M F McClelland and Ms T Baker for the Director of Proceedings

Mr H Waalkens for Dr L S Gray.

**The Charge**

1. Pursuant to Sections 102 and 109 of the Medical Practitioners Act 1995 ("the Act") the Director of Proceedings ("the Director") charged that between 14 October 1997 and February 1998 Dr Gray had a sexual relationship with his patient, Mrs A and was therefore guilty of disgraceful conduct.

**Background to the Charge**

2. In June 1996 Dr Gray moved his family from Roxburgh to the small town of xx which is near Balclutha. Prior to moving to xx, Dr Gray was the sole charge medical officer at Roxburgh Hospital as well as the only GP in a practice caring for approximately 2,300 patients.

3. In April 1995 the Roxburgh Hospital closed and Dr Gray was left as the sole practitioner in Roxburgh without the 24 hour nursing support, equipment and facilities previously available to him at the hospital as an after hours base. From June 1995 through until mid-1997 Dr Gray was also involved in professional disciplinary proceedings following the death of a young child under his care. Dr Gray considers that the findings by the Medical Practitioners Disciplinary Committee that he was guilty of professional misconduct, and medical error by the ACC, were unfair.

4. In January 1996 Dr Gray suffered a nervous breakdown and sought psychiatric care from February 1996 until April 1997. This care continued for the first 10 months of him commencing practice in Balclutha.

5. When Dr Gray moved to Balclutha, he and his family occupied a house near to the A family. The two families became friendly. At the time Mrs A was consulting another practitioner in Balclutha. In 1994 Mrs A had suffered from depression and for much of 1995 was prescribed antidepressant medication. In 1996 she started to experience excruciatingly painful headaches and pain on the right hand side of her face. This pain significantly affected her ability to function at work and at home.

6. In October 1996 Mrs A had a wisdom tooth extracted. At the time, and while still recovering from the wisdom tooth extraction, Dr Gray informally suggested that she may be suffering from trigeminal neuralgia. As the sedative given at the time of the tooth extraction wore off, Mrs A suffered a lot of pain and became distressed. She asked Dr Gray for some pain relief and he administered an injection of pethidine.

7. On 12 October 1996, and impressed by the care Dr Gray had given her, Mrs A asked Dr Gray if she could transfer her own and her family's records to him and consult him as their general practitioner. Dr Gray agreed. He referred Mrs A to Balclutha Hospital for a series of tests to try to ascertain the source of her pain. Initially Mrs A was told that she may have a brain tumour, then an alternative diagnosis of multiple sclerosis was made. That diagnosis has never been confirmed.

8. Dr Gray took over responsibility for the medical care of the family and Mr and Mrs A and their children consulted him regularly. Mrs A was prescribed Tegretol, a medication which requires regular blood tests. Mrs A also continued to consult Dr Gray for headaches, hayfever, cervical smears and certain other health problems.

9. Throughout the period from November 1996 to mid-1997 Mrs A was unwell and very unhappy in her personal life. She told the Tribunal that she confided in Dr Gray in relation to various personal and health issues. In mid-1997 Mrs A sought counselling of her own initiative.

10. It was Mrs A's evidence that she had been raped by an acquaintance when she was 17. She had not reported the rape to the police at the time but since that time she had suffered 'flashbacks' and also difficulties in her sexual relationship with her husband. Mrs A's

evidence was that Dr Gray was aware of the counselling and the reasons for it. Dr Gray denied that Mrs A had told him about the reasons for the counselling.

11. In November 1997 Dr Gray and Mrs A commenced their sexual relationship. They gave conflicting accounts as to how the relationship began and who instigated it. However both agreed that the relationship was consensual. Throughout the period of the relationship Mrs A and her family continued to consult Dr Gray as their family doctor. At no time did Dr Gray suggest that either Mrs A or her husband or their children should transfer their care to any of the other practitioners available in Balclutha at the time.

12. Both Dr Gray and Mrs A agreed that there was no sexual intercourse between them during any clinical consultation. However, Mrs A gave evidence that there was physical contact of a sexual nature between them in the course of at least two consultations and on one occasion they had engaged in 'phone sex' while Dr Gray was at the surgery. Dr Gray denied both of those allegations.

13. Prior to the commencement of their sexual relationship both Dr Gray and Mrs A had strong religious affiliations. Mrs A was a member of the local xx congregation, but when the sexual relationship commenced she stopped and distanced herself from her faith. Dr Gray and his wife were both members of the local Anglican Church.

14. By the time the sexual relationship ended in February 1998, Mr A was also very depressed. His father had recently died and his marriage appeared to have broken down completely. He also had a troubled past having suffered physical and sexual abuse as a child. In the course of his consultations with Dr Gray, Mr A told Dr Gray that he was sure that his wife was sleeping with someone else. Dr Gray assured him that would not be the case and referred him to counselling.

15. There was some delay between that referral and the commencement of the counselling from a psychologist in Balclutha. During this period of around 6-8 weeks Dr Gray counselled Mr A and prescribed him the anti-depressive medication, Prozac.

16. By May 1998 Mr and Mrs A had decided to separate. Mrs A told her husband about her affair with Dr Gray. Mr A was devastated by this news and shortly thereafter told Mrs Gray about the relationship. Dr Gray and Mrs Gray visited Mrs A at her home. There was an altercation between Mrs Gray and Mrs A which was witnessed by Mrs A's children and the police were called.

17. In July 1998 Mr A made a complaint to the Health and Disability Commissioner but later withdrew his complaint. Mrs A made her complaint to the Commissioner in November 1999.

**Evidence for the Director of Proceedings**

18. Evidence for the Director was given by Mr and Mrs A and Mrs B, a friend of Mrs A during the time she lived in xx.

**Evidence for Dr Gray**

19. Evidence for Dr Gray was given by Dr and Mrs Gray; Dr James W B Walshe, a registered medical practitioner and psychiatrist of Christchurch; Mrs A M Miller, a practice nurse of Balclutha; Mrs P M Stevenson; Dr R F Henderson a general practitioner of Invercargill; Dr Peter Geddes, general practitioner of Balclutha; and Dr P J Farry, general practitioner of Queenstown. Dr Farry's statement of evidence was admitted by consent.

**The Law**

20. Dr Gray was charged with disgraceful conduct in a professional respect, the most serious of the range of professional disciplinary findings available to the Tribunal. In opening the case for the Director, Mr McClelland referred to a number of decisions from courts in New Zealand, Australia and the United Kingdom. Most recently, this Tribunal has considered whether or not certain conduct may be characterised as "disgraceful" in the context of the 1995 Act in the Parry case (Decision No. 139/00/62D).

21. The Tribunal's decision on that issue has been upheld on appeal (*Parry v Medical Practitioners Disciplinary Tribunal* NP4412/00, DC Auckland, 30/5/01, Judge Hubble)

but that latter decision is itself currently under appeal to the High Court. However, the decision in the Parry 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 and that case therefore involved very different considerations to those present in this case.

22. The Tribunal therefore approached its consideration of the legal issues present in this case by reference to those cases involving sexual misconduct referred to by the Director, and to the Medical Council's Statement entitled "Sexual Abuse In the Doctor/Patient Relationship – Statement For the Profession" which came into effect on 16 June 1994, and which was in effect at the time of the events giving rise to this charge.

23. A decision on which Mr McClelland placed a good deal of reliance is that of *Brake v Preliminary Proceedings Committee* [1997] 1 NZLR 71. In that case, the High Court (Tompkins, Cartwright and Williams JJ) held:

*"The test for "disgraceful conduct in a professional respect" was said by the Court of Appeal in Allison v General Council of Medical Eduction 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 constitute 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 that 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."*

24. 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 number 69/98/36C, and in *Parry* (supra).

25. 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.

26. That principal purpose of the Act is of course consistent with the underlying purpose of the Medical Council's policy on sexual abuse in the context of the professional relationship. As was said in *Brake*, 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.

27. The Medical Council's statement for the profession is expressed in terms of 'zero tolerance'. It states:

*"Sexual behaviour in a professional context is abusive. Sexual behaviour comprises any words or actions designed or intended to arouse or gratify sexual desires…*

*Council condemns all forms of sexual abuse in the doctor/patient relationship for the following reasons:*

- *The ethical doctor/patient relationship depends upon the doctor creating an environment of mutual respect and trust in which the patient can have confidence and safety.*

- *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. It is not acceptable to blame the patient for the sexual misconduct.*

- *The doctor is in 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.*

- *The doctor/patient relationship is not equal. In seeking assistance, guidance and treatment, the patient is vulnerable. Exploitation of the patient is therefore an abuse of power and patient consent cannot be a defence in disciplinary hearings of sexual abuse.*

- *Sexual involvement with a patient impairs clinical judgement in the medical management of that patient.*

*Council will not tolerate sexual activity with a current patient by a doctor.*

***The guiding principle is that there is no exploitation of the patient or their immediate family members.***

*The Council rejects the view that changing social standards require a less stringent approach. The professional doctor/patient relationship must be one of absolute confidence and trust. It transcends other social values and only the highest standard is acceptable.*

*The Medical Council believes the issue of the power differential between patient and doctor means that consent of the patient is not a defence in disciplinary findings of sexual abuse. It may become an issue in consideration of penalty. Each case must be examined in relation to the degree of dependency between patient and doctor and the duration and nature of the professional relationship.*

*DEFINITIONS*

*For the purposes of disciplinary action, the Council has defined sexual abuse under three categories:*

*sexual impropriety*

*sexual transgression*

*sexual violation*

…

***Sexual violation*** *means doctor/patient sexual activity, whether or not initiated by the patient. Recent disciplinary cases have included such examples as:*

*masturbation or clitoral stimulation*

*other forms of genital or other sexual connection."*

28. These principles have been reaffirmed in a further Medical Council document dated July 2000 entitled "*Trust in the Doctor/Patient Relationship*".

29. Mr McClelland also referred the Tribunal to the statement in *Brake* (at p78) in which the Court stated, in the context of a doctor entering into a sexual relationship with a patient:

*"The medical profession has for long recognised that any sexual behaviour between a doctor and a patient while a doctor/patient relationship is in existence is completely unacceptable. In a discussion document the Medical Council issued in 1992 it adopted 'the principle of zero tolerance with respect to a doctor who engages in sexual activity with a current patient'.*

*Doctor Robin Briant, the former chair of the Medical Council said in 1994 (Newsletter of the Medical Council, (no 9) March 1994):*

> *'The doctor-patient interaction is for the patient's benefit and there is no place in it for a sexual liaison. It would do immense harm to the quality of doctor-patient interactions generally if it were even suspected that intimate or sexual relationships may evolve from medical consultations. Only when people feel safe in a professional relationship can they entrust it with their most private, emotional, psychological and physical secrets'.*

*She went on to say that 'there is nothing new about medical council policy on sexual abuse in the doctor/patient relationship; Hippocrates said it all long ago (500 BC) and much more succinctly: 'into whatever houses I enter, I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief or corruption; and further, from seduction of females or males or free men or slaves'.'*

*In June 1994 – well after the events to which this appeal relates – the Council issued a statement for the profession on sexual abuse in the doctor/patient relationship. The statement confirms that the doctor must ensure that every interaction with a patient is conducted in a sensitive and appropriate manner with full information and consent, and that the council condemns all forms of sexual abuse in the doctor/patient relationship for reasons set out in the statement. It points out that the onus is on the doctor to behave in a professional manner, that total integrity of doctors is the proper expectation of the community and of the profession, that the doctor is in a privileged position which may increase the risk of boundaries being broken, that sexual misconduct by a doctor risks causing psychological damage, and that the doctor/patient relationship is not equal – in seeking assistance, guidance and treatment, the patient is vulnerable.*

*Although this 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 has 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."*

30. Mr McClelland also referred to two decisions of the Privy Council (on appeal from the Professional Conduct Committee of the GMC). In one of which, *de Gregory v General Medical Council* [1961] AC 957, 965-966, Lord Denning, on behalf of the Judicial Committee, addressed the question of the impropriety of sexual relations between a medical practitioner and a patient or former patient. Lord Denning stated:

> *"A doctor gains entry to the home in the trust that he will take care of the physical and mental health of the family. He must not abuse his professional position so as, by act of words, to impair in the least the confidence and security which should subsist between husband and wife. His association with the wife becomes improper when by look, touch or gesture he shows undue affection for her, when he seeks opportunities of meeting her alone, or does anything else to show that he thinks more of her than he should. Even if she sets her cap at him, he must in no way respond or encourage her. If she seeks opportunities of meeting him, which are not necessary for professional reasons, he must be on his guard. He must shun any association with her altogether rather than let it become improper. He must be above suspicion.*
>
> *It was suggested that a doctor, who started as the family doctor, might be in a different position when he became a family friend; his conduct on social occasions was to be regarded differently from his conduct on professional occasions. There must, it was said, be cogent evidence to show that he abused his professional position; it was not enough to show that he abused his social friendship. This looks very like a suggestion that he might do in the drawing room that which he might not do in the surgery. No such distinction can be permitted. A medical man who gains the entry into the family confidence by virtue of his professional position must maintain the same high standard when he becomes the family friend."*

31. In a more recent case from Australia, *Re A Medical Practitioner* [1995] 2 Qd R154 the Court held:

> *"The complainant became a patient of the respondent, a general practitioner, in 1989 when she presented with gynaecological problems. In 1990 the complainant underwent a hysterectomy performed by the respondent. The complainant's and respondent's accounts of the relationship that developed between them were wildly different. Dowsett J found that in early 1991 the pair commenced regularly to take bush walks together; that in the course of those walks it became evident to the respondent that the complainant was romantically interested in him, and he subsequently reciprocated that interest. His Honour found that in July 1991, the respondent and complainant travelled to Byron Bay, where they stayed for a night, and where sexual intercourse occurred. However, after the visit to Byron Bay, His Honour found that the respondent became remorseful and sought to terminate the relationship.*

*The respondent submitted that one act of intercourse could not constitute a relationship for the purpose of charges of professional misconduct. However, Dowsett J noted that "sexual relationship" has a wider meaning than simply sexual intercourse. Rather, it is descriptive of the totality of the relationship between two people, which relationship has some sexual aspect. The expression is commonly used to describe all of the incidents of intimacy between a man and a woman which lead up to and follow their consummating that relationship by intercourse. Such incidents may include social outings and the exchange of gifts.*

*His Honour referred to various authorities, and identified a number of themes which he said ran through the traditional approach to misconduct of this kind by medical practitioners. He listed those themes at pp. 163-164:*

*1. The practice of medicine involves intimate access to the body and psyche of the patient.*

*2. Such practice may also involve access to the patient's home.*

*3. A medical practitioner is therefore in a position of special trust toward and power over a patient.*

*4. The need for medical care and the sympathetic way in which such care is likely to be provided render the recipient at risk of becoming emotionally involved with and/or dependent upon the provider.*

*…*

*6. A medical practitioner must be aware of these risks and ensure that his or her conduct does not aggravate the position, that no advantage is taken of any such susceptibility, and that there is no abuse of the practitioner's special position.*

*7. A medical practitioner who becomes aware that a patient has developed a romantic attachment to him or her must take steps to sever the attachment. Normally, the doctor and patient relationship should be terminated.*

*8. A medical practitioner who becomes romantically attached to a patient should realise that his or her own objectivity and capacity to provide appropriate treatment have been impaired and terminate the doctor and patient relationship.*

*…*

*11. It is professional misconduct to engage in acts of intimacy with a patient whilst the doctor and patient relationship continues.*

> 12. *It is professional misconduct to exploit a discontinued professional relationship. Thus a medical practitioner should only commence or continue an association with a former patient if there can be no suggestion that he or she is exploiting a dependency created in the course of the professional relationship.*
>
> 13. *From the point of view of the profession as a whole and from the public viewpoint, it is as important that the appearance of propriety be maintained in each doctor and patient relationship as that such propriety actually exist. Thus it will be professional misconduct for a medical practitioner to permit the appearance of a romantic relationship with a patient or to lead a patient to believe that he or she has an interest in establishing such a relationship.*
>
> 14. *As with all misconduct, individual examples may vary in severity. the more serious the misconduct, the more likely it will be that the interests of the public will dictate removal from the register. It cannot be said that every case of misconduct of this kind will dictate such removal.*
>
> 15. *The gravamen of this misconduct is breach of trust, misuse of power and exploitation of vulnerability. Sexual misconduct is only an example of such misconduct."*

**Submissions on behalf of Dr Gray**

32. For his part, Mr Waalkens, on behalf of Dr Gray, accepted that Dr Gray's conduct in engaging in a sexual relationship with Mrs A while she was his patient was conduct warranting an adverse disciplinary finding. However, while he accepted that it was for the Tribunal alone to determine which of the categories of professional disciplinary offending Dr Gray's conduct falls into, it was his submission that for a number of reasons, Dr Gray's conduct could more accurately be categorised as professional misconduct, rather than disgraceful conduct as charged.

33. Mr Waalkens referred to the New Zealand case of *Haye v Psychologist Board* [1998] 1 NZLR 591. Mr Waalkens' point was that notwithstanding that Dr Haye had originally been found guilty of professional misconduct and conduct unbecoming, rather than disgraceful conduct, "professional misconduct" was a finding that nevertheless had grave consequences for a professional person. In that case the court noted that the threshold of

professional misconduct has often been illustrated by reference to such words as "reprehensible", "inexcusable", "disgraceful", "deplorable" or "dishonourable". The Court (Chisholm J) held that "*while conduct unbecoming indicates a less serious level of conduct, even then the conduct needs to be sufficiently serious to justify such a finding*".

34. However, the Tribunal records that the statutory regime applying in *Haye* provided that there were only two levels of professional disciplinary offence – professional misconduct and conduct unbecoming. In the context of the psychologists professional practice it was (and still is) not possible to bring a charge of disgraceful conduct against a psychologist; professional misconduct was the most serious of the charges available, and the epithets applied by way of descriptive analogy must be considered in that context.

35. Mr Waalkens did not suggest that Dr Gray's conduct fell into the lowest category of professional disciplinary offence – conduct unbecoming – however he submitted, it was most accurately characterised as "professional misconduct".

36. The factors which Mr Waalkens relied upon in support of this submission were as follows:

(a) The Medical Council's policy is a guideline only. The policy itself makes it very plain that the Tribunal must look at the facts of each case to determine how it assesses the level of offending;

(b) The Tribunal must look at the facts of the case and analyse the facts against the various assumptions and assertions made in the Medical Council's statement;

(c) The *Brake* case was a very different case. In that case, Mr Waalkens submitted, Dr Brake was counselling and treating the patient concerned for a very serious psychiatric illness, he had prescribed benzodiazapines and the patient evidently had some kind of dependency develop in that regard. The patient was exceptionally vulnerable and no indication of any vulnerability on the part of Dr Brake, which, in Mr Waalkens' submission made the *Brake* case "*so different from the run of the*

*mill doctor/patient sexual relationship that sadly this Tribunal has to deal with*";

(d) Mr Waalkens referred to the District Court's decision in *Parry* (supra) in which the District Court discussed the appropriate test for disgraceful conduct. The Court's findings in that case, Mr Waalkens submitted, "*…meant, and is plainly intended to mean, that disgraceful conduct requires a degree of seriousness such that it has to be an indifference to the consequences of the Act – that type of categorisation. It is for this reason that its not enough to look at the actions that have occurred; the Tribunal must make some assessment of the culpability of the doctor. That is why Dr Gray's vulnerability has largely gone unchallenged and it is what puts this case in a different category to the ordinary case of a doctor having sex with a patient*".

(e) It was not reasonable in this case for the Tribunal to assume that Dr Gray was in a position of dominance or that his position was overpowering in relation to Mrs A. Mrs A "*has a good deal of responsibility in this case and it would be entirely wrong for the Tribunal to dump all this responsibility on Dr Gray and the unusual circumstances of this case and say he is to be labelled with a finding of disgraceful conduct, a finding of professional misconduct would be grave enough for him*";

37. Mr Waalkens submitted that factors in favour of finding Dr Gray guilty of a lessor offence than that charged were, first, the consensual nature of the relationship. Two factors to take into consideration in this context were that there were no predatory actions on the part of this doctor and the contested issue of who was the instigator of the relationship.

38. Secondly, Dr Gray's own vulnerability. On the evidence presented to the Tribunal, Mr Waalkens suggested, there could be no challenge that Dr Gray was emotionally and physically frail at the relevant times. That was a vital factor for the Tribunal in grading the culpability on the part of this doctor. It deflates the power imbalance that is the undercurrent of the Medical Council's policies. There was plenty of evidence of Dr Gray's vulnerability.

39. Thirdly, the issue of rural doctors which was the subject of Dr Henderson's evidence, and an environment ripe for the breakdown suffered by Dr Gray in 1996 including "*those ghastly Roxburgh years and the stress that that caused*".

40. Fourthly, the fact that Dr Gray had been receiving care from psychiatrists in the period that pre-dated his relationship with Mrs A.

41. Fifthly, Dr Walshe's evidence that Dr Gray suffered a major mood disorder and that he was clinically depressed.

42. Sixthly, Dr Farry's evidence that, although Dr Gray was not a friend, he saw quite a bit of him over the 1996/97 period and, in his view, Dr Gray had the signs and symptoms of someone suffering from a post-traumatic stress disorder.

43. Mr Waalkens also referred to a large number of references and correspondence submitted from patients and members of the local community in support of Dr Gray. He submitted that the underlying impression from all of this material is that, given the circumstances of this case, a finding of disgraceful conduct would be out of touch with what the public's view was.

44. Mr Waalkens refuted the Director's submissions as to any particular vulnerability on the part of Mrs A. Mr Waalkens' submission was that the Tribunal must bear in mind how Mrs A presented to Dr Gray.

**The Standard of Proof**

45. The standard of proof in professional disciplinary proceedings is the civil standard, the balance of probabilities. The standard of proof will vary according to the gravity of the allegations founding the charge and the standard of proof may vary within a single case, particularly in a case such as this where the practitioner is defending a charge brought at the most serious level of professional disciplinary offences and where the credibility of the principal witnesses is an issue and much of the evidence is contested.

46. All elements of the 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.

47. This so called "sliding scale of probability" has recently been confirmed by the District Court in *Chan v Complaints Assessment Committee* (NP1638/01, DC Auckland, 8/8/01, Judge Doogue) a case on appeal from this Tribunal.

**The Burden of Proof**

48. The burden of proof is borne by the Director of Proceedings.

**The Decision**

49. The Tribunal has carefully considered all of the evidence presented to it (documentary and oral), and counsels' very helpful and extensive submissions. It has also had the opportunity to assess the credibility of each of the key witnesses, in particular Dr Gray and Mrs A. For the reasons set out below, the Tribunal is satisfied that Dr Gray is guilty of disgraceful conduct in a professional respect in terms of section 109(1)(a) of the Act.

**Reasons for Decision**

50. As stated above, Dr Gray did not deny the fact of his engaging in a sexual relationship with Mrs A while she was his patient. On the basis of that admission of the fact giving rise to the charge, the task for the Tribunal was solely to determine the degree of Dr Gray's culpability in terms of the range of professional disciplinary offences provided for in the Act. That is, to determine which category of professional disciplinary offence most fairly characterises Dr Gray's conduct.

**The Council's policy**

51. As stated in *Brake* (supra), the test for disgraceful conduct which is applicable in this case is relatively straightforward and uncomplicated - Dr Gray's conduct must be judged against the standards of the profession at the relevant time. The Tribunal must be satisfied that the Director has established, to the requisite degree of proof, that Dr Gray's conduct in engaging in a sexual relationship with Mrs A while he was her general practitioner would

be reasonably regarded by his professional brethren as disgraceful and dishonourable; that is, serious misconduct according to the rules of the profession.

52. In *Pillai v Messiter* (No 2) [1989] 16 NSWLR 198, 201, referred to with approval in *Brake* (supra), the Court (per Kirby J) observed that "'*Misconduct' generally means wrongful, improper or unlawful conduct motivated by premeditated or intentional purpose or by obstinate indifference to the consequences of one's acts.*" For conduct to be disgraceful, "*it must be considered significantly more culpable than professional misconduct…*" (*Brake*, at p.77).

53. In this regard it is relevant that in *Bottrill v A* (unreported CA 75/00, 13/6/01) and in the context of determining whether exemplary damages may be awarded only where the negligent conduct is reckless or deliberate and not merely inadvertent, Their Honours (Richardson, Gault, Blanchard JJ) commented that "*while the judicial epithets often used to describe conduct qualifying for an award of exemplary damages are not determinative of the scope of the remedy, they do give a flavour of the misconduct that is required*".

54. The Tribunal considers that is equally the case in relation to a charge of "*disgraceful conduct in a professional respect*". Even without resorting to the use of epithets, the words of the charge themselves 'do give a flavour of the misconduct that is required'. That is especially the case when the words of the charge are considered against the background of the Council's Statement, and the principal purpose of the Act.

55. The 'assessment of degree' in terms of the three levels of misconduct referred to in the Act, and in terms of the reasonableness of the standards applied, is ultimately a matter for this Tribunal; *B v Medical Council* (unreported) High Court, Auckland, 11/96, 87/97.

56. In assessing the degree of Dr Gray's culpability against this legal framework, the starting point for the Tribunal's deliberations was the Medical Council's Statement. This statement of the professional standards which are applicable in the circumstances of this case was circulated to all practitioners in June 1994 and was current at the time of the events giving rise to the charge. Dr Gray conceded that he was aware of the Medical Council's policy

on doctor/patient relationships when he entered into his relationship with Mrs A, and he was aware of the seriousness of his misconduct.

57. In his defence, Dr Gray told the Tribunal that he was mentally and physically weakened by the events of the previous few years and he was unable to resist Mrs A's advances to him. His evidence was supported by Dr Walshe's evidence that, in his opinion, Dr Gray's ability to resist Mrs A's advances was affected by an intermittent "*unstable or mixed mood disorder*" from which he had suffered since his teens as well as recurrent depressive episodes of some duration which he had suffered from for many years. The latter, Dr Walshe suggested, was a condition that had not been properly recognised and never adequately treated. This mood disorder is characterised, in its depressive phases, by a desperate "*need for gratification*" that, from time to time, overwhelms commonsense when spirits are low.

58. However, the Council's policy on doctor/patient sexual relationships is expressed in unequivocal terms. All sexual behaviour in a professional context is abusive. The onus is on the doctor to behave in a professional manner and it is not acceptable to blame the patient for sexual misconduct.

59. In terms of the Medical Council's categorisation of sexual abuse, Dr Gray's sexual relationship with Mrs A falls into the most serious of the three categories; sexual violation. "*Sexual violation*" is defined in the Statement as *"doctor/patient sexual activity whether or not initiated by the patient*".

60. The Tribunal accepts entirely Mr Waalkens' submission that each case must be considered on its own facts. However both the relevant cases cited to it, and the Council's Statement make it quite clear that a doctor's decision to embark upon a sexual relationship with a patient cannot be characterised as anything other than the most serious breach of trust.

61. The reasons for such a policy are fundamental. The ethical doctor/patient relationship depends upon the doctor creating an environment of respect and trust in which the patient can have confidence and safety. In the context of the relevant statutory regime, the primary purpose of which is stated to be to ensure the health and safety of members of the

public generally, not just specific patients, it appears to this Tribunal that it must approach its task on the basis that misconduct of the kind alleged in this case constitutes the most serious breach of fundamental professional obligations. On that basis, it may properly be categorised as disgraceful conduct unless there is evidence presented to the Tribunal which would make an adverse finding at that level unfair or unreasonable.

62. The Tribunal is of the view that there are several factors which might be persuasive in terms of finding a practitioner guilty of a lesser charge. For example, it may be the case that both the doctor and the patient are single persons of similar age, background and interests; and that the doctor/patient relationship was transitory and did not involve any personal or intimate touching or disclosures, and that the doctor/patient relationship was either not resumed if transitory or was terminated immediately the doctor and the patient became aware that either or both of them wished to pursue a personal relationship outside of the doctor/patient encounter.

63. In contrast, the Director submitted that in this case there were a number of aggravating factors present. These included:

- The fact that Mrs A had previously suffered and been treated for at least a year for depression;

- Dr Gray's care of Mrs A involved a high degree of intimate and personal disclosure on her part, including attendance for a cervical smear examination;

- Mrs A was possibly suffering from serious physical illness (multiple sclerosis, anorexia). In short, she was under stress, unwell and unhappy, and therefore exceptionally vulnerable;

- Dr Gray knew, or ought to have known, that Mrs A had sought counselling for the rape she had suffered as a young woman;

- The sexual relationship impaired Dr Gray's clinical management and judgement such that Mrs A did not receive the medical care and treatment she needed;

- Personal comments made by Dr Gray to Mrs A in the context of the sexual relationship dissuaded her from undergoing any further cervical smear examinations, which were required as a result of her medical history in that regard;

- The fact that Dr Gray was the A's family physician, exacerbated by the fact that Mr A sought Dr Gray's care and counselling in relation to the breakdown of the marriage and the disintegration of the family unit; and

- The consequences for Mrs A's children as a result of their witnessing the altercation with Mrs Gray, which altercation appears to have occurred solely as a result of Dr Gray's denial of his affair with Mrs A.

**The Tribunal's finding in relation to these factors**

64. The Tribunal considers that even if not truly 'aggravating factors' as alleged, these factors are nevertheless highly relevant. They are matters which Dr Gray was or should have been aware of. They are certainly illustrative of the reasons underlying a) the Statement and b), its terms. The Tribunal finds it impossible to avoid a determination that Dr Gray's conduct in embarking upon a sexual relationship with Mrs A notwithstanding the presence of all of these factors, constituted the most fundamental breach of his professional obligations towards her and her family.

**Other findings**

65. Having carefully observed both Mrs A and Dr Gray giving their evidence, and after considering and reconsidering the evidence given by all of the witnesses, lay and professional, in general, the Tribunal prefers the evidence given by Mrs A. It is equally not satisfied that there is anything disclosed in support of Dr Gray that would justify a finding at a lower level of professional disciplinary offence than that charged.

66. The Tribunal is also satisfied that, even if Mrs A did present to Dr Gray as a self confident and independent young woman, her medical records submitted in evidence to the Tribunal suggest otherwise. On this point, it does not accept Dr Gray's evidence that he was unaware of Mrs A's history of depression, her concerns about the possibility that she was

suffering from a serious illness, the fact that she was unhappy in her marriage, and that she had once been raped and, for that reason, sought counselling.

67. In this regard it considers that if it is wrong in that finding then Dr Gray, as Mrs A's general practitioner responsible for her health and wellbeing at the time, should have been aware of these factors, all of which were either documented in her records or, on her evidence (which the Tribunal accepts) she reported to Dr Gray, or could have been ascertained by Dr Gray had he taken an adequate medical and personal history from Mrs A when she became his patient.

68. Given the presence of all of these factors, Dr Gray, who is a very experienced general practitioner, should have been aware of Mrs A's 'clinical picture' and been alert for the signs and symptoms of her depressive illness. As such, the Tribunal is satisfied that Mrs A was vulnerable, and therefore susceptible to abuse and/or exploitation. The potential for disaster should have been plain to Dr Gray.

**Findings in relation to the evidence in support of Dr Gray**

69. The Tribunal does not accept that Dr Gray's failure to conduct his professional relationship with Mrs A appropriately can be adequately explained, for present purposes, by his being in a weakened emotional and/or psychological state.

70. In relation to the issue as to which of Dr Gray or Mrs A instigated the relationship, and the consensual nature of it, the Tribunal accepts that the Council's policy expressly provides that consent on the part of the patient is no excuse and there is no reason, in this case, to depart from the policy. Given the potential for abuse in the context of a relationship that depends for its existence on the patient's ability to trust his or her doctor, the Tribunal does not see how the policy could be expressed or applied otherwise.

71. In relation to the evidence given by Dr Walshe, the Tribunal has determined that it should be treated cautiously. Dr Walshe confirmed that he had met with Dr Gray for approximately 8 to 9 hours, at the request of his counsel. He had not reviewed any of Dr Gray's prior medical history or records, nor had he interviewed Mrs Gray, or anyone involved in providing him with care or treatment, or any other person. Dr Walshe

provided a comprehensive, and sympathetic, psychological profile of Dr Gray. He also described the signs and symptoms of the mood disorder, which Dr Walshe considers accounts for much of what has occurred in Dr Gray's personal and professional life.

72. For example, Dr Walshe gave evidence that the mood disorder manifests itself as depressed mood, sometimes as 'mixed mood', "*but his usual pattern, when he is depleted by his mood disorder, is characterised by an immoderate neediness, loss of resolution, and ebbing fixity of purpose, a wavering of faith, a confusion of imputative longings.*"

73. It was Dr Walshe's conclusion that:

> *"It would seem more than likely, given his long term vulnerability, his history of recurrent major mood disorder and his recent tribulations, manifest depressive depletion and uncompleted treatment by Dr Harvey that he was still clinically depressed (only partially recovered) when he was endeavouring to rebuild a practice in Balclutha in 1997, when he was still being professionally abased, and when he found himself coping with the persistent attentions of Mrs A. There is no way that, without having been there, any of us can know for certain but I suggest the above likelihood of the balance of probabilities.*
>
> *And in those circumstances he would not have been in a position to hold out for long, his defences against the offer of a tender, warming 'love' pathetically we can find mood disorder. This is not offered as an excuse so much as a retrospective elucidation."*

74. Dr Walshe's evidence whilst expressly given by way of explanation rather than excuse, nevertheless attempts to account for each of the incidents of misfortune which have befallen Dr Gray by reference to others. To the extent that this evidence is relevant to the Tribunal's consideration of the charge, it agrees with the submissions made on behalf of the Director that Dr Gray appears unable to accept responsibility for his own actions, he does not accept fault and he blames others when things go awry.

75. It is therefore the Tribunal's conclusion that, despite protestations to the contrary, Dr Gray still lacks insight into the nature and extent of the harm caused to Mr and Mrs A and their family as a result of his failure to fulfil his professional obligations.

76. The Tribunal has also borne in mind the evidence of Dr Henderson regarding the particular problems faced by rural GPs who are frequently isolated from their professional colleagues, and who are often required to provide 24 hour care, 7 days a week to their local community for long periods of time.

77. The Tribunal ultimately does not accept that there could be different standards applied to rural GPs, or indeed any particular class of practitioners. The standards set out in the Council's Statement are adhered to by the vast majority of practitioners, many of whom practice under difficult conditions and in isolation from their peers and other professional support. It is a fact of life that all practitioners face pressures of one sort or another in contemporary medical practice.

78. Such pressures have risks for doctors and patients alike. But the quality of the doctor/patient relationship, involving as it does a degree of intimacy and personal disclosure that is unique in terms of professional relationships, requires that certain standards of care and conduct must be explicit, certain and unequivocal. Any suggestion that standards may vary according to geography or from practice to practice would undermine public confidence in the medical profession. In such circumstances, the health and safety of members of the public would be placed in jeopardy.

79. Finally, there were many letters of support and other evidence in the nature of character evidence presented to the Tribunal on behalf of Dr Gray at the hearing. This material was submitted in part as evidence that the community may take a different view of Dr Gray's offending to that contained in the Council's policy. The Tribunal rejects the submissions made in this regard. As stated above, the Medical Council's Statement expressly rejects the view that changing social standards may require a less stringent approach. The policy provides:

*"The professional doctor/patient relationship must be one of absolute confidence and trust. It transcends other social values and only the higher standard is acceptable".*

80. The Tribunal is not persuaded on the basis of any of the evidence presented at the hearing that it would be unfair or unreasonable to depart from that standard in the circumstances of this charge.

**Conclusion**

81. The Tribunal has concluded therefore that the submissions made on behalf of Dr Gray to the effect that it ought to find him guilty of professional misconduct rather than disgraceful conduct relate to matters which more appropriately go to mitigation therefore ought to be taken into account when the Tribunal turns to determine penalty; they are not factors which are sufficiently exculpatory in terms of the level of charge in all the circumstances of this case. It also accepts the Director's submissions that much of the evidence is 'after the fact', and therefore irrelevant for the purposes of determining the charge before it.

82. The Tribunal has carefully considered and reconsidered all of the material and evidence submitted in Dr Gray's defence but it has ultimately decided that the many references and other material submitted should be put to one side for present purposes. That material may of course be resubmitted for consideration when the Tribunal considers the penalty which ought to be imposed on Dr Gray.

83. The Tribunal's decision is unanimous.

84. Finally, the Tribunal wishes to record that, while the focus of this charge was on Dr Gray's sexual relationship with Mrs A, it considers that his conduct generally towards Mr A and the A family was appalling. Notwithstanding that Mr and Mrs A are separated, Mr A drove from xx to Dunedin to give evidence at the hearing (a journey of some two days duration each way).

85. At the time he was seeking counselling and support from Dr Gray, as his general practitioner, he was completely unaware of the true nature of Dr Gray's relationship with his wife, and thus the true nature of his involvement with his family.

86. Mr A had every justification for making a complaint about Dr Gray's professional conduct to the Health and Disability Commissioner. The possibility that he was subsequently persuaded, subtly or otherwise, to withdraw his complaint, if true, would be reprehensible.

**Orders**

87. The Tribunal orders as follows:

(1) the charge laid against Dr Gray is established and Dr Gray is guilty of disgraceful conduct in a professional respect;

(2) the names of the complainant and the complainant's witnesses together with any identifying details are not to be disclosed;

(3) the Director is to lodge submissions as to penalty not later than 10 working days after the receipt of this decision;

(4) submissions as to penalty on behalf of Dr Gray are to be lodged not later than 10 working days thereafter.

**DATED** at Wellington this 29th day of August 2001

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W N Brandon

Chair

Medical Practitioners Disciplinary Tribunal